

UNIVERSITY OF
WESTMINSTER[⌘]

What does successful social prescribing
look like?

Mapping meaningful outcomes

Dr Marie Polley
Dr Jayne Whiteside
Sonya Elnaschie
Dr Alison Fixsen
February 2020



Acknowledgements

This work was funded by the National Lottery Community Fund and we are grateful to all the stakeholders that participated in this research. We are also grateful to Dr Karen Pilkington, Dr Marcello Bertotti and Dr Richard Kimberlee for their contribution to the initial documentation of outcomes and to Dr Helen Seers for her contribution to proofread the document.

Disclaimer

The views expressed in this report are those of the authors and do not necessarily represent those of the National Lottery Community Fund

How to cite this report

Polley M, Whitehouse J, Elnaschie S and Fixsen A (2019) What does successful social prescribing look like – mapping meaningful outcomes, London, University of Westminster.

Main Contact:

Dr Marie Polley,
M.Polley01@outlook.com

“People often going to their GP, for example, because they’re trusted, and the sorts of issues which unresolved legal problems can then manifest particularly in things like stress, but also in physical illness, mean that we saw that a large proportion of health service time is being devoted to, not even dealing with these problems, just encountering these problems.”

(Legal Advisor)

“We’ve tried to harness this whole person approach, but also the people taking more control of their own situation and the community taking more control, maybe presented as taking more responsibility or maybe taking more control, whichever side of the political spectrum you’re on, but most people agree that’s a good thing.”

(Social Prescribing Service Manager)

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Executive Summary

This study aimed to investigate and collate all the outcomes that are being experienced in link worker based social prescribing schemes.

We found this reflects a large evidence gap where research money needs to be invested. Data from this study highlighted that VCSE organisations engaged with social prescribing are not receiving full attribution for their contribution to improving the health and wellbeing of people. Within the literature, there are a range of reports and research articles that support the use of community organisations and services. Little of this knowledge or impact, however, is contextualised within the terms of link worker based social prescribing schemes.

Phase 1 identified outcomes that were already present in social prescribing literature up to March 2018, searching Medline, PubMed, Cochrane Library, Google Scholar, and reference lists for relevant studies published in peer-reviewed journals. A table of outcomes (Table 1) was constructed with 67 individual reported outcomes organised in 6 categories (general, physical, psychological, welfare, spiritual and social).

- Of the 67 individual outcomes reported in literature, only 60% of them were being measured. The rest were reported as qualitative data.

Phase 2 took Table 1 to stakeholders outside of the medical sector to capture their experiences of social prescribing link worker schemes and the outcomes they experienced. A large focus was understanding what outcomes were important for the VCSE sector.

Sixteen interviews and 2 focus groups were conducted consulting 31 people in organisations including voluntary and community groups, large and small charities, social enterprises, social care, community pharmacy, ambulance service, housing organisations, legal support and welfare advice (Table 2). Stakeholders supported a wide range of long term conditions as well as complex social care and welfare needs.

99 individual outcomes were identified cumulatively in Phase 1 and Phase 2. Of these,

- 23% (23/99) were only reported in qualitative social prescribing literature
- 37% (37/99) were not normally reported in social prescribing literature
- **60% (60/99) of outcomes are not routinely measured**

The 99 individual outcomes were then organised into 2 themes (Table 3 & 4).

37 outcomes were associated with wider determinants of health (Table 3, 8 categories). Of these,

- 19% (7/37) were only reported in qualitative social prescribing literature
- 59% (22/37) of outcomes were not previously reported
- **78% (29/37) of outcomes are not routinely reported**

62 outcomes were associated with health (Table 4, 6 categories). Of these,

- 26% (16/62) of outcomes were only qualitatively reported and not measured
- 24% (15/62) of outcomes associated with health were not previously reported
- **50% (31/62) of outcomes associated with health are not normally measured**

A further 14 system-based outcomes were identified,

- 9 outcomes in Phase 1
- 5 outcomes during Phase 2 interviews

To support a shared understanding of evaluation across all sectors involved in social prescribing, particularly the VCSE sector:

- more support and resources explaining the difference between outcomes, outputs and indicators would be beneficial to improve the general knowledge of all stakeholders in social prescribing link worker schemes.
- More support for identifying meaningful outcomes as a measure of social prescribing schemes needs to be provided. A co-production approach with service users and the full range of stakeholders is recommended.
- The inclusion of everyday language instead of technical language where possible.

In light of the findings that 60% of the individual outcomes in this study were not being routinely measured, or had never been captured formally, more discussion and research funding is needed on the following areas:

- The contribution that the measurement of outcomes makes towards ascertaining the full impact of social prescribing.
- Whether outcomes are the only means to gather data or should more community friendly approaches be explored and utilised? For example, the use of realist methods in evaluation and data synthesis¹.
- The inclusion of a broader range of outcomes to capture those relating to the social determinants of health. For example, outcomes relating to crime, legal welfare, and housing which are rarely if at all currently reported.
- The inclusion of spiritual wellbeing outcomes as an accepted contributor to overall wellbeing.
- A review of PROMs and tools used to quantify outcomes, to determine what tools can be recommended for which outcomes and in which populations. Specifically, the identification of tools to capture missing outcomes is urgently needed.
- A review of the NHS Common Outcomes Framework against the outcomes in this research to support its evolution to capture more of the outcomes achieved in social prescribing schemes by VCSE organisations.

¹ Pawson R (2013). *The Science of Evaluation: A Realist Manifesto*. London. SAGE publications Ltd.

To support and develop an acceptable approach to measuring and monitoring social prescribing and therefore understanding the full impact, the following need to be considered:

- Bring together key stakeholders, including service users and decision makers in a range of societal sectors, to review this report and discuss what data is essential from their perspective to determine the full impact of social prescribing.
- To ensure researchers are all aligned in this new paradigm of working, bring together research funding bodies and National Institute of Clinical Excellence to discuss what data needs collecting to address evidence gaps in the research literature and to agree research methods that are acceptable to be used.
- To test the use of a community capitals framework as an underpinning theoretical model for social prescribing. This would enable the interactions between individuals and as well as the individual and community, to be appropriately incorporated into analysis, in line with the multi-sector nature of social prescribing.

Introduction

Personal Health and Wellbeing – changing times

Personal Wellbeing goes beyond traditional health measures- it is about *“how satisfied we are with our lives, our sense that what we do in life is worthwhile, our day to day emotional experiences (happiness and anxiety) and our wider mental wellbeing”*². The World Health Organisation agreed a definition of wellbeing as *‘Well-being exists in two dimensions, subjective and objective. It comprises an individual’s experience of their life as well as a comparison of life circumstances with social norms and values’*³. Life circumstances are broad; they include health, education, work, social relationships, constructed and natural environments, security, civic engagement and governance, home and work-life balance.

The measurement of population wellbeing has been carried out by the UK Office for National Statistics since 2010⁴, while the establishment of What Works Centre for Wellbeing by the government in 2014 was recognition of the growing importance of understanding how different aspects of life and experiences impact on our wellbeing, and the need to gather and use these data to inform future policy.

Wellbeing hasn’t always been seen as an asset or a gateway to social capital, but rather as ‘soft’ and ‘subjective’, and without clout. This thinking stems from an era in healthcare in which health was viewed as an absence of disease (disease being primarily related to a physical organ or system in the body). This model is associated with sickness and illness and a paternalistic doctor-centric approach. This model uses language that places blame on patients for their illness and creates a patient who is a passive recipient, with little to no involvement in decision making relating to their care. Over time this has changed, from a doctor-centred to a patient-centred approach⁵ and more recently to a co-partnership model of health⁶.

Over the past twenty years there has been the growing acceptance of patient-centred care, co-production with patients and a valuing of the patient experience. Evidence now clearly demonstrates associations between positive patient experience, clinical effectiveness and

² <https://whatworkswellbeing.org/about/what-is-wellbeing/>

³ World Health Organisation (2012). Measurement of and target-setting for well-being: an initiative by the WHO Regional Office for Europe. http://www.euro.who.int/__data/assets/pdf_file/0003/180048/E96732.pdf

⁴ <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/personalwellbeingsurveyuserguide>

⁵ Scambler,G (1997) Health and illness behaviour. In Ed Scambler,G: Sociology as Applied to Medicine (4th.Ed). London; W.B.Saunders

⁶ NHS (2019) Universal Personalised Care: Implementing the Comprehensive Model.

there is now a much better understanding of the two-way relationship between health and wellbeing⁷ and the effect of social deprivation on health and wellbeing⁸.

The role and impact of the VCSE sector in health and wellbeing

There is also greater awareness of those within the healthcare sector concerning the value that the voluntary, community and social enterprise sector (VCSE) have to impact health and wellbeing. Citizen engagement in local VCSE organisations has been a longstanding aspect of society in the UK and indeed internationally⁹.

There are many forms of community-based engagement and they can be vital in supporting people with social welfare needs¹⁰, such as debt advice¹¹, housing issues¹², legal advice¹³. This type of local, personal support helps citizens to overcome difficult social welfare problems and promote community inclusion. It also has multidirectional effects on other aspects of life, especially health and wellbeing. These effects can be physical, psychological or even spiritual¹⁴.

The ways in which people engage in the community can vary – it may be involvement as a volunteer, partaking in some type of physical activity, being in the natural environment, getting involved in cultural activities, being creative, spending time with other people who have a shared interest, or combinations of the above. Community engagement can support people to lead an active, healthy life and flourish, adding meaning, connections, social elements and a sense of worth¹⁵.

The Marmot's Fair Society report⁴ brought great attention to the relationship between the social inequalities and health inequalities. For the VCSE sector, those working in this sector

⁷ Howell RT, Kern ML and Lyubormirsky S (2007). Meta-analytically determining the impact of well-being on objective health outcomes. *Health Psychology Review* 1(1) p83-136.

⁸ Marmot, M. (2010) *Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010*. ISBN 9780956487001

⁹ Parsfield M et al (2015). *Community Capital. The Value of Connected Communities*. RSA Action Research Centre, London.

¹⁰ Woodhead C, Khondoker M, Lomas R, Raine R. Impact of co-located welfare advice in healthcare settings: prospective quasi-experimental controlled study. *British Journal of Psychiatry*. 2017;211(6):388-95.

¹¹ Evans G, McAteer M. (2011) Does debt advice pay? A business case for social landlords: The Financial Inclusion Centre p1-91.

¹² Holding E, Blank L, Crowder M, Ferrari E and Goyder E (2019), Exploring the relationship between housing concerns, mental health and wellbeing: a qualitative study of social housing tenants. *Journal of Public Health*. doi: 10.1093/pubmed/fdz076. [Epub ahead of print]

¹³ Holl M, van den Dries L, Wolf JRLM. Interventions to prevent tenant evictions: a systematic review. *Health & Social Care In The Community*. 2016;24(5):532-46.

¹⁴ Weston A, Bull D, Joy I and Bagwell S (2016). *Untapped potential: bridging the voluntary sectors strength to healthcare transformation*. NPC, The Richmond Group of Charities, London.

¹⁵ Steptoe S and Fancourt D (2018). Community group membership and multidimensional subjective well-being in older age. *J Epidemiol Community Health* 72:376-382.

witness the impact of inequalities on a daily basis. For the medical sector, the social inequalities are not traditionally part of the medical curriculum (although there is gradual change occurring). The Marmot's Fair Society report¹⁶ has been crucial in leading the health sector to think differently and arguably underpins the social prescribing movement.

In the last 5 years there have been several concurrent changes that have, or are going to have, an effect on how society values different types of support, particularly support offered by the VCSE organisations. The convergence of all of these areas (set out below) has led to a focus on *patient-based health outcomes* being used to evidence the impact of social prescribing. In reality one could argue that the broader measurement of *wellbeing of citizens*, would be a more comprehensive and inclusive approach to monitoring the impact of social prescribing.

Operating in austerity

Despite growing evidence of benefit from the research studies and organisations themselves, the operating environment for VCSE organisations has been tough, and continues to get tougher, due to the harsh spending cuts brought about by government austerity. Increasingly groups and organisations cannot continue to operate for the benefit of their community without a new sustainable model of funding across the UK.

Concurrent to the financial landscape, the new architecture of social prescribing is being implemented particularly across England as well as in Scotland, Wales and Northern Ireland . Social prescribing seeks to join up the different sectors to support a person with their non-medical needs. From the perspective of Social Networking theory¹⁷, social prescribing is deliberately creating ties or connections between nodes or sectors who have specific knowledge, in order to make this knowledge and expertise flow across the sectors. This is in recognition of the fact that at least 20% of GP consultations are not for a medical situation¹⁸ and these citizens are best supported predominantly by VCSE organisations who are so well placed to provide this tried, tested and established support in the local communities.

¹⁶ Marmot, M. (2010) Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010. ISBN 9780956487001

¹⁷ Valente TW and Pitts SR (2017). An Appraisal of Social Network Theory and Analysis as Applied to Public Health: Challenges and Opportunities. Annual Review of Public Health; 38:103-118

¹⁸ The Low Commission. (2015). The role of advice services in health outcomes: evidence review and mapping study, June 2015

Expectations of evidence

Despite the increasing recognition of the role of VCSE organisations in creating a healthy society, the funding models are yet to be concretised, to ensure the sustainability of this new architecture. For decades community engagement and the VCSE sector has been viewed as ‘nice to have’ or a place to visit if you want to ‘feel good’, or that it is all a bit ‘soft and fluffy’, particularly from the perspective of the medical establishment.

Further to this, has been the expectation from the medical profession that something is only evidenced as worthy and beneficial if there has been a randomised controlled trial (RCT) conducted. In the medical profession RCTs are used to determine the efficacy of pharmaceutical drugs. This is a linear cause and effect model, where one takes a prescription drug and it causes a primary effect – deemed the primary outcome.

A model such as social prescribing is not a linear model, and, arguably subscribes more to systems theory¹⁹ and complexity theory²⁰ in terms of understanding how a person at the centre of social prescribing actually benefits. From a sustainable community perspective, social prescribing is utilising organisations that provides services across many sectors of society. One could, therefore, argue that a community capitals framework would be another appropriate theoretical framework for social prescribing. Simply put, community capital is the “*sum of assets including relationships in a community and the value that accrues from these*”²¹. Different authors organise community capital in different ways^{22,23}, however, Parsfield et al²⁰ describes a direction of flow as:

“Capacity to Connect leading to Social Relationships which produced Benefits.”

The benefits described relate to different types of capitals that support a sustainable community, for example wellbeing, citizenship, capacity building and economic benefits.

This difference in theoretical paradigms is rarely discussed, however, is now the basis for growing discordance in how data is gathered and used to ‘evidence’ the effect or outcomes in social prescribing. If the NHS is moving from a biomedical paradigm to a biopsychosocial paradigm, then the approach to data gathering has to shift accordingly.

Indeed, the word ‘evidence’ has different meanings to different professional sectors, which is troubling at this stage of implementation of a cross-sector model of personalised care. Until

¹⁹ Cabrera D, Colosi L and Lobdell C (2008) Systems thinking. *Evaluation and Program Planning* 31(3): 299–310.

²⁰ Jackson MC (2019) *Critical systems thinking and the management of complexity*. New Jersey: John Wiley & Sons.

²¹ Parsfield M et al (2015). *Community Capital. The Value of Connected Communities*. RSA Action Research Centre, London.

²² Roseland M. *Toward Sustainable Communities Solutions for Citizens and Their Governments - Fourth Edition*. New Society Publishers

²³ Flora, C.B. and J.L. Flora. 2013. *Rural Communities: Legacy and Change*, 4th Edition. Boulder, CO: Westview Press.

every stakeholder around the implementation table is on the same theoretical page, it will be impossible to collect data on outcomes that all stakeholders will deem to be the most appropriate outcomes.

Difficulties in understanding the overall impact of social prescribing exist because:

- i) Schemes have developed from an asset-based position, using whatever resources the ‘champions’ have identified in their geographical area.
- ii) There have also been a range of approaches to determining which group of the population in a geographical region are being identified as suitable for referral into a social prescribing scheme.
- iii) The geographical region could include just a village, or town, or it could be as large as a whole Clinical Commissioning Group or Primary Care Network.
- iv) Stakeholders in different sectors have different requirements to show the investment in social prescribing is having a desired effect

With all these combinations, a much larger range of outcomes needs be taken into consideration than has been documented to date.

What is an outcome?

Just as evidence means something different to different sectors, so does the word ‘outcome’. An outcome is something that is expected to change from the result of an intervention. The first reference to ‘outcome’ was by Donabedian in 1966²⁴. Donabedian argued that quality of medical care could be measured by analysing structure, process and outcome. This approach was specifically related to the physician-patient interaction but *not* to delivery of medical care in the community.

Donabedian also acknowledged that some outcomes are “*concrete and seemingly amenable to measurement*” (death as an example) whilst other outcomes are not clearly defined, therefore implying they are harder to measure or that measurement would produce inaccuracy. These outcomes included patient attitudes, satisfaction levels and social restoration.

Some definitions of outcomes can be much broader, moving into the realm of “*less amenable to quantify*”, for example “*changes, benefits, learning or other effects that happen as a result of a project or organisation’s work*”²⁵. For most, the default setting when referring to outcomes, however, still relates to individuals and to the medical sector.

Whilst Donabedian started the ball rolling with outcomes in medicine, the issue still remains that social prescribing is not carried out in a medical establishment most of the time. Having

²⁴ Donabedian A.(1966) Evaluating the quality of medical care. Milbank Mem Fund Q; 44: 166–206.

²⁵ NCVO <https://knowhow.ncvo.org.uk/organisation/impact/about-impact-and-evaluation/understanding-the-language-1/understanding-the-language>

spent time with a citizen, most link workers are likely to prioritise issues that are often not discrete or easy to quantify. Yet, there is a lot of pressure to identify and quantify changes and outcomes as a result of social prescribing interventions.

This is something that needs thoughtful working through and the question raising – are outcomes the right or only way to measure change in social prescribing services? Could other approaches also be used? Ultimately, social prescribing is about the individual getting the right support in a compassionate way in their time of need. This needs to remain the focus, and the challenge for evaluation is to capture meaningful data.

The growth of patient reported outcome measures

Within the health sector there has been a growing use of Patient Reported Outcome Measures (PROM) in the last 20 years. A PROM is a type of questionnaire that includes a list of items about an aspect of health, which a patient is asked to complete by scoring the severity of each item, without the doctor or healthcare provider being involved. This score is then used to quantify that situation.

PROMs may be used as part of a clinical service to capture the patient perspective and are regularly used in health-based research. This increased use of PROMs has been underpinned by research data showing that clinical outcomes for patients are better when a clinical opinion is combined with data from a PROM²⁶. Whilst PROMs have been instrumental in giving patients a say in their health, they are primarily designed for the health sector and therefore do not normally include outcomes that relate specifically to the wider determinants of health. Some PROMs capture a general picture of quality of life or wellbeing, the latter being a measure that encompasses the non-health aspects of our lives, but these are not detailed.

Evidencing the value of the VCSE sector

Given the need for VCSE organisations to evidence their worth, they have adopted the use of a range of outcome measures that are valued by the health sector in order to gain credibility when reporting impact. Sometimes PROMs are chosen with a clear rationale, sometimes not²⁷. The ‘lift and shift’ effect is highly prominent in social prescribing reporting at the moment. This is where a PROM that has been validated in one situation and context is applied to another context, irrespective of whether the PROM was designed for the new context. More guidance on how to choose a PROM can be found here²⁸.

²⁶ Mead N, Bowers P. Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med* 2000; 51(7): 1087-1110.

²⁷ Rempel ES et al (2017). Preparing the prescription: a review of the aim and measurement of social referral programmes. *BMJ Open* 7:e017734.

²⁸ Polley M and Richards R (2019). A Guide to Selecting Patient Reported Outcome Measures (PROMs) in Social Prescribing, London, University of Westminster. Available at: https://www.london.gov.uk/sites/default/files/a_guide_to_selecting_outcomes_measures_in_social_prescribing_final.pdf

The emphasis continues to be on valuing the impact of social prescribing on health status. It is, however, paramount to ensure all the outcomes that affect health status, including those associated with the wider determinants of health are identified and documented. There is now a potential situation whereby the majority of social prescribing schemes and VCSE organisations do not actually measure all the outcomes that are being experienced by citizens. This is to the immense detriment of VCSE organisations - It is only when the wider outcomes are collected that different sectors (e.g. Department for Work and Pensions, Statutory Sector, or Local Authorities) can robustly describe economic returns on social prescribing investments to individuals, to communities and to the system^{29, 30}.

Co-creating with stakeholders

The involvement of stakeholders in formulating the research and evaluation questions enables the translation of the results into practice. It is imperative that all social prescribing stakeholders are involved in the design of evaluation and research of social prescribing at the earliest stage possible. Recent examples of this co-production approach can be found here^{31,32}.

The introduction of the social prescribing into the GP contract, the development of a common set of measures³³ and the fully reimbursed funding of link workers through Primary Care Networks signals the commitment to universal personalised care from NHS England. Moreover, the recently launched National Academy for Social Prescribing demonstrates the growing appetite to work across sectors to deliver social prescribing. This increases the urgency to understand the full value of VCSE organisations in the social prescribing model. This can only happen when the full gamut of outcomes in social prescribing have been documented.

This report details research carried out over 2 years, collating and discussing actual and potential outcomes of social prescribing interventions. The primary researcher has been involved in social prescribing since 2014 and has founded and co-chaired the Social Prescribing Network since 2016. During this time, it became apparent that what is being measured and therefore quantified is not necessarily mirroring what has so far been experienced by stakeholders and citizens. To understand the impact of social prescribing further research was needed for seemingly 'invisible' outcomes to be documented.

²⁹ Edwards, R., Charles, J and Lloyd-Williams, H. (2013) Public health economics: a systematic review of guidance for the economic evaluation of public health interventions and discussion of key methodological issues, BMC Public Health 2013, 13:1001.

³⁰ Arvidson M, (2013). Valuing the social? The nature and controversies of measuring social return on investment (SROI).

³¹ Swift M. People Powered Primary Care: learning from Halton, Journal of Integrated Care (2017) 25(3) 162-173.

³² ImpactAgewell (2019) An integrated community development approach to improving the health and well-being of older people. Sharing Our Learning. <https://dunhillmedical.org.uk/wp-content/uploads/2020/01/21-01-20-FINAL-IMPACTAgewell-Sharing-Our-Learning-Report.pdf>

³³ NHS England (2019 Social prescribing and community based support summary guide): Annex D

Phase 1– The Starting Point: What outcomes have already been reported in social prescribing literature?

This section explains how we arrived at a starting point of identifying what outcomes were being reported in social prescribing literature such as peer reviewed papers of evaluations, reports and grey literature.

Identifying appropriate literature

Building on a previously curated database of social prescribing literature, we used accepted methods³⁴ to identify and appraise the content of all reports and peer reviewed research on social prescribing between Feb 2017 and March 2018. We searched Medline, PubMed, Cochrane Library, Google Scholar, and reference lists for relevant studies published in peer-reviewed journals. Reports and papers were included if they:

- were in the public domain
- identified as a social prescribing scheme
- contained 3 elements – a referrer, a link worker and an onward referral to the VCSE, or appropriate organisation
- reported primary data about social prescribing

The emphasis on the link worker fits with the dominant model of social prescribing, which is now part of the Social Prescribing Connector schemes³⁵.

Identifying potential outcomes in social prescribing

Identified reports and research publications were screened to see if they fit the inclusion criteria above. Information on each publication was extracted and added to a database. A preliminary categorisation of the extracted data on outcomes was made. This enabled the research team to understand the range of outcomes being reported and whether these outcomes are being quantified or only reported in qualitative accounts.

Organising potential outcomes

All the outcomes we could extract from the literature were grouped into preliminary categories and documented in Table 1. When documenting outcomes, we avoided documenting a direction of change. During an evaluations, it is important to allow outcomes to be capture change irrespective of whether something has improved or deteriorated. We

³⁴ Pilkington K, Loef M, Polley M (2017). Searching for Real-World Effectiveness of Health Care Innovations: Scoping Study of Social Prescribing for Diabetes. *J Med Internet Res.* 19(2):e20. Published 2017 Feb 2. doi:10.2196/jmir.6431

³⁵NHS (2019) Universal Personalised Care: Implementing the Comprehensive Model.

expect that individual projects set an intended direction of change. This study was purely to highlight outcomes per se. We did note the following:

- outcomes measured in the social prescribing literature
- outcomes only reported in qualitative data

Phase 1 – Results

The researchers identified potential 67 outcomes and made a preliminary grouping into 7 categories - see Table 1 below.

Researchers noted that there was a lot of detail under some categories such as physical and psychological outcomes. Some categories such as welfare contained outcomes which were lacking in detail, e.g. housing/ debts/ benefits. Furthermore, researchers identified a category for spiritual wellbeing.

Table 1 was then used as a visual aid during interviews and focus groups in Phase 2

General	Physical	Psychological	Welfare	Spiritual	Social
General wellbeing	Blood Glucose	Anxiety	Volunteering & employed	Sense of purpose	Reduced loneliness
Quality of life	Blood pressure	Depression	Education/ qualifications/ skills	Fulfilling potential	Reduced social isolation
Selfcare	Cholesterol	Self-esteem	Feel well informed	Relaxation	Increased independence
Social adjustment	CVD risk score	Confidence	Ability to access services	Broadening horizons	Increased social identity
Empowerment	Drug use: tobacco	Suicide ideation	Ability to do everyday activities	Enlightened	Builds self-worth
Social connectedness	Aches / pains	Trust	Housing / debts/ benefits	Inspired	Feeling supported & listened to
	BMI weight: waist circumference	Hope for future	Coping with bereavement/ separation	Enjoyment: happiness	Increased self-awareness
	Alcohol	Sense of control	Improved relationships; friendships;		Builds knowledge
	Illegal drug	Anger	Concern about family/carers		Friendship
	Prescription drug	Motivation	Sense of achievement		Connectedness
	Quality of sleep/ less fatigue	Ability to concentrate	Better management/ coping with long term conditions		
	Healthier diet	Personal resilience/ ability to cope	Ability to identify and address problems		
	Physical activity: exercise activation	Positive decision making			
	Stamina	Feeling positive			
		Cheerful			
		Relaxed			
		Absorbed			
		Encouraged			
		Pride in appearance			

Table 1. Social Prescribing Outcomes identified in published research and evaluation reports

Phase 2 – Identifying outcomes
experienced by stakeholders in social
prescribing connector schemes:
Interviews and focus groups

This section details how we used the existing data collated from the social prescribing literature in Phase 1. Stakeholders who worked predominantly outside of the health system and who had experience in social prescribing connector schemes took part in interviews and focus groups. The researchers wanted to understand if there were further outcomes experienced by stakeholders in social prescribing that had not previously been reported.

Recruitment

Suitable stakeholders in Scotland, Wales, England and Northern Ireland were purposively identified to ensure a broad representation of the VCSE sector, local government, welfare services, commissioners as well as link workers and project coordinators working within social prescribing. Stakeholders were invited to take part in either a one-to-one interview or a focus group about outcomes in social prescribing. Respondents were reassured about anonymity and confidentiality and the study was approved by the University of Westminster Research Ethics committee (ETH1718-2331).

A participation information sheet, consent form and list of outcomes was sent to stakeholders in advance of the interview/focus group. All stakeholders signed consent for their interview/focus group to be recorded. Between July 2018 and January 2019, 16 interviews were conducted either face to face or over the telephone. Two focus groups were also conducted resulting in over 22 hours of interviewing.

The first focus group was with a multidisciplinary team of 10 link workers and project managers in Northern Ireland giving insights into rural communities, over 65s and the needs of multiple stakeholders involved in social prescribing. The second focus group took place with 7 link workers and social prescribing coordinators in London giving insights into immigrant needs, high deprivation, individuals in crisis and cancer care.

During the interviews and focus groups, stakeholders were consulted on the following:

- Are there any outcomes (from Table 1) that in their experience appear to be missing?
- An exploration of the language associated with outcomes. Is the language used meaningful? Easily understood? Is the language specific to a certain sector or audience?
- What categories of outcomes are most relevant? Are there any outcomes which feel superfluous?
- Contextual issues around outcomes such as priorities for different stakeholder groups and the issues around measurement of outcomes.

The researchers did not set out a definition of what is considered an outcome, allowing participants to reveal how they perceived outcomes. The interviewers made notes of responses during the interviews and focus groups in addition to recording the interviews.

<p>Link workers/ Social prescribing scheme coordinators:</p> <p>Working with a wide range of clients in areas of high deprivation, inner city and rural areas.</p>
<p>Voluntary, Community, Social Enterprise sector:</p> <p>A range of VCSE organisations including CIC (Community Interest Company), social enterprise and charities and organisations representing the voluntary and community sector. Charities and social prescribing project co-ordinators and link workers working with the following patient groups: Diabetes, Cancer, Dementia, Coronary care, patients with long term health conditions and presenting with comorbidity.</p>
<p>Social care and welfare:</p> <p>Including housing association, work-related organisation, social care and legal advice. Several VCSE organisations also see people with multiple and complex social care and welfare needs.</p>
<p>Commissioners:</p> <p>Including council representatives, policy makers and public health</p>
<p>NHS stakeholders:</p> <p>Including GPs, ambulance service, community pharmacy</p>

Table 2. Representation of stakeholders who were interviewed or took part in focus groups.

Data analysis

The interviews and focus group recordings were listened to several times and were transcribed. Qualitative data was analysed by JW and AF. The responses were coded and categorised and used to enrich and contextualize the findings from the outcomes identified in the literature (Phase 1). Any additional notes made by researchers, or stakeholders during the interviews and focus groups were also analysed. Table 2 was added to if new outcomes were identified from stakeholders or a more detailed understanding of outcomes elucidated, and an area could be expanded (see housing as an example).

The existing data (Phase 1) and new data (Phase 2) was then discussed amongst the research team and the list of outcomes reorganised. The categorisation and codes were checked again for jargon, politicization and anything which may be open to misinterpretation. Once a final list of outcomes was constructed, sense checking with stakeholders was carried out.

Phase 2 Results

This section details the findings of the interviews and focus groups. It first of all describes a general overview of the messages that emerged, highlighting three themes that were interwoven throughout the stakeholder responses. The section then goes on to present and explain the outcomes that were identified in addition to what has already been reported. These outcomes are in three tables (See Tables 3 & 4).

General overview:

Stakeholders first impressions of the list of outcomes currently reported in social prescribing (Table 1) were positive. Having all outcomes in one place was seen as beneficial for several reasons:

- As an opportunity to gauge how one's own service was performing
- To identify outcomes that may not previously have been thought about
- Support the design and commissioning a social prescribing service
- Support discussion during a multidisciplinary meeting or within a primary care network.

Three overarching themes were threaded through all of the research interviews and focus groups:

1. Measurement and monitoring
2. Using a holistic approach
3. Relationship between social prescribing and the community

These themes will be explained and discussed over the following pages.

Theme 1. Measurement and monitoring

Seeing all the outcomes in one table raised concerns about measurement of the outcomes. Would all outcomes need to be measured? This would be impractical especially to organisations that do not have dedicated staff or resources to do this³⁶.

*"There is so much which is good, but I hope we don't have to measure them all!"
(Link worker).*

³⁶ NB by identifying all the social prescribing outcomes, the authors do not advocate measuring them all.

Stakeholders identified some outcomes as useful for triggering or prompting *referral into social prescribing* but wouldn't necessarily see the same outcomes as *markers of success of social prescribing*. Link workers, in particular, reported that their consultations revealed complex and interconnecting issues, thus what emerged as a priority at the end of the consultation (and therefore what will be monitored), might differ from the reason a person was referred.

The above linked in with a point raised by several link workers that it was not always appropriate to push for responses from clients or set KPIs for certain outcomes in particular situations, for example:

"I couldn't even think of advocating a smoking cessation programme with my client when they are dealing with their son being sent to prison" (Link Worker)

Theme 2. Using a holistic approach

The initial outcomes relating to social prescribing (Table 1) were deemed by many stakeholders as somewhat medical. This highlighted the need to ensure that the outcomes also include the wider social determinants of health and are not confined to medical outcomes.

*"I would like to see even more social determinants of health in there."
(Social Prescribing Coordinator).*

"The physical and lifestyle components feel a bit medical. I would really have no understanding of these." (Link Worker).

This was valuable feedback as it offered the opportunity to adjust the balance of outcomes in this section.

Many stakeholders also highlighted that the 'magic' of social prescribing is its focus on the whole persons' wellbeing and it is the cumulative change to psychological, social, welfare and lifestyle elements which make the differences to health outcomes.

“The kinds of issues that people are referred to us are really broad, often it can be about practical support, so if people are struggling financially as a result of their cancer diagnosis. Often people are feeling very low emotionally and can be quite socially isolated, coming to terms with their diagnosis. Then...it might be more about gaining a bit of strength and stamina after treatment and finding physical activities. It might be about connecting to the community.” (Link Worker).

Theme 3. Relationship between social prescribing and the community

This research set out to identify outcomes associated with individuals who experience social prescribing. Many stakeholders discussed the relationship between social prescribing and the community. It was felt that the impact of social prescribing on a community was not reported or valued in the same way as the medical outcomes despite the contribution that social determinants have to overall health.

Sometimes stakeholders identified outcomes at a community level that were already being monitored and sometimes as aspirations and recognition of the wider potential impact of social prescribing. Community impact was identified as having value to the user, the social prescriber and the funder. This is explored further below.

Capacity to connect

It was felt that social prescribing structures that used a link worker were particularly good at supporting a person to improve their capacity to create social connections. This was partly through the 1:1 support a link worker provides and the time afforded to the link worker consultations.

“Very rarely do people get this hour that we’re giving them to describe the problems on their, on their own way, in all their complexity because we tend to just say, we’ll put this bit in that box and this bit in another box and have a whole load of different boxes and the future.” (Social Prescribing Manager)

Stakeholders in England and Scotland identified the need to improve travel options particularly in rural community settings, so people are more able to access what is being offered in the community. Without the investing in the capacity for people to connect to the VCSE, further benefits are unlikely to occur.

“In a rural area like ours....transportation is a major issue in general. So that’s an issue that I would say that social prescribing should be looking to address, that’s a perfect example of an issue that is hard to address by an individual service necessarily, but communities should be thinking about that and find solutions.” (Social Prescribing Commissioner).

Creating connections

The actual creation of human connections was one of the most frequently reported points. This was described in a range of ways including ‘building community networks’, ‘robust and supportive communities’, ‘developing a community circle’, ‘cohesive communities’ and ‘being the glue between the NHS and VCSE’. Connections were often described between individuals and VCSE organisations:

“Some might want luncheon clubs....other people have got leather crafting....archery, it could be anything at all that they like. And you’re trying to find them information about it, and that’s part of our role, to connect them to maybe the groups that they didn’t realise were there, and help them see that there’s more outside on...their local doorstep.” (Social Prescribing Project Officer).

“Quite often [I think] instead... we can redirect to charities that do similar support, like Age UK Take Home & Settle service or British Red Cross that go into people’s homes and do some practical support. For example, parenting courses or trying to help parents become better parents before it all escalates... or autism support or any, where the GP can only think.” (Link Worker)

Creating more connections between existing organisations in the locality was also reported. A change in approach to working collaboratively across the VCSE organisations and other sectors as opposed to competitively was also identified.

“if a healthcare professional or a council or police, or anybody like that, identify somebody in need of isolation or handyperson, or any of those things, they can contact us and we signpost them to a service. “ (Social Prescribing Manger)

Capacity and sustainability

Allowing communities to articulate their own needs and viewing communities as an asset in their own right was reported several times in this study. Not only does this enable a local offer to be created that suits the local residents, but it was envisaged that social prescribing could unlock more capacity to reach people in the community who may not visit a health professional or who would be classed as *'hard to reach'*. This is an example, therefore, of also dealing with the wider social determinants of health at a community based level, especially since some housing association social prescribing schemes also seek to overcome barriers to employment and have high success rates for people who have *"been in the system for years"*. This was also linked to deprivation status, which was identified as missing as a measurable outcome by VCSE stakeholders. Finally, the idea of social prescribing having the capacity to support different cultural beliefs and contexts within communities was viewed as important.

The sustainability of the VCSE sector long term has been an ongoing discussion since social prescribing first became visible and was still a concern expressed by many stakeholders.

"...what I find really frustrating is that the social prescribing service is only as good as the voluntary sector and community around it..." (Link Worker, VCSE)

Sustainability of the wellbeing benefits that people gain when part of the social prescribing service was also discussed. Again, sustaining improved wellbeing related to the availability of services in the local area. Once people have the capacity and confidence to make connections, they could become more self-sufficient.

"... it's not always about they need a social worker, it's like if they can have the support or something like peer support or somebody who can actually provide them with information, the guidance and some form of short term intervention that they can actually go on and manage on their own." (Link Worker)

Not all of the discussion around the relationship between social prescribing and the community provided specific outcomes that were ready to use. This data has however highlighted the need to reframe how impact is valued and the ensure the role of the community is appropriately captured and valued. Further research in this field is urgently needed.

The remainder of the results section will describe how outcomes were identified and reorganised into 2 distinct tables. The first addressing outcomes associated with social determinants of health (Table 3) and the second addressing outcomes associated with health more directly (Table 4).

Outcomes associated with the wider determinants of health

It has been well established that the wider determinants of health impact on specific health conditions³⁷. Complex adverse conditions relating to multimorbidity include poor housing and related respiratory problems, food poverty and malnutrition, poor health literacy, suicidal thoughts, social isolation and depression.

The following section of this report sets out all of the outcomes that we have identified and listed under wider determinants of health (See Table 3). Wider determinants of health were partially documented from our initial analysis of reported literature. The stakeholder interviews and focus groups, however, provided a much greater level of context and ‘unpacking’ of outcomes in this area, often based on the stakeholders’ experiences.

Stakeholders noted that a lot of the people who come to social prescribing are experiencing adversity, which impacts on a person’s health and ability to look after their health. Stakeholders also said that many people they work with had complex problems and needed external support to deal with personal, circumstantial or welfare issues. Typically, clients are referred for support by services provided by through VCSE sector.

*“With stuff like welfare advice and housing issues, they may be quite long-term issues and so often times it’s quite like a cumulative effect and then they’ve come on to see us. We’re quite lucky where we have services in house, so it’s quite easy.”
(Link Worker)*

Overall, 37 outcomes were identified and organised into 8 categories, including Work and Volunteering; Social; Education and Skills; Crime; Housing; Legal; Income and Welfare.

- 22% (8/37) outcomes were reported and often measured
- 19% (7/37) outcomes were only reported in qualitative literature
- 59% (22/37) outcomes were identified in Phase 2 of this research

Overall we can conclude that 78% (29/37), of outcomes relating to the wider determinants of health have not been routinely measured in the social prescribing literature.

³⁷ Marmot, M. (2010) Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010. ISBN 9780956487001

Of note is complete absence of outcomes associated with the Crime and Legal categories in our initial analysis of reported social prescribing outcomes (See Table 1).

On the following page, Table 3 provides an overview of the outcomes identified in each category associated with social prescribing and the wider determinants of health, accompanied by further explanation of those that were highlighted by the stakeholders in this study.

Outcomes relating to work and volunteering:

The role that social prescribing can play in helping a person become more employable, gain employment or take up volunteering was highlighted by many stakeholders from a range of organisations.

*“Accessing employment, I think was the other one I’d made a note of there [that is missing from the table], either being able to go back to work or to get a new job.”
(Legal Advisor)*

Stakeholders from work-based organisations were quick to point out the important difference between **becoming more employable** through use of social prescribing and **gaining employment**. If there are no jobs in the locality, then measuring employment per se could mis-represent the benefit of social prescribing.

The point was also made by stakeholders in the housing sector that employability and obstacles to employment, when broken down, consist of a range of outcomes. These include; reduction in anxiety and increase in confidence, increased number of connections with other people, increase in skills and using volunteering to consolidate ability to take on work and reintegrate into the community. Self-employment was considered as a separate outcome by several stakeholders, but in all likelihood covers many of the outcomes listed above

The elements to employability have been already been identified as outcomes in other parts of this research project and reported in Tables 3 & 4. This highlights the importance of viewing outcomes in a holistic manner, and **supporting people to become more employable is, in all likelihood, a very under reported outcome of successful social prescribing**

interventions. The availability of jobs locally was seen as linked to the health of the community.

“A lot of projects at this centre have led to micro enterprises which created employment because the, they, it’s become clear that people are being affected by something... But it requires sometimes infrastructure support or some mobilisation support or something to help get it off the ground.” (Social Prescribing Manager)

Work and volunteering	Social	Education and skills	Crime	Housing	Legal	Income	Welfare
Volunteering	Loneliness	Qualifications	Fear of crime	Housing conditions	Accessing legal advice	Reviewing and accessing benefits	Access to welfare advice
Employment / unemployment	Social isolation/connectedness	Skills acquirement	Effect of criminal behaviour	Home safety	Wills	Debt	Access to welfare services
Self-employment	Independence	Parenting skills	Anti-social behaviour	Home adaptations	Probate	Loan sharks	
	Social adjustment & functioning		Disclosure of domestic abuse	Nuisance neighbours		Increasing income	
	Social identity		Gangs	Ability to pay rent / mortgage		Fraud avoidance	
	Carer and family support			Fuel poverty		Adversity and hardship	
	Friendships & relationships			Relocation			
	Intergeneration engagement						

Table 3. Outcomes in social prescribing associated with wider determinants of health (n=37). Outcomes in light yellow - identified and often measured in social prescribing reports (8/37, 22%). Outcomes in orange - identified in qualitative reporting only (7/37, 19%). Outcomes in green - rarely or never reported or measured in social prescribing literature and were derived from the interviews and focus groups in this study (22/37,59%). Outcomes can improve or deteriorate, so no direction of travel is specified.

Only volunteering had been consistently identified in previously published reports and papers on social prescribing and many examples of volunteering were cited by stakeholders. Whilst volunteering is already known to be strongly associated with social prescribing schemes, an important point raised was the timeframe that may be involved. Volunteering may be an initial outcome from social prescribing.

“It was a link worker from the wellbeing service that went and saw this person and they organised some voluntary work for this person in a school, so that meant that they would go in and doing some reading with some school children and, again, that’s reduced the call volume slightly.” (Paramedic)

Volunteering was also seen as a long term outcome associated with social prescribing, highlighting once more the many ways in which a person can be supported and motivated by social prescribing. Very little research has been done in terms of documenting the longer-term outcomes that are associated with social prescribing, however one participant reported the following:

“People who were in crisis three years ago are now interested in volunteering, for example, a very long journey, but yeah.” (Link Worker)

Outcomes relating to social wellbeing:

The majority of outcomes in this category have been identified in social prescribing reports and academic papers, making it one of the most highly reported areas of social prescribing. Predominantly it is levels of loneliness, social isolation or levels of independence that are measured, as reiterated in the following quote relating to dementia:

“How dementia and isolation fit we do not know, but we do know that lack of exercise contributes to dementia. We also know that dementia can lead to social isolation on a number of levels. Primarily dementia can decrease social networks partly through confidence. Diagnosis can impact on existing social networks because family and friends will often withdraw.” (Programme Manager)

Social prescribing was, according to several stakeholders, helping people to engage in daily life and to stay in their own homes. This was achieved by link workers making the appropriate assessments.

*“In terms of outcomes, I don’t know if you’ll ever list them all...So that lady is able to stay at home now, as opposed to getting in respite, which would cause upset, cost the health service more money. But that carer is able to go and get time off. “
(Northern Ireland Focus Group Member)*

Other outcomes of social prescribing relate to social identity, social adjustment and functioning and friendships and relationships. Stakeholders were agreed on the importance of social prescribing in helping people make friends and feel part of the community:

“I think a lot of it is isolation... And it’s just friendship more than anything. But the Good Morning Services [ring in service] are very good in that, they provide that contact every day, if that’s the case maybe, or once a week. And...sometimes they’ll go out to home visits and they will have events on as well. The clubs are very good as well, and then the libraries provide different wee activities, and community centres too would do that.” (Northern Ireland Focus Group Member)

Outcomes associated with family and carer support illustrate some of these issues that carers experience such as carer burden, burnout, access to benefits and services³⁸. Stakeholders reported the devastating effect of carer burden, the issues co-ordinating who is doing which aspect of the carers’ role. People who didn’t formally identify as a carers were supported by link workers to register as a carer and access support and benefits entitled to them.

“Carer breakdown is a major cause of admissions to hospital and social care costs, because if someone can’t keep caring for someone informally then the state has to step in and if someone has a crisis then they end up giving up on the caring and then the person ends up in hospital” (Social Prescribing Manager)

“ We’ve identified an awful lot of people who’ve got onto the carer’s registers at the trust, but they would never have seen themselves as a carer. So...then get the offer of some support from the trust for respite or support, or they get access to benefits that are Carer’s Allowance or such” (Northern Ireland Focus Group Member)

³⁸ Jolliffe et al (2018). Impact of Penny Brohn UK’s Living Well Course on Informal Caregivers of People with Cancer. J Altern Complement Med 24(9-10) p974-980.

Outcomes relating to crime:

The category 'crime' covered a range of related outcomes and was completely missing from findings in Phase 1 of this study, therefore outcomes relating to crime are likely to be under-reported in the social prescribing literature. People were either experiencing the impact of crime or were fearful of the crime in their neighbourhood- even if they hadn't experienced it directly themselves. Several stakeholders gave examples of people disclosing domestic abuse during link worker consultations, and other forms of anti-social behaviour.

"...we also see people who maybe are victims of domestic abuse, marriage breakdown, but there's, it's a mixture of people with low level as well as complex needs." (Link Worker).

As highlighted above, many people have complex and interconnected needs, which relate to several categories of outcomes identified in this research. The effect of crime may also relate to a family member.

"I have a client who is terminal [terminally ill]. She could no longer work but didn't know where to get financial support. She has used loan sharks and is feeling threatened. House is damp and unsuitable and son has just been released from prison and needs to get out of the neighbourhood but doesn't know how to do this and fulfil probation requirements."(Link Worker)

Outcomes relating to housing:

Outcomes relating to housing were identified in the first analysis of social prescribing reports but with very little accompanying context or details (Table 1). Stakeholders identified a range of issues that relate to the housing category, all of which could impact on health and were being supported by organisations predominantly within the VCSE sector.

Link workers in our study explained how GPs would refer homeless to people to their social prescribing scheme, also highlighting the non-medical issues that GPs may be faced with.

“Normally they come to the GP and then the GPs come, oh this person is homeless, and I don’t know what to do with them, can you take over? (Link Worker)

“People sleeping on the floor, sofa surfing, homelessness.” (Link Worker)

Other stakeholders identified further outcomes relating to the condition and safety of the home, which could include damp, overcrowding, fuel poverty or problems paying rent or mortgage. All of these issues have recognised downstream impacts on health.

“There was a scheme, the Warm Homes Scheme, where utility companies were making grants available to do things like replace boilers and insulate windows. So you had older people that were going to bed at 4.00 in the afternoon because they were cold, being able to actually address that [would be a good outcome].” (Legal Advisor)

*“[They] were at risk of running out of electricity, which connects into heating their home and being able to cook, and falling because [of] no lights”
(Northern Ireland Focus Group Member)*

Outcomes relating to legal advice:

Providing legal advice is not something for which link workers are equipped or allowed to do as part of their role, thus enabling a person to access legal support is essential. Legal areas highlighted by stakeholders included needing legal advice about immigration or resident status, housing and benefits entitlements. Stakeholders considered that the impact of not having legal support can be extremely serious for some people

“Secured immigration status. We know that that’s a massive cause of destitution, is, which are people ending up living on the streets because their immigration status isn’t clear. Which can often be resolved with a short piece, a short bit of help from an immigration solicitor, which is what’s so tragic.” (Legal Advisor)

Unresolved legal issues were linked to a direct impact on people’s health, in some cases being linked to people feeling suicidal.

“A community navigator in a practice in London...was pleased to hear the focus on social welfare law...the issues that she’s desperate for help with are benefit appeals and houses in disrepair, and then this really chilling phrase she said, these are the problems that make people suicidal.” (Legal Advisor).

Outcomes relating to Income:

In this category we identified outcomes related to income or lack of income for people. Initial analysis of reported literature identified outcomes relating to a wish to increase income, access to appropriate benefits payments and debt issues. Stakeholder interviews identified new outcomes on the impact of loan sharks and fraud as well as reiterated some unquantified Phase 1 findings.

“ I had a mum who had no recourse to public funds, who had a six month old baby, and the health visitors and everyone, they all thought...she was strange... Then she told me that she actually had no money... to come to the appointments, to pay the bus and she was just feeling really, like very tensed up.” (Link Worker)

In particular enabling people to get the income through benefits that they are entitled to was identified by several stakeholders.

“We [the link workers] are not qualified to give benefit advice or housing advice, or anything like that, but it would be connecting someone to a service where they wouldn’t know where to go or they wouldn’t know that they were eligible for certain benefits.” (Link Worker)

“So if you help somebody to secure income through benefits, they’re entitled to that. They are lawfully entitled to that. And at the moment, we know that it’s massively under claimed.” (Legal Advisor)

Outcomes relating to health

This next section focuses on the outcomes of social prescribing schemes that relate to health. These outcomes may be directly associated with the benefits of social prescribing or indirectly, as a result of a social prescribing scheme addressing the wider determinants of health.

Overall 62 outcomes were identified and grouped in 6 categories which included 'General health and wellbeing; 'Physiological outcomes; 'Outcomes relating to modifiable risk factors; Psychological outcomes; Outcomes relating to empowerment and Outcomes relating to spiritual wellbeing.

- 50% (31/62) were reported and often measured
- 26% (16/62) were only qualitatively reported and not measured
- 24% (15/62) were associated with health were not previously reported
- **50% (31/62) were associated with health are not normally measured**

Only 50% (31/62) of outcomes directly related to health are being routinely measured.

General health or wellbeing

As outlined in the introduction, health, wellbeing and quality of life all have different definitions. These terms are often used interchangeably - rightly or wrongly – however, for social prescribing, a general overview of wellbeing would be most appropriate. It is important to consider, however, that quality of life has been the standard measurement in health related research literature as opposed to wellbeing. Even quality of life measures have differences between them. For example, most quality of life measures miss out spiritual wellbeing items.

In this study we did not probe stakeholders on how they interpreted the terms 'health', 'wellbeing' and 'quality of life' hence we have separated them out into different categories. It was clear however that any use of these terms related to a general understanding of health and wellbeing as opposed to a detailed picture of a known disease or chronic condition.

A snapshot of overall wellbeing status using a minimal number of items on the questionnaire can be an invaluable piece of data, particularly when investigating the overall impact of a service. Service users are more likely to complete a few questions on a questionnaire that directly relate to their wellbeing than a long list of questions.

General health or wellbeing	physiological outcomes	Outcomes relating to modifiable risk factors	Psychological Outcomes	Outcomes relating to Empowerment	Outcomes relating to Spiritual Wellbeing
General Wellbeing	Blood glucose levels	Smoking cessation	Anxiety	Confidence	Hope
Quality of Life	Blood pressure levels	Alcohol intake	Depression	Positive decision making	Sense of purpose
General Health	Cholesterol levels	Substance abuse	Self-esteem	Problem solving	Personal fulfilment
	Body Mass Index	Cardiovascular disease risk	Suicide ideation	Feeling well informed	Enlightenment
	Waist circumference	Physical activity	Anger	Ability to carry out everyday activities	Trust
	Fatigue	Healthier diet	Encouraged	Motivation	Inspired
	Energy levels	Sight checks	Cheerfulness	Sense of control	Engagement with religion
	Aches and pains	Hearing checks	Relaxation	Personal resilience	Forgiveness
	Stamina	Quality of sleep	Absorbed	Pride in appearance	
	Weight e.g. obesity or malnutrition	Sexual health	Supported /listened to	Increased self-awareness	
	Lung function	Frailty	Enjoyment	Activation levels	
	Tooth decay	Memory loss	Concentration		
		Mobility	Body image		
			Sexuality		
			Guilt		

Table 4. Social prescribing outcomes associated with health. Outcomes in light yellow - identified and often measured in social prescribing reports (31/62, 50%). Outcomes in orange - identified through qualitative reporting only (16/62, 26%). Outcomes in green - rarely or never reported or measured in social prescribing literature but were identified during Phase 2 of this study (15/, 24%). Outcomes can improve or deteriorate, so no direction of change has been indicated.

Physiological outcomes

Physiological outcomes are arguably the easiest to measure as this type of data is often electronically recorded. In addition to biomedical language, stakeholders reported the use of everyday language, which we have also listed. For example, ‘aches and pains’ was a term frequently used by individuals to explain how they know social prescribing is having an effect, e.g., ‘my aches and pains are getting better’. While it does not determine the causes of aches and pains, it conveys the subjective change that an individual describes, using terms that mean something to them:

“What I often see [is] where a GP refers to me because they know there’s something else going on, but they [the patient] present with very physical aches and pains. And, yeah, you just go on the journey with them to try and identify what’s going on and also give them other options to deal with aches and pains than just medication because they kind of hope for very, external medical answers where actually the answer is a bit of stretching, a bit of exercise.” (Link Worker)

“Two weeks ago I spoke to a lady who attends yoga for, well when they’re recovering from cancer and she said that after a few sessions she stopped feeling pain in her joints.” (Link Worker)

A further example of this type of individualised language was in describing ‘energy levels’ and ‘stamina’. As a discrete phenomenon, ‘stamina’ was not a concept understood by all stakeholders, however they did use it in the context of recovering from the effects of treatment for cancer.

Outcomes relating to modifiable risk factors

Social prescribing has evolved initially to address an acute need for non-medical support. Whilst interviewing stakeholders, more modifiable risk factors were identified which are not being routinely monitored or measured. This highlights untapped potential to prevent ill-health, or worsening of existing conditions, and to support well-being in older age. By preventing or reducing the severity of many situations before they manifest as disease the increasing pressure on health service resources can also be reduced.

“We should be looking at areas where people have no agency, have high risk, and they’re on a journey, a really unhealthy journey to multi morbidity in later life and we should be heading them off, we shouldn’t be waiting for them to get their multi-morbidity, then doing loads and loads of initiatives on frailty once they’re already extremely frail and there’s very little progress you can make with someone at that stage” (Social Prescribing Commissioner)

The discussions around dietary change demonstrated once more that issues are not always straight forward and several outcomes may be involved before a person reaches an appropriate weight. Talking about diet with clients had brought different (including socioeconomic) issues to light, such as food poverty and malnutrition, or dietary management for long term conditions such as diabetes. Therefore, responses to clients’ needs could be vary from understanding further the causes of food poverty, or referral on to cookery classes to build up confidence, socialise and understand how to meet the dietary messaging that is about.

*“The effects on *lifestyle change* particularly in public health, where we have been tackling lifestyle changes with very little effect for some years.”
(Social Prescribing Commissioner)*

Frailty was another outcome suggested for inclusion into the table of outcomes. Related to this was mobility and falls prevention.

“Those with the long-term conditions, the elderly, the falls...they usually go under lower priorities (for call outs) because they're not life threatening- but they can be on an ongoing basis, they can be quite life changing so to speak.” (Paramedic)

“They [the paramedics] are looking at the frailty index, they're now looking at ‘how does that impact on that person's wellbeing, not only is it their physical movement that's possibly restricted or inhibited but how does that inhibit their mind, how does that restrict how they feel?’” (Paramedic)

Several stakeholders specifically identified the opportunities for link workers to be supporting health checks and screening campaigns.

“If social prescribing is about all round health and wellbeing should there also be a remit to encourage the take up of screening programmes, visual checks, hearing check etc if the circumstances are right?” (Northern Ireland Focus Group Member)

Finally, sleep quality was also seen as an important indicator of people feeling less stressed and more supported. Whilst the stakeholders discussed how it may be subjective to measure, sleep quality was viewed as important to include.

Psychological outcomes

Psychological outcomes are some of the most frequently measured in social prescribing reports e.g. anxiety and depression. We noted that psychological outcomes could be described negatively, such as in terms of suicidal ideation, and positively such as in terms of affirming emotions such as cheerfulness. New psychological outcomes were identified including guilt, sexuality and body image, when interviewing stakeholders.

Guilt was reported to impact on peoples’ lives and social prescribing interventions were seen as helpful for people to face this issue.

“That sense of being a burden on people is something that comes up all the time and is so frustrating because at first it was really hard to change someone’s mind about that. That like.. “oh I don’t want to burden to someone so I won’t call them to ask them to see me”, their grandchildren or their children whatever. I’m really struggling to physically look after myself and I don’t want to be a burden on my family.”
(Link Worker)

Body image and sexuality were also reported as important outcomes by stakeholders. Stakeholders felt that attitudes to both could have a strong impact on people’s health and wellbeing, and that interventions such as social prescribing could help people to come to

terms with physical changes. This was often the case for clients who had been undergoing cancer treatment:

“So often body image is affected by cancer treatment and so that comes up as a really big one. And then also another one which I don’t think is there is sexuality as well, like people’s responses to that.” (Link Worker)

It was also noticeable that in interviews, stakeholders made a number of references to incidents relating to suicidal ideation and suicidal impulses in clients they had seen. Whilst most social prescribing schemes are not set up to take referrals of people who are feeling suicidal, the time speaking to a compassionate link worker may allow these thoughts to be voiced.

“Just the one lady in particular comes to mind who had suffered bereavement that I went to see. And on the first visit with her she had disclosed to me that she had tried, she had thought about killing herself. And we had got very quickly involved with the team. GP rang her, reassured her. Then her pharmacy got involved in that occasion, had a wee look at the medication and everything else, so she was very much supported...She got involved with the bereavement group as well, and she found that very helpful.” (Northern Ireland Focus Group Member)

Stakeholders spoke of the positive psychological outcomes of social prescribing interventions, often again demonstrating the inter-related nature of people’s lives and experiences. For example, stakeholders spoke about the importance of sense of control in people’s lives, and the effect this has on their emotions or psychological state, including their self-esteem.

Stakeholders reported beneficial changes in moods through supporting people in difficult circumstances. The change in psychological state was often the observable impact of the social prescribing service, from the stakeholder’s perspectives – even if it was not the only impact.

“I think under psychological and emotional, things like sense of control are really important. One of the things that you witness yourself when you see somebody come into an advice centre, they’re angry, stressed, confused, and suddenly when somebody says, let’s look at the issues that are going on here. Now, with these debts, we can prioritise those ones, we can manage all these others. And then you just see this relief wash over people.”(Legal Advisor)

Feeling supported and heard was an important outcome of social prescribing, one which is often reported in social prescribing service users’ narratives. One stakeholder described it like this:

*“I think the biggest [outcome] that I would hear is...feel[ing] supported and listened to. Sometimes people just want to know somebody’s there at the end of the day. “
(Northern Ireland Focus Group Member)*

Outcomes relating to individual empowerment

In this category there were several outcomes identified such as sense of control, personal resilience, increased self-awareness and activation levels that can all be classed as aspects of personal empowerment. Within the anecdotal world of social prescribing, the term empowerment is used frequently, however, is it likely that people attach different meanings to the concept of empowerment.

Empowerment has been associated with patient-centred medicine as far back as 1964 aimed at requiring doctors to focus on medical-technical aspects as well as emotional, spiritual and relational dimensions of a person³⁹. Empowerment has also been used in reference to social injustice and community⁴⁰. Further investigation of definitions and measures of empowerment suggests that it relates to a person’s ability to cope with a situation, but also their relationship with and in the community, and their ability to affect change within it⁴¹.

The High Quality Care for All policy⁴² refers to the need to involve empowerment in health policy, marking the start of a move toward empowering and involving patients to make

³⁹ Balint M, (1964) *The Doctor, His Patient and the Illness*, Pitman Medical, London, 1964 International Universities Press.

⁴⁰ Kieffer CH (1983) Citizen empowerment: a developmental perspective. *Prev Hum Serv* 3 (2-3), 9-36

⁴¹ McAllister M et al.(2015) Assessment of patient empowerment – a systematic review of measures. *PLoS One* 10(5)

⁴² Darzi A. (2008). *High quality care for all: NHS next stage review final report*. London: Stationery Office.

informed decisions. More recently this has been realised through the use of the Patient Activation Measure (PAM)⁴³ and the Universal Personalised Care Strategy⁴⁴, where health budgets and shared decision making are key concepts.

By reporting empowerment as a category on its own, the different outcomes that contribute to individual empowerment can more easily be recognised, along with the relationship between empowerment and wider determinants of health.

The support provided by social prescribing schemes and the link workers in particular was identified as a key aspect to improving levels of empowerment. For instance, the conversation with the link worker can help to break down practical barriers, provide information and help to activate people to get out to activities in the community.

“I have people across late 80s that wanted to maybe just go to their hairdressers, or go for coffee with their friend, and not realising that if they phone the taxi company and explain, ‘I need the taxi driver to actually come to my door,’ they will do it. They just don’t know they do...it’s giving that information as well.” (Northern Ireland Focus Group Member)

“There’s also a massive bit about motivating people as well because people may know that there’s a physical activity group vaguely, but they would never actually go there without that kind of support. So I think it’s getting people to that point as well, where they feel more able.” (Link Worker)

Outcomes relating to spiritual wellbeing

Spiritual wellbeing describes a persons’ level of purpose, meaning and peace in life. It has a variety of definitions and explanations, although they share the same core points. Levels of spiritual wellbeing have been shown to affect our overall wellbeing⁴⁵, and therefore deserve more importance and visibility within the current measurement system.

⁴³ Hibbard, J. H., et al (2004). Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers. *Health services research*, 39(4 Pt 1), 1005–1026.

⁴⁴ NHS England (2019) Universal Personalised Care Strategy.

⁴⁵ Whitford HS, Oliver IN (2012). The multidimensionality of spiritual wellbeing: peace, meaning, and faith and their association with quality of life and coping in oncology. *Psychooncology*;21:602-610.

We identified sense of purpose', 'personal fulfilment', 'inspired', hope and 'enlightenment' in Phase 1 of this research, frequently in qualitative research. During Phase 2 research, further outcomes emerged e.g. 'engagement with religion' and 'forgiveness' which this led us to consolidate spiritual wellbeing as a distinct category.

Previous data evaluating a holistic person-centred service to support people with cancer demonstrated that improvement in spiritual wellbeing was the largest contributor to improvements in peoples' overall health-related quality of life⁴⁶, reinforcing the need for spiritual wellbeing to be measured in social prescribing research and evaluation.

⁴⁶ Polley, M. J., et al. (2016). Using a Whole Person Approach to Support People With Cancer: A Longitudinal, Mixed-Methods Service Evaluation. *Integrative cancer therapies*, 15(4), 435–445.

Outcomes associated with system usage

The primary aim of this research was to understand the outcomes that are associated with individuals in a social prescribing programme. This was so that full extent of these could be monitored and researched and the full impact of social prescribing beyond the health system can then be identified and researched.

Stakeholders in this study also identified the impact of social prescribing at a system level. Many system level outcomes have previously been identified in the social prescribing literature; these include:

- number of visits to GP practices
- number of GP home visits
- admissions to A&E
- referrals to secondary care
- inpatient admissions
- unplanned hospital admissions
- length of secondary care stay
- ambulance conveyancing
- number of prescriptions issued

Additional system-level outcomes identified included:

- GP waiting times
- level of hospital conditioning
- number of referrals to social care
- screening programme uptake
- medication reviews

Some stakeholders reiterated the importance of people being treated holistically, the interplay between wider determinants of health and the health system per se. The issue of medical professionals being able to recognise when a person has underlying issues that relate to wider determinants of health was also raised. This could therefore result in the person receiving the right support as opposed to or additionally to a pharmaceutical prescription.

“When I was doing this work in London, the GPs would say, we collected data...over the course of the period when we were in the surgery; we reduced GP waiting times, we reduced prescription charges, and we increased attendance at appointments. And the GPs completely loved it, and they just said, “when these issues come up, I can just say, go and see the Welfare Rights Worker”. (Legal Advisor)

The positive role that community pharmacy can play in the wider social prescribing structure was also highlighted. The role related to supporting the appropriate use of prescription medication as well as advising on over the counter medication. Examples put forward were - changing the time a diuretic is taken to allow people to make social engagements confidently; misuse of over the counter medication leading to confusion and dizziness; reviewing multiple medications how and when they are taken.

“[One] patient was calling us up to 40 to 50 times per month via 999 and the calls generally were resulting in a high priority response. So, we were sending an ambulance response car and a double crewed ambulance to the scene and generally, the main issue was with this person that the medication needed adjusting to manage some ongoing symptoms, but they also needed some education around it”. (Ambulance Service)

Conclusion

This study aimed to investigate and collate all the outcomes that are being experienced in link worker based social prescribing schemes. Data from Phase 1 established the range of outcomes in existing social prescribing reports and research papers. 67 outcomes were initially identified, only 60% were measured, the rest reported qualitatively.

Interviews and focus groups carried out in Phase 2 with stakeholders in a range of sectors revealed 32 more outcomes that they felt needed to be included in the outcome table (Table 1). By the end of the research, the outcome categories were reorganised, expanded and split into 3 broad areas –

- i) outcomes associated with the determinants of health;
- ii) outcomes directly associated with health;
- iii) outcomes related to system usage – predominately the health system.

The data from this study has clearly identified that social prescribing operates in a complex interconnected way, as opposed to a linear way associated with a biomedical and pharmaceutical paradigm. This complexity requires a holistic approach to be adopted by link workers to ensure a person's needs are fully met – in essence a paradigm shift.

Whilst a degree of measuring and monitoring of outcomes was seen as necessary, link workers noted that using an outcome measure in the consultation could at times be inappropriate and that referral reasons were not always the issue prioritised as in need of immediate support by the service users. All of these points raise the need to be pragmatic and flexible about approaches to data collection, measurement and monitoring.

During the interviews and focus groups, the researchers did not define how an outcome was to be interpreted. This could be seen as a limitation of the study as some of the outcomes in Tables 3 and 4 may be seen as outputs or indicators as opposed to outcomes. This revealed the need for more support and training for all stakeholders to be more confident with this research language. Another limitation was that some stakeholders did not take part in the research. A list of these stakeholders can be found in Appendix 2.

The relationship between the individual and the community was seen as crucial in the social prescribing journey. Many stakeholders explained how social prescribing supported the capacity to make connections and the number of human connections made. This led to more engagement in VCSE based organisations and improved wellbeing by service users.

It was striking to note that the majority of outcomes associated with the social determinants of health were identified in Phase 2 interviews. Overall, 78% of these were *not* routinely measured, indeed 59% were rarely if at all measured. Given that the VCSE sector is highly active in supporting the social determinants of health with a broad range of organisations, services and interventions, the lack of routine measurement and reporting of these outcomes

in the social prescribing literature can only be detrimental to the VCSE sector. In a time where governmental austerity has caused severe financial distress in this sector, the push to measure and monitor outcomes, and then calculate impact using only outcomes predominantly related to a biomedical paradigm is no longer fit for purpose.

As social prescribing is scaled up, the broad range of outcomes identified by stakeholders would map more appropriately onto a community capitals framework^{47,48,49}. This would enable the interconnected elements required to create sustainable communities to be incorporated and valued in research studies, particularly where the economic value of social prescribing is being determined at scale. Without sustainable communities and a VCSE sector that is appropriately and fairly valued for the contribution it makes, social prescribing at scale is at risk of failing.

⁴⁷ Parsfield M et al (2015). Community Capital. The Value of Connected Communities. RSA Action Research Centre, London.

⁴⁸ Roseland M. Toward Sustainable Communities Solutions for Citizens and Their Governments - Fourth Edition. New Society Publishers

⁴⁹ Flora, C.B. and J.L. Flora. 2013. Rural Communities: Legacy and Change , 4th Edition. Boulder, CO: Westview Press.

Recommendations

To support a shared understanding of evaluation across all sectors involved in social prescribing, particularly the VCSE sector

- more support and resources explaining the difference between outcomes, outputs and indicators would be beneficial to improve the general knowledge of all stakeholders in social prescribing link worker schemes.
- More support for identifying meaningful outcomes as a measure of social prescribing schemes needs to be provided. A co-production approach with service users and the full range of stakeholders is recommended.
- The inclusion of everyday language instead of technical language where possible.

In light of the findings that 60% of the individual outcomes in this study were not being routinely measured, or had never been captured formally, more discussion and research funding is needed on the following areas:

- The contribution that the measurement of outcomes makes towards ascertaining the full impact of social prescribing.
- Whether outcomes are the only means to gather data or should more community friendly approaches be explored and utilised? For example, the use of realist methods in evaluation and data synthesis⁵⁰.
- The inclusion of a broader range of outcomes to capture those relating to the social determinants of health. For example, outcomes relating to crime, legal welfare, and housing which are rarely if at all currently reported.
- The inclusion of spiritual wellbeing outcomes as an accepted contributor to overall wellbeing.
- A review of PROMs and tools used to quantify outcomes, to determine what tools can be recommended for which outcomes and in which populations. Specifically, the identification of tools to capture missing outcomes is urgently needed.
- A review of the NHS Common Outcomes Framework against the outcomes in this research to support its evolution to capture more of the outcomes achieved in social prescribing schemes by VCSE organisations.

To support and develop an acceptable approach to measuring and monitoring social prescribing and therefore understanding the full impact, the following need to be considered:

- Bring together key stakeholders, including service users and decision makers in a range of societal sectors, to review this report and discuss what data is essential from their perspective to determine the full impact of social prescribing.

⁵⁰ Pawson R (2013). *The Science of Evaluation: A Realist Manifesto*. London. SAGE publications Ltd.

- To ensure researchers are all aligned in this new paradigm of working, bring together research funding bodies and National Institute of Clinical Excellence to discuss what data needs collecting to address evidence gaps in the research literature and to agree research methods that are acceptable to be used.
- To test the use of a community capitals framework as an underpinning theoretical model for social prescribing. This would enable the interactions between individuals and as well as the individual and community, to be appropriately incorporated into analysis, in line with the multi-sector nature of social prescribing.

Appendix 1: Interview Schedule

Outcomes Consultation: Professionals

Introduce the study:

Confidentiality and ethics: Signatures: I have read and understood the above and give my permission for this discussion to be recorded for research purposes.

Introduction (15 min)

Please introduce yourself and tell me a bit about your job role

- A bit about you: the job you do and day to day responsibilities, how long in role
- Introduce the organization: GP, VCS, funding body
 - Size, its service, budget capacity, region

To what extent are you aware of or have been involved in social prescribing?

- As part of the job / as part of the organization
- How long have you been working in the area of SP?

How has social prescribing developed over that time?

- What role does it play? Types of people have taken part?
- Is this different from other parts of the UK? If so, in what way?
- **Thinking specifically about your role at the moment, tell me a little bit about the SP programme?**
 - What is the aim of the social prescribing programme?
 - When set up? What populations/ patient base? What referral system? Link worker or navigator? Some estimate of size in terms of referrals/ area covered...
 - Urban or rural community?

Identifying outcomes (20min)

To date, what would you say are the achievements of the social prescribing schemes?

Specifically, what do you see as the success or benefit of the SP programme?

- For the individual user?
- For the community?
- For the NHS/ system?
- Other

And for the SP scheme/s you are involved in, what makes social prescribing work?

- Characteristics of the staff? Time offered to clients?
- Type of funding? The network of stakeholders?
- The time offered to patients?

Have there been any difficulties or developments which you did not expect in how the SP programme has developed?

- Practical issues – transport of clients, meeting specific clients needs, volume of referrals
- Funding and monitoring the SP programme? Tracking clients?
- Meeting expectations of other VCSE/ GP/ Commissioning bodies?

When is SP least likely to work?

- Funding? Types of clients? Capacity of VCS? Explore...

Outcomes framework (30min)

Individual outcomes

I would like to show you a list of all the individual outcomes we have identified so far. These have been collected from published papers, stakeholder surveys and case study notes and observations.

Reading through this list... what are you first impressions? The first thing which comes to mind?

- Do you need anything clarified or have any questions?
- Are there any individual outcomes missing?
- Is there anything there which you are surprised to see? Why?
- Is here anything there which you do not understand or may be open to misinterpretation? Language doesn't feel right?

Overall what outcomes are most commonly identified as part of the SP programme you work on? Place an 'x'

- What categories do you have most 'x' against? Why?

Thinking about some of the clients you have worked with, could you read through the list and identify outcomes pertinent to them?

- What are clients most likely to present with? What other outcomes are most likely to be achieved as a result of engagement with the programme?
- Anything missing?

Take another look through the list, if we had to simplify or condense the list, what outcomes could we rule out? Why? Cross out

Community outcomes

Moving on from the individual level, I would like to think about the wider impact of social prescribing on the community/ society.

What would you say is the wider impact of social prescribing?

- Changes in service usage? Health? Benefits & welfare?
- Changes in voluntary and community sector?
- Changes in how the individual perceives and acts with regard to health and wellbeing
- On how communities work?

Introduce Table 2 - Reading through this list... what are you first impressions? The first thing which comes to mind?

- Do you need anything clarified or have any questions?
- Are there any community outcomes missing?
- Is there anything there which you are surprised to see? Why?
- Is there anything there which you do not understand or may be open to misinterpretation?

How do you see the first list differing from the second list?

Summary (15 mins)

Could you put a tick against what outcomes are particularly important?

- Discuss why – funding? Job role? Clients/ community needs?

Looking through the list of all the outcomes

- Anything missing?
- Anything which is not easily understood or could be misinterpreted?
- Anything which is not required?

What data, if any, do you currently collect for monitoring or programme evaluation purposes?

- How has the monitoring or evaluation been going?
- What feedback would you or the staff have about how programme evaluation is conducted?
- Have your clients had any difficulties? If so what?

What would you like to see happen over the next 5 years with regard to the development of social prescribing? What would help make this happen? What would hinder this?

Table used as a visual aid in focus groups and interviews: Outcomes from published research and evaluation reports

Outcomes themes	Full list of outcomes taken to stakeholder opinion
General	Empowerment General wellbeing Quality of life Selfcare Social adjustment Social connectedness
Physical	Blood Glucose Blood pressure Cholesterol CVD risk score BMI weight: waist circumference Aches / pains
Lifestyle behaviour	Drug use: tobacco alcohol illegal drug prescription drug quality sleep/ less fatigue Healthier diet physical activity: exercise : activation Stamina
Psychological	Anxiety Depression Self-esteem Confidence Suicide ideation Trust Hope for future Sense of control Anger Motivation Ability to concentrate Personal resilience/ ability to cope Feeling positive Positive decision making Cheerful Relaxed Absorbed Encouraged Pride in appearance
Welfare	Volunteering & employed

	<p>Education/ qualifications/ skills</p> <p>Feel well informed</p> <p>Ability to access services</p> <p>Ability to carry out everyday activities</p> <p>Housing / debts/ benefits</p> <p>Coping with bereavement/ separation</p> <p>Improved relationships/ friendships (concern about family/carers)</p> <p>Sense of achievement</p> <p>Better management/ coping with long term conditions</p> <p>Ability to identify and address problems</p>
Spiritual	<p>Sense of purpose</p> <p>Enjoyment: happiness</p> <p>Relaxation</p> <p>Fulfilling potential</p> <p>Broadening horizons</p> <p>Enlightened</p> <p>Inspired</p>
Social	<p>Reduced loneliness</p> <p>Reduced social isolation</p> <p>Increased independence</p> <p>Increased social identity</p> <p>Builds self-worth</p> <p>Feeling supported & listened to</p> <p>Increased self-awareness</p> <p>Builds knowledge</p> <p>Friendship</p> <p>Connectedness</p>

Appendix 2: Stakeholders not included in the research

While the variety of stakeholders consulted has been comprehensive the limitations of the research must be acknowledged. Due to timing and budgetary constraints the following sectors have not been included:

- Fire service
- Police
- Prison service and organisations working with ex-offenders
- Education sector
- Individuals or clients attending social prescribing schemes
- Class coordinators/ teachers delivering social prescribing referrals such as pottery, exercise, coffee mornings, green gyms, gardening projects etc
- Services for young people families and children
- Process evaluation outcomes have not been included in this study. These included the type of outcomes measured to understand the running and management of a social prescribing scheme such as referral type, number of contacts

Whilst the researchers endeavoured to interview stakeholders from England, Northern Ireland, Scotland and Wales, they were unable to secure participants from Wales.

END

