CONTENTS

Executive summary .................................................................................................................. i

Introduction ........................................................................................................................... 1
   Defining social prescribing ................................................................................................. 1
   Rationale for social prescribing .......................................................................................... 2
   Overview of the pilot ............................................................................................................ 3
   Evaluation aims .................................................................................................................. 4
   Evaluation methods .......................................................................................................... 4
   Report structure ................................................................................................................ 5

Client numbers and profile .................................................................................................... 6
   Profile of clients ................................................................................................................ 6
   Reasons for referral .......................................................................................................... 8
   Summary ............................................................................................................................ 9

Social prescribing outcomes .................................................................................................. 10
   Patients’ perceptions of own health and wellbeing ......................................................... 10
   Service outcomes ............................................................................................................. 13
   Types and frequency of GP and unplanned primary and secondary care appointments .. 14
   Summary ........................................................................................................................... 15

Social prescribing process and model ................................................................................... 17
   The exploratory nature of the pilot .................................................................................. 17
   The social prescribing model piloted in Richmond ......................................................... 17
   Summary ........................................................................................................................... 31

Conclusions and recommendations ....................................................................................... 33
   Recommendations ........................................................................................................... 33

References ............................................................................................................................. 36
Appendix 1: Primary and secondary evidence contributing to the evaluation............................ 38
  Primary evidence.............................................................................................................. 38
  Secondary evidence ........................................................................................................ 39
Appendix 2: Demographics.............................................................................................. 43
Appendix 3: Wellbeing Star Analysis Summary ................................................................. 45
Appendix 4: Client Case studies....................................................................................... 46
EXECUTIVE SUMMARY

Social prescribing allows GPs and others working in primary care to offer a broad range of options to build tailored support for an individual that goes beyond clinical intervention. In doing so, patients receive a greater level of care than they would have from a short GP appointment. A social prescribing pilot was in operation in three GP practices in Barnes, south London, between October 2017 and July 2018. The pilot was conceived as a way of supporting primary care patients’ health and wellbeing, by linking them to various non-medical services in the community and focusing on psychosocial wellness rather than just illness.

The pilot was commissioned by Richmond Clinical Commissioning Group (CCG) and delivered by Richmond AID, a local charity providing services to disabled individuals in the borough. According to the description of the service outlined in the specification, GPs evaluate whether patients are suitable for social prescribing and then refer them to a Community Navigator. The Community Navigator acts as a mediator between the patient and the services they require. After an initial consultation, an action plan is created and the patient is referred to one or more service. The Community Navigator also ensures, through regular follow-ups, supports the patient to access services often supporting the patient to remove the barriers to access.

Chrysalis Research, an independent research organisation, was commissioned by Richmond CCG to carry out an evaluation of the social prescribing pilot in Barnes. In this report we describe the reach and outcomes of the service, analyse the pilot processes, reflecting on both outcomes achieved and wider evidence, and distil learning that can be taken to future commissioning and delivery of social prescribing.

Client numbers and profile

The rate of referrals was lower than expected; 94 patients were referred between October 2017 and June 2018 against a target of 130 for the first six months of the project. The majority of referred clients were female and 65 or older and most clients were referred due to social isolation. This profile of clients is consistent with wider evidence about social prescribing. The data shows that the social prescribing pilot reached a high proportion of people from minority ethnic groups and people from vulnerable groups, including those with mental and long-term physical health conditions.
Social prescribing outcomes

The majority of clients involved in the social prescribing project saw improvements in multiple areas of wellbeing, resulting in reductions in frustrations and concerns around money or housing, greater socialisation and levels of physical activity linked to their participation in local groups, and feeling more positive overall as a result.

Some patients showed little or no improvement in their well-being. The evaluation was not able to explore why these patients did not appear to benefit from their involvement in social prescribing.

For nearly half of the patients (37 out of 75) there was a decrease in GP appointment numbers following their engagement in the social prescribing project. Although this is consistent with other schemes, these positive outcomes cannot be attributed solely to these patients’ involvement in the social prescribing pilot.

There were significant gaps in the data related to types of non-elective attendance and relevant contextual information, which impaired findings and analysis, and need to be rectified in future data collection.

Social prescribing process and model

The evidence suggests that there was a lack of clarity about the experimental and exploratory nature of the project, including an expectation for a specific delivery model of social prescribing to be developed and tested. This had important implications for the pilot and needs to be considered in future commissioning. A clear description of the model to be tested should be required during the commissioning stage, with a plan of how it can be developed and adapted during any pilot, and how community assets can be utilised and developed.

The delivery approach that was used appeared to be effective at engaging clients and improving client outcomes. At the same time, the available evidence suggested that there might have been instances where a more streamlined, focused, structured and cost-effective approach would have been sufficient and achieved similar results.

Considerations for scaling up the service

Delivery of the Richmond social prescribing pilot has had a positive impact on many clients’ lives, yet there is a need to consider and develop the following areas if the existing model of social prescribing were to be continued or scaled up.
Partnership working was one of the key areas where the delivery of the pilot service encountered challenges. In particular, this related to Community Navigators’ and GP practices’ involvement in social prescribing and sharing information. To ensure successful delivery of social prescribing in the future, it will be important to ensure enough attention is given to:

- Developing relationships and communication
- Organisational readiness (GP surgeries becoming ‘navigator ready’)
- Developing a shared understanding between clinical and non-clinical staff
- Planning for information sharing
- General practice staff engagement

Developing clear criteria for referral into social prescribing, including an understanding of how minority or vulnerable groups are to access the service

Focus on empowering patients so that, in the longer term, they can manage their own needs, and look after their health and wellbeing without depending on the service

Optimisation of the delivery processes, focusing on consistency of experience, efficiency and cost-effectiveness, and evidence gathering and sharing

Clarity about whether and how the systems for different referral pathways can be integrated or aligned; whether a social prescribing service can become a single point of referral for GPs, or if there should be parallel mechanisms with their specific purpose and application clearly defined

Greater levels of engagement of GP practices in social prescribing; taking account of GP practices’ capacity, priorities and existing ways of working.
INTRODUCTION

Defining social prescribing

Social prescribing was highlighted in 2006 in the White Paper *Our health, our care, our say* as a mechanism for promoting health, independence and access to local services (DoH, 2006). The NHS Five Year Forward View and General Practice Forward View have triggered a significant change in the focus of patient care, aiming to adopt a more joined-up approach with the individual at the heart of healthcare. Recently, the Royal College of General Practitioners has called for every GP practice to have access to a social prescribing service in order to help tackle GP workloads.

The King’s Fund defines social prescribing as “…a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.” Similarly, delegates at a recent conference of the Social Prescribing Network (SPN), produced the following definition, “[social prescribing enables] healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing.” Social prescribing aims to play a preventative and treatment role for individuals who may benefit from other types of support in addition to, or instead of, formal health and social care. It is characterised as a way of complementing or, in some cases replacing, clinical care and medication.

Initially, approaches to providing prescriptions on a non-medical basis included exercise on referral, referrals to smoking cessation support, and counselling. However, with the voluntary sector now being identified as a significant delivery partner within health and social care provision, there is access to a greater range of support via signposting and referral by GPs. This also extends to the role of statutory health and local authority services in helping to address housing and benefit needs as this can also help to improve an individual’s health.

---


The purpose of social prescribing is to allow GPs and others working in primary care to offer a broader range of options to build tailored support for an individual that goes beyond clinical intervention, so that patients also receive a greater level of care than they would have from a short GP appointment. Furthermore, patients sometimes choose to access a GP as the ‘default’ option when the support they need relates more to navigation around the systems and services available, if they do not otherwise have the confidence or knowledge to do so. Social prescribing also aims to connect individuals to their local community and enhance wellbeing through access to supportive networks, which can then help to build resilience at a community and individual level.

**Rationale for social prescribing**

Evidence suggests that social prescribing can be an effective way to provide a more holistic framework of addressing patient needs at the primary health care level and has the potential to be a cost-effective way of reducing GP and A&E attendance and increase psychosocial wellbeing of certain population groups (South, Higging et al., 2008; Cawston, 2011; Langford et al., 2013). International evidence has also highlighted the potential benefits of social prescribing which is being used in the Netherlands as a first response by general practitioners for patients exhibiting symptoms of depression instead of prescribing them medicine. It is hoped that this would result in lowering the high use of antidepressants (nearly 1,000,000 users) within the Dutch population (Sheldon, 2012).

A number of pilot social prescribing programmes have been delivered in local boroughs across England and independent evaluations of these have noted several positive impacts.

An evaluation of the Wellspring Healthy Living Centre’s Social Prescribing Wellbeing Programme for GPs encountering patients with certain mental health conditions found that the programme can “deliver improved wellbeing, lessen depression and anxiety, ameliorate isolation, lessen GP attendance, enhance physical health and improve employment chances for the majority of their beneficiaries” (Kimberley, Ward, Jones and Powell, 2014, p.70). Another evaluation, of a six-month pilot social prescribing programme in Tower Hamlets, revealed that patients took up a variety of activities including exercise and volunteering, stopped smoking and were more in control of managing their finances as a result of the intervention (Hogarth et al., 2013).

One of the aims of the social prescribing programme is to empower patients to care for themselves effectively and to encourage them to engage more with their own health in a holistic way (Stokes-Lampard, 2018). This involves supporting individuals to manage their own wellbeing and health on a day to day basis and to become more involved in decisions about their care. This outcome was noted in the East Merton social prescribing evaluation (Healthy Dialogues, 2017) whereby patients were reported to not only have stronger health because of participation in the programme but also were able to better self-manage their own care.
An evaluation of a social prescribing pilot in Rotherham (Sheffield Hallam University, 2014) noted improvements in patients’ wellbeing, particularly in respect to their mental health, a reduction in social isolation and increased autonomy especially for those patients who had limited mobility due to physical condition and a general increase in levels of physical activity among patients. Outcomes for the public sector included a reduction in patients’ hospital and GP attendance which was a direct result of a growth in patients’ independence accompanied with feeling supported enough to better manage their condition (Sheffield Hallam University, 2014).

A few systematic reviews (Bickerdike, Booth, Wilson, et al., 2017; Wilson and Booth, 2015; Polley, Bertotti, Kimberlee et al., 2017; Kinsella, 2016; Wilson and Booth, 2015) have questioned the robustness of evaluations of social prescribing, with an emphasis on a high risk of bias, methods used in the evaluations, and lack of control in the data group. While this has implications for stakeholders, it has been recommended that the development of a common evaluations framework could help put the strengths of social prescribing into perspective and enhance the quality of evaluations as well as their reporting (Polly et al., 2017). Furthermore, the qualitative evidence reported in all the independent evaluations clearly suggests that users of services as well as health care professionals including GPs, find social prescribing to be of benefit (Smith and Skivington, 2016).

**Overview of the pilot**

The Richmond Clinical Commissioning Group (CCG) and London Borough of Richmond introduced a social prescribing pilot in October 2017 in three GP practices in Barnes. Barnes, an affluent area with some deprivation, has high numbers of community and voluntary organisations and other assets that can be tapped into in order to improve health and wellbeing of vulnerable populations. Patients considered suitable for the social prescribing pilot in Richmond included frequent attendees of GP and/or A&E, having moderate mental health issues, experiencing social isolation, and people living with long term health conditions.

The pilot was commissioned by Richmond CCG and delivered by RichmondAID, a local charity providing services to disabled people and people with long term health conditions in the borough.

The delivery aim was to:

*To develop and implement a pathway for GP practice staff to refer patients to a Community Navigator, who will provide one to one assessment sessions for service users to understand patients’ social needs, and promote connection with local community assets that support the five ways to wellbeing.*

**Richmond social prescribing pilot service specification**
Evaluation aims

Chrysalis Research was commissioned to evaluate the Richmond social prescribing pilot. The aim of the evaluation was to address the following questions:

• How is the social prescribing programme being delivered in practice? Who is being referred and what intervention do they receive?
• How effective is the pilot – has any change been observed on the outcomes of interest? Can these be attributed to the social prescribing pilot?
• What worked well and what did not? What are the key barriers and facilitators to implementation? How were the identified barriers overcome? What factors were responsible for a successful (and less successful) implementation within GP practices? To what extent does it fill a gap in existing provision for certain population groups?
• Can the project be scaled up in the future? If so, how and what practically needs to be in place in order to do this well? Are there any gaps in provision which need to be addressed?

Evaluation methods

The evaluation was designed to be mainly formative, although it also considers the outcomes data that was available in order to gauge the effectiveness of the pilot. It draws on a range of primary and secondary evidence as described below. With limitations of other evaluations in mind, we would state that the Richmond evaluation assesses the available evidence from the Richmond social prescribing scheme and makes recommendations from the findings for the short to medium term.

Appendix 1 describes the evidence base in full, which comprised primary and secondary sources. The primary evidence comprised telephone and face to interviews with:

• Users of the social prescribing service – carried out at the three-month stage of the project
• Two GP practice managers and one GP
• Representatives from the service provider, three community navigators and four community organisations – again primarily carried out after three months of delivery
• A representative of the commissioning body, Kingston and Richmond CCGs.

The secondary sources used comprised:

• Service and referral data provided by Richmond AID
• ‘Feedback to GP’ forms prepared by Richmond AID
• Wellbeing Star\(^4\) data collected and processed by Richmond AID

• Information on the number and types of participating patients’ GP and other primary and secondary care appointments, assembled by the GP practices at the request by the CCG.

**Report structure**

In the main body of this report we first consider reach and outcomes of the service followed by the analysis of the pilot processes, reflecting on both outcomes achieved and wider evidence, and distilling learning that can be taken to future commissioning and delivery of social prescribing. The final section of the report offers overarching conclusions and recommendations.

\(^4\) The Wellbeing Star is a validated outcomes measurement tool used with individuals who have a long-term health condition to establish their current needs, design action plans and goals, and measure progress and outcomes over time, see [http://www.outcomesstar.org.uk/using-the-star/see-the-stars/well-being-star/][1] Accessed 19\(^{th}\) June 2018.
CLIENT NUMBERS AND PROFILE

Profile of clients

By mid-June 2018, a total 94 patients had been referred to Richmond AID. Of these, 80% had been referred by GPs, followed by self-referrals (13 per cent), referrals from Castlenau Community Centre (6 per cent) and the Mental Health and Social Care Team (1 per cent). There were no referrals from pharmacies. The rate of referrals was lower than had been anticipated in the provider’s bid, which stated that 130 patients would be referred in the first six months of the service against an achieved 94 between October 2017 and June 2018. The service specification required 100 client referrals within five months of the pilot.

There are a number of possible reasons why referrals were lower than anticipated, although the evaluation did not establish the extent to which these had an impact:

- The CILS information Navigation project, commissioned by the local authority and delivered by Richmond AID, has established referral routes for professionals and individuals for supporting people to access services in their community, though the projects use different methodologies for support and evaluation. Therefore, the Social Prescribing pilot was wholly reliant on GP referrals and referrals from pharmacies and a limited number of referrals from other sources were received.

- Richmond AID’s bid anticipated having space at GP practices to see patients. This was not possible until a few months the project delivery when they were able to negotiate half a day of delivery in two practices. Therefore, the majority of appointments with clients were home visits or local venues. This meant project delivery was more time consuming than predicted.

- Richmond AID anticipated having a closer working relationship with GPs, regularly attending practice meetings to update GPs. They reported that they were invited to one meeting in each practice at the start of the pilot but not to any further meetings, despite making requests.

The profile of clients referred to Richmond AID was different to the local population. The client population included a higher proportion of older people, people from minority ethnic groups and women. Appendix 2 shows how the profile of clients referred for social prescribing compares with that of the Barnes population or, where this is not available, with that of the Borough of Richmond. The data shows that:
• 42 per cent of referrals were aged over 65, compared with 21 per cent in Barnes as a whole
• 48 per cent of referrals were female, compared with 30 per cent across Barnes
• 48 per cent described themselves as white compared with 85 per cent across Barnes (note that ethnic group was not recorded for 36 per cent of referrals).

The data shows that the social prescribing pilot reached a high proportion of people from vulnerable groups, including those with mental and long-term physical health conditions (Figure 1). There was no data recorded on socio-economic status, however, of those for whom living status was recorded more than half (27 out of 51 referrals) were living in social housing with just over one-fifth (11 out of 51) living with family or in a home they own. In Barnes as a whole, more than half of households are owner occupied.

**Figure 1: Health status of patients referred for social prescribing**

Source Richmond AID service data (base = 94)

<table>
<thead>
<tr>
<th>Population of Richmond Upon Thames</th>
<th>Social prescribing clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Health icon] 10% have long term health conditions</td>
<td>27% have long term health conditions</td>
</tr>
<tr>
<td>![Health icon] 11% have depression, anxiety or another common mental disorder</td>
<td>31% have depression, anxiety or another common mental disorder</td>
</tr>
<tr>
<td>![Health icon] 1% have neurological conditions</td>
<td>4% have neurological conditions</td>
</tr>
</tbody>
</table>

---

5 Richmond-Upon-Thames population is 194,733 based on data from JSNA Richmond, 2017
**Figure 1b: Clients’ main disability/ health condition**

<table>
<thead>
<tr>
<th>Condition</th>
<th>%</th>
<th>Condition</th>
<th>%</th>
<th>Condition</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression or anxiety</td>
<td>16</td>
<td>Stroke</td>
<td>2</td>
<td>HIV</td>
<td>1</td>
</tr>
<tr>
<td>Arthritis</td>
<td>6</td>
<td>Alcohol addiction/ alcoholism</td>
<td>1</td>
<td>Multiple sclerosis</td>
<td>1</td>
</tr>
<tr>
<td>COPD</td>
<td>4</td>
<td>Alzheimer’s</td>
<td>1</td>
<td>Osteoporosis</td>
<td>1</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3</td>
<td>Amputation</td>
<td>1</td>
<td>Other neurological conditions</td>
<td>1</td>
</tr>
<tr>
<td>ADHD</td>
<td>2</td>
<td>Cancer</td>
<td>1</td>
<td>Schizoaffective disorder</td>
<td>1</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>2</td>
<td>Diabetes</td>
<td>1</td>
<td>Spinal injuries</td>
<td>1</td>
</tr>
<tr>
<td>Other mental health conditions</td>
<td>16</td>
<td>Other physical disability</td>
<td>6</td>
<td>Other health needs</td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>21</td>
<td>No disability</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reasons for referral**

Social isolation was the most common reason for a referral. For around one-third (34 per cent) of patients this was the concern cited by the GP as the reason for referral (Figure 2). Many patients also presented with physical or mental health issues, with depression and anxiety the most common (16%). This aligns with the East Merton pilot where the most common reason for referral was mild to moderate mental health concerns with the second most common presenting issue as long-term physical conditions. In the Tower Hamlets evaluation of social prescribing, it was noted that the most common reason for patient referral was exercise followed by weight management. This may have been influenced by the services offered in the respective pilots.

**Figure 2: Reasons for referral (Base = 94)**

- Social Isolation: 34%
- Help with benefits: 9%
- Financial, community or social care support services: 8%
- Debt, employment, transport and support for carers: 3%
The service specification identified the type of clients who would be most likely to avail the services of social prescribing. These included the vulnerable and at-risk clients, including those suffering from depression or anxiety, had a long-term condition, low-income, single parents, recently bereaved older population, and frequent attendees of primary and/or secondary care. The specification also states that clients for referrals were fit for purpose for social prescribing if they presented with, “specific social issues, that may be below the threshold for statutory services, but create a risk of impacting on patients’ and/or their families’ wellbeing and quality of life and which may benefit from holistic assessment and referral to one or more community assets.”

The GP who took part in the evaluation felt that the right people were ultimately being referred, but that the referral criteria were very broad Feedback from a practice manager also suggested that the definition of social prescribing was unclear, which may result in difficulties at the patient identification stage.

*Part of the problem is we can refer to Social Prescribing, but my GPs don’t still really know what they’re referring to.*

*Practice manager*

**Summary**

The available evidence suggests that within the Richmond social prescribing pilot

- The rate of referrals was lower than expected
- In relation to the local population, a higher proportion of referred clients were female or aged 65 or older
- Social isolation was cited as reason for referral for most clients.
SOCIAL PRESCRIBING OUTCOMES

The service specification for the pilot project stated two main types of intended outcomes:

- Improved ratings for health and social wellbeing, measured via an outcomes tool, the Wellbeing Star
- Changes in types and frequency of GP and unplanned primary and secondary care appointments, recorded three months before and three months the social prescribing pilot.

We consider these outcomes in turn in this section.

**Patients’ perceptions of own health and wellbeing**

The Wellbeing Star, originally developed by Triangle in partnership with NHS North East Essex with funding from the Department of Health for working with people with long term health conditions, was used as the main mechanism for measuring change in patients’ wellbeing within the pilot.

The Wellbeing Star covers eight areas. For each area, patients rated themselves on a five-point scale.

*Figure 3: Wellbeing star areas and scale*

<table>
<thead>
<tr>
<th>Eight areas</th>
<th>Each measured on a five-point scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Your lifestyle</td>
<td>• Not thinking about it</td>
</tr>
<tr>
<td>• Looking after yourself</td>
<td>• Finding out</td>
</tr>
<tr>
<td>• Managing symptoms</td>
<td>• Making changes</td>
</tr>
<tr>
<td>• Work, volunteering and other activities</td>
<td>• Getting there</td>
</tr>
<tr>
<td>• Money</td>
<td>• As good as it can be</td>
</tr>
<tr>
<td>• Where you live</td>
<td></td>
</tr>
<tr>
<td>• Family and friends</td>
<td></td>
</tr>
<tr>
<td>• Feeling positive</td>
<td></td>
</tr>
</tbody>
</table>
During the pilot, statistically significant improvements (p<0.05) were recorded across all eight areas measured by the Wellbeing Star, as shown in Figure 4. Details of the confidence intervals and statistical tests are shown in Appendix 3.

A total of 57 patients had both a baseline and follow-up Wellbeing Star assessment. Figure 4 shows that the mean scores of patients improved by one point on the scale in four areas – feeling positive, looking after yourself, money, and lifestyle – and in two further areas improvements of 0.8 and 0.9 were recorded. The two areas where improvements were less noticeable, though nonetheless very positive, had the highest average baseline scores suggesting that patients were initially most content with these areas – where you live and family and friends.

**Figure 4: Mean pre and post Wellbeing Star assessments**  
(base = 57 patients with matched records)

East Merton also used the Wellbeing Star tool. Many of the areas started from a lower baseline compared with Richmond, but like Richmond the biggest improvement for East Merton were of around one point; for your lifestyle, looking after yourself and managing your symptoms. The Tower Hamlets scheme used a different tool to measure wellbeing – MyCAW – but the baseline measure was not universally collected.

Analysis of the Wellbeing star data shows that, for the majority of patients (68 per cent of those for whom matched records were available), their scores increased in five or more areas, i.e. they felt that their health and wellbeing had improved in these areas. For nearly one-quarter (23 per cent) scores increase across all or all but one of the areas (Figure 5). All patients showed improvements in at least one area.
For eight patients (out of 57) the self-rated scores decreased in one or more areas. Two of these patients rated themselves lower after the pilot in three of the eight areas and the other six rated themselves lower in one area only. This means that, of more than 450 pre- to post-pilot changes (57 patients across eight areas), only 12 (3 per cent) of showed a decrease in health and wellbeing. Around one-third (33 per cent) of all measures showed no increase or decrease (baseline matched the follow up score).

Evidence gathered by the delivery provider (e.g. ‘Feedback to GP’ forms for each of the clients) and interviews carried out by the evaluation team, further illustrate how concrete steps to change people’s lives and offer them support where it matters to them, can lead to improvements in the state of their overall wellbeing. The documents showed patients feeling supported and less socially isolated, which they often linked to an improvement in their overall well-being. Many were frustrated and unhappy about particular issues prior to their involvement in the social prescribing scheme, yet unable to make much progress with them and feeling not being listened to. Community navigators either resolved the issues or made good progress, for example through supporting clients to join exercise classes and social groups, or providing funding for items for the home (see case study, right). Many patients engaged in an activity or interest for the first time in years – a strong indicator of the success of the social prescribing pilot for some patients.

**Case study**

One patient, a recovering alcoholic, had received some practical help to buy a new fridge and was hoping to get a new oven. During an interview she said that she ate more healthily as a result of having the fridge and was taking more pride in her home. While not all her concerns had yet been fully addressed, she was very positive about the service. She was planning to start yoga or pilates classes in the next few months. Importantly, she felt more able to contact voluntary organisations to seek help as a result of working with her navigator.
Patients appreciated both the attention they received and how the changes affected their daily lives, while community navigators commented that the biggest change was in attitudes amongst people, from thinking about their lives or circumstances in quite a negative way to feeling more positive. Appendix 4 documents case studies of two further pilot participants.

One patient was very complimentary about the service but said she would have liked it to provide longer term support. She had a combination of physical (obesity and arthritis) and mental (OCD and agoraphobia) health issues and was looking for housing that she felt was appropriate for her as she was living with her father at the time of interview. She had started attending a local community centre to socialise with other people but her housing situation had not been resolved at the time of interview. She felt that it can take some time her to trust and open up to someone and that she was just becoming comfortable with her navigator when support ended.

*It [social prescribing] has helped me realise that there’s life behind my front door, and there are people out there who are willing to help. And that there is a service there, that is actually really needed for people like me. And I felt like I was very lucky to have been offered it. I’m just gutted that it didn’t last that long.*

**Female, 30-39 years**

**Service outcomes**

The evaluation team performed an assessment of 87 ‘Feedback to GP’ forms to determine the extent to which the issues that were identified as negatively affecting each individual patient’s wellbeing during the initial assessment by the community navigator had been resolved because of their engagement with the service. For 72 of these the majority or all their issues were resolved or processes put in place to resolve them.

44 patients had one or more issues, for which the first steps were taken by the service provider but the outcomes of the patient had not yet materialised. For instance, in one case, a 49-year old presented with three issues concerning mental well-being, housing and assistance with benefits. His mental health deteriorated, in part due to stress he experienced liaising with the housing and benefits team. Support was provided to help him with liaising with the different agencies for his benefits and housing, and to support with his physical and mental health and social isolation through accessing a gym, a community centre and volunteering. The patient felt that his mental well-being had improved, despite continuing to have some health issues which did not allow him to follow each activity.
‘[Name of a community navigator] has been really helpful in introducing me to activities. She is a really kind lady and listens to me. I’ve not followed through on all of the actions as yet but plan to when I’m feeling better.

**Male 40-49 years**

Other patients had disengaged from the service, were not contactable or had expressed that they would return to the service when they felt ready at a later date. Four patients had concerns that could not be addressed, including in one case a grant application was refused as the patient had savings above the limit required for a grant, in another patient, a housing application was refused due to space limitations.

A further 20 patients received additional support, which were not counted in the total number of issues. There did not seem to be a clear pattern as to why additional support was provided to some in the way of multiple referrals for the same issue while it was not provided to others who had also raised a similar concern.

The analysis of the GP feedback forms shows that high proportions of clients were helped to deal with their issues through the social prescribing scheme and supports the feedback from clients in the primary research, who described their experiences of the service – and the community navigators in particular – in very positive terms. Most participants felt that social prescribing had either having resolved or partly resolved their issues.

**Types and frequency of GP and unplanned primary and secondary care appointments**

GP appointments data for 75 patients was analysed to explore the impact of the social prescribing scheme on GP appointments, non-elective attendance and prescriptions. GP practices were asked to measure data from 12 weeks before and 12 weeks after their first appointment with the Community Navigator. There was some evidence of a reduction in the number of GP appointments made following the social prescribing scheme, but little to suggest an impact on non-elective attendance or prescriptions.

Of the 75 patients for whom GP appointments data was available 12 weeks pre and post their involvement in the social prescribing pilot, the number of such appointments post participation:

- Increased for 17 patients (23 per cent)
- Remained the same for 21 patients (28 per cent)
- Decreased for 37 patients (49 per cent).
Seven of the 17 patients for whom there was an increase in the numbers of GP appointments had ongoing mental or physical health issues which needed monitoring and or treatment, according to the notes added by Richmond AID. For the remaining ten patients, no explanation was provided as to why there was an increase.

With regards to non-elective attendance, 60 patients out of the 75 had no change noted in their non-elective admission figures pre and post pilot. For six patients there was a decrease and for nine patients there was an increase in non-elective attendance. There was little contextual information available for non-elective attendance to further understand these changes.

The number of prescriptions rose for 22 of the 75 patients, decreased for 15 patients and remained the same for 38 patients. No difference was noted in smoking status before and after taking part in the social prescribing project for all patients. It should be noted that receipt of prescriptions and smoking status of patients data were not outlined in the service specification.

The Richmond data is consistent with other social prescribing schemes. East Merton also carried out a 12-week pre and post GP appointment review and found that GP attendance reduced from 1,641 before social prescribing, to 1,098 – a reduction of 33%.

**Summary**

Evidence about the participating patients’ perceptions of their wellbeing, gathered through the Wellbeing star, ‘Feedback to GP’ forms and interviews carried out by the evaluation team, portrays a positive picture overall. For the majority of the clients involved in the social prescribing pilot there were improvements in multiple areas of wellbeing, resulting in reductions in frustrations and concerns around money or housing, greater socialisation and levels of physical activity linked to their participation in local groups, and feeling more positive overall as a result. For many patients it was very important to feel supported and listened to.

Yet, there were some patients for whom improvements were small in one of more areas of wellbeing, which could not always be explained by the short period of their engagement with the service. These patients were not represented in the telephone interviews and so further evidence is needed to better understand negative or neutral outcomes.

Given the importance of the Wellbeing Star evidence when gauging the service outcomes, going forward, quality assurance of the process of capturing the assessment data by the delivery provider is recommended, to ensure rigor and minimise the risk of bias.

For nearly half of the patients (37 out of 75) there was a decrease in GP appointment numbers following their engagement in the social prescribing project. Although this is consistent with other
schemes the evaluation cannot determine whether these positive outcomes can be attributed solely to these patients’ involvement in the social prescribing pilot.

There were significant gaps in the data related to types of non-elective attendance and relevant contextual information, which impaired findings and analysis, and need to be rectified in future data collection.
SOCIAL PRESCRIBING PROCESS AND MODEL

The exploratory nature of the pilot

The social prescribing project was conceived as a pilot. The commissioner described it as an opportunity to test the feasibility of implementing social prescribing in Richmond and identifying a model that would work effectively in the local context. The evidence suggests that, from the outset, there was a lack of clarity about the experimental and exploratory nature of the project amongst the involved stakeholders. For example, the delivery service specification does not state a requirement for a clear delivery model to be tested. Instead, it invites proposals for implementing a care pathway – a social prescribing service – and specifies the service components expected. Similarly, while the pilot objectives include a number of areas to be explored, these are not reflected in the delivery objectives, so it is unclear how the pilot objectives could be achieved and by whom. As a consequence, the pilot objectives appear to have been interpreted by the provider as ‘for information’ rather than a call for action that would have guided the design and delivery of the pilot.

In their proposal, the provider outlined their approach to delivering the social prescribing service and collecting evidence about its effectiveness. The document does not offer a conceptually clear model of social prescribing. Such a document would have enabled the provider to make strategic decisions during the mobilisation and delivery phases when encountering obstacles and challenges, rather than being reactive in their approach and attempting to deliver the service as close to their original plans as possible. The commissioner reported that their attempts to secure clarity from the provider about the delivery model proved a challenge.

The social prescribing model piloted in Richmond

In the absence of a clearly defined model – the effectiveness of which could be tested in its entirety as well as its individual elements – the evaluation team had to define the model based on the evidence available. In doing so, Chrysalis Research drew on the wider research and evidence about social prescribing, including evaluations of relevant schemes carried out elsewhere, in order to crystallise the Richmond model and make judgements about its effectiveness where possible.

As stated earlier in the report, there is not a single model of social prescribing. There have been several attempts to propose a typology of social prescribing models, however. One of them
(Kimberlee, 2013; Kimberlee et al 2014)\(^6\) provides the following classifications of social prescribing: *signposting, social prescribing light, social prescribing medium and social prescribing holistic*. Some of the parameters that differ between the different types in this classification are as follows:

- The extent to which referrals from GP surgeries to community projects are coordinated and, in particular, whether there are feedback loops, information sharing channels and outcomes evidence gathering in place.
- Involvement of a mediator or facilitator, a role that is typically carried out by third sector and voluntary organisations.
- The breadth or specificity of patient needs addressed via social prescribing.
- The extent to which primary care practitioners are involved in co-design of the service and the extent to which it is an integral part of what a GP surgery does.

A recent systematic review\(^7\) provides a slightly different typology:

- **Model 1: Information service.** This service is an information only service, with advertising and directory access to SP in a primary care practice.
- **Model 2: Information service and telephone line.** This service advertises social prescribing on leaflets and notice boards in a primary care practice. Based on this information, patients can self-initiate a telephone discussion with a worker.
- **Model 3: Primary care referral.** Primary health care professionals assess patients during consultation and refer them to social prescribing services if appropriate, for example if patient have non-clinical issues and require psychosocial support. Referrals to social prescribing services are opportunistic.
- **Model 4: Practice-based generic referral worker:** Primary care patients can be referred by health workers, or self-refer to a social prescribing link worker. Clinics are held in the GP surgery, so that it can act as a “one stop shop”.
- **Model 5: Practice-based specialist referral worker:** A specialist worker works from primary care practice and patients can be referred through primary care referral or self-referral.

---


advice and specific services, such as Citizens Advice, may be offered, as well as referral or signposting onwards.

- **Model 6: Non-primary care based referral worker**: Patients are referred to an external referral centre by primary care practice staff, offering one-to-one facilitation, for example an outreach service set in the community.

The second typology considers different parameters, compared to the first one, such as the mode and intensity of the social prescribing intervention, the source of referral, the place of referral and intervention.

The service delivered as part of the Richmond pilot spanned multiple delivery models and classifications. For example, relating the Richmond pilot to the first typology, some aspects of its delivery fit with the descriptions of each of the four types.

**Applying the Kimberley typology to the Richmond pilot**

<table>
<thead>
<tr>
<th>Classifications</th>
<th>Exemplification in the Richmond pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signposting:</strong></td>
<td>For example, co-ordinators or GPs directing patients to local organisations and charities such as Age UK as part of their established referral processes</td>
</tr>
<tr>
<td><strong>Social prescribing light</strong></td>
<td>Feedback, monitoring and information sharing within the pilot was initially informal but evolved over the course of the pilot</td>
</tr>
<tr>
<td><strong>Social prescribing medium</strong></td>
<td>The breadth of client needs that the service attempted to address in most instances fits with ‘social prescribing holistic’, yet the degree of integration with primary care is very different from it.</td>
</tr>
</tbody>
</table>

Similarly, applying the second typology,

<table>
<thead>
<tr>
<th>Classifications</th>
<th>Exemplification in the Richmond pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model 5: Practice-based specialist referral worker</strong></td>
<td>the service specification and provider project plans were most consistent with Model 5</td>
</tr>
<tr>
<td><strong>Model 6: Non-primary care-based referral worker</strong></td>
<td>In practice, the pilot was closer to this model, with co-ordinators not based in GP practices</td>
</tr>
</tbody>
</table>
Following our analysis of these and other studies, as well as the pilot documentation and other evidence, we have identified a range of elements that comprise the social prescribing model piloted in Richmond, each of which is considered below.

**Source of referral**

Within the vast array of the social prescribing models there are many ways in which patients can be referred to relevant community assists. These broadly include:

- Self-referral
- Referral by GP practices, within which there GP referrals and referrals by other staff
- Referrals by other health and related organisations, such as pharmacies.

The majority of patients in Richmond were referred by GP practices, but there were also instances of self-referral.

Based on their engagement with pharmacies, the service provider stated that pharmacies would be unlikely to recommend social prescribing to their customers directly, but would be more likely to advise customers to see their GP. With one of the clear aims of social prescribing being to minimise GP workload, pharmacies directing their patients to GPs to discuss social prescribing would be counterproductive from the point of view of reducing GP workload and therefore is not recommended going forward. Evidence from elsewhere however\(^8\) shows that pharmacies can act as referrers directly to social prescribing coordinators for an initial assessment, so if the commissioner wishes to explore involving pharmacies in the future this should be clearly stated as a direct rather than mediated referral route.

GP practices were the most common source of referral. The practice managers reported that two approaches were used within the pilot.

- Initially, referrals came via the practice managers rather than directly from GPs. Practice managers discussed which patients might be suitable candidates, often those who were frequent attenders at GP appointments.
- More recently, referrals have come directly from GPs.

The first of these has the potential to direct patients to social prescribing to trigger improvements to their health and wellbeing, without negatively impacting on GP’s time and workload. However, it

---

may have affected how engaged GPs felt in the pilot since they were not involved in the referral process to begin with. Furthermore, patients were not always aware they had been referred for social prescribing and expressed surprise when first contacted by the navigator.

A hybrid approach – where practice staff consider their patient data and ‘flag up’ patients who appear to fit the criteria to GPs for confirmation – may be more effective in ensuring the right patients are referred to the service and GP workload is minimised. In parallel, GPs would screen for those who could benefit from social prescribing as part of their appointments with patients.

Based on the evidence available, from the pilot and schemes delivered and evaluated elsewhere, it is not possible to conclude that only one approach or source of referral is right. In this context, it will be important to ensure that who referrals patients is monitored for effectiveness and efficiency by delivery provider and commissioner so that changes to the process can be made. Equally important will be to involve staff in all relevant roles to define and co-create the process so that it is as tailored to be consistent with their existing systems and ways of working as possible.

**Referral process, data collection and sharing**

There was no operating model for the process of referral, the exact mechanics of how it would work between GP practices and social prescribing coordinators (community navigators), prior to the start of the service delivery. At the start of the project the provider had an NHS email account to receive referrals. A referral form and consent form for data sharing was developed and agreed with commissioners information governance for the CCG. Posters and leaflets were developed, and an information leaflet was produced.

The first point of the referral pathway is indicated in the provider’s bid as ‘Referral received by Community Navigator’. Partly this was because it was both the commissioner’s and the delivery provider’s expectation that the delivery provider would be based at the participating GP practices and have access to relevant patient’s clinical records, neither of which were possible to put in place within the pilot. There is no evidence of planning or concrete strategies for engaging GP practices in the process, or for putting the necessary systems and structures in place for the social prescribing delivery mechanisms with the aim of optimising their efficiency. For example, most referrals were made via email but existing systems were not utilised to make this more effective – the practice managers commented there were no automatic reminders for GPs about referring for social prescribing or anything that flagged up whether a patient might be eligible for the pilot.

Similarly, the referral process remained unsystematised even in the final stages of the pilot. GPs in the pilot practices already had a referral pathway in place for clients with non-medical issues to be referred to the Community and Independent Living Service (CILS) and Age UK, but no advice or guidance was given to GPs about whether to use these routes or social prescribing. Interviewees
with one of the community organisations, a GP and the practice managers highlighted that it might be confusing for GPs to have been given another referral route – although it was not possible to verify this with the other GPs.

Clarity is needed about whether and how the systems for these different referral pathways can be integrated or aligned. A decision about whether a social prescribing service can become a single point of referral for GPs in future, or there should be parallel mechanisms with their specific purpose and application clearly defined, needs to be made in consultation between the commissioner, delivery provider, GP practices and other relevant local stakeholders, including organisations currently referred to alongside social prescribing. An alternative approach would be to test different referral routes and whether they can co-exist, in different participating practices. The outcome of these activities, i.e. the updated guidance about the referral process, would need to be clearly communicated to all involved to streamline the referral process and avoid any confusion.

Access to clinical records has been shown to be important for information sharing and efficiency of social prescribing mechanisms. For example, the evaluation of Tower Hamlets’ social prescribing scheme found that the use of EMIS improved communication between social prescribing coordinators and GP practices and for those that did not have access to EMIS, several omissions were noted especially in respect to feedback to clinicians (Healthy Dialogues, 20189; Ferguson and Hogarth, 201810). Feedback from the provider also suggests that lack of access to clients’ medical records might have negatively affected the service ability to secure the best possible outcomes for patients. Community navigators said having patients’ records information would have allowed them to gather contextual information about the client, their health and circumstances which might have helped to inform the social prescribing approach.

This suggests that access to patient records for social prescribing coordinators:

- is possible, despite the difficulties of putting this in place as part of the pilot
- is highly useful in delivering social prescribing
- but is not the only way in which patient information can be shared. The process of information sharing can be challenging to put in place quickly and ensure it is streamlined and works for all involved. It requires thought and planning and should be requested as part of the initial delivery plans.

---

The range of client needs and ways of addressing them through social prescribing interventions

Unlike some social prescribing schemes that target specific types of client needs or limit the number of issues that can be tackled, the approach adopted by the delivery provider during the pilot can be described in most cases as holistic, in-depth, highly personalised and bespoke. Below we explore the stages at which social prescribing coordinators (community navigators) working with clients to gauge the effectiveness and efficiency of such approach.

Patient assessment by the community navigator

The service specification suggests that when a client is referred for social prescribing, they should first be assessed by a community navigator to determine their needs. This should be a holistic assessment, the exact areas to be agreed with the commissioner but including general health, social factors (e.g. isolation) and wider determinants (e.g. housing). Although not outlined explicitly in the service specification, it is assumed that this assessment would be based on information in the referral form and through accessing client’s clinical records. Following referral, a phone call should be arranged between the client and navigator. This would introduce the client to the service and their navigator and allow the navigator to assess whether a face to face meeting should take place or whether signposting to community assets is sufficient.

Amongst those whose case was closed, 13% did not have a face to face meeting with a navigator. These individuals were either signposted to a community asset or did not engage with the service.

Little is known about the patients who did not engage with the more intensive levels of social prescribing support and it is therefore not possible to deduce whether sign-posting, as the least resource-intensive approach, led to similar positive outcomes for clients as did more in-depth levels. Nor is it possible to say whether the profile and needs of such patients were different from those who participated in multiple meetings with the community navigator. It appears however, that an effective social prescribing model should include ‘light-touch’, signposting, interventions, following an initial – possibly brief – assessment of client needs. Sign-posting can be inexpensive and cost-effective and might be sufficient to achieve the desired outcomes for some of the clients referred to social prescribing. Greater attention would need to be paid to evidence gathering for such patients, ensuring that it is commensurate with their level of engagement.

For the remainder of the clients, the initial face to face meetings focused on the client and navigator getting to know each other and information gathering, for example, regarding their health status or living situation. This session could take up to two hours as navigators felt it was important to give new clients the time and space to tell their story. The approach was very client-focused and tailored to their individual needs and circumstances. The delivery partner commented that this tailored and
person-centred approach made it difficult for them to map out a written process or model detailing, for example, how many meetings are appropriate, how long and where they should be or where an individual should be referred on to another organisation since these decisions take into account a number of factors such as how motivated an individual is, how mobile they are and their mental health state.

The Wellbeing Star was used in the initial meetings to identify the areas the client wishes to focus on with their navigator. While the navigators found it to be a useful tool on the whole, completing it was a time-consuming process, especially with those clients who have multiple reasons for referral.

Action plans were made with some, although not all, clients. One of the navigators said she understood the theoretical need for standardisation of the process and the idea of enabling or empowering people, but that action plans were not appropriate for everyone. Clients can often be quite vulnerable when they initially present for social prescribing and may be unable to act upon an action plan. This is taken into consideration at the first or second meeting by the navigator when designing the approach.

Overall, the available evidence suggests that initial patient assessments were comprehensive and, in many ways, determined the success of the intervention for some of the clients. For some clients the highly tailored and person-focused approach that was adopted was justified and appropriate. Giving such clients high levels of additional support and time to share the many issues they were dealing with was essential to engage them with the service and start making progress towards changing the state of their wellbeing for the better. Yet it is unclear whether such an approach was justified in all cases where it was used. There appeared to be no central guidance or training, rather it was dependent on individual community coordinators and their levels of expertise.

Equally, evidence about action plans not completed during the initial meetings poses questions about whether enabling patient self-management and self-help was indeed at the heart of the service as was originally anticipated. There may have been instances of community navigators being so focused on resolving issues affecting client wellbeing that they found it difficult to support clients to manage their wellbeing independently.

Whilst advocated in some previous research and studies, the highly person-centred and bespoke approach adopted in the pilot is certainly in contrast with many other social prescribing schemes, which appear to be more structured in their approach to initial meetings and subsequent delivery. Based on the evidence available, it is however impossible to conclude whether the pilot in Richmond

---

was able to achieve better outcomes and in particular to engage clients who would have opted out and disengaged if more structured and focused approaches were used.

Evidence suggests that an effective delivery model should comprise three tiers:

- Light-touch signposting
- Structured and focused assessment and support
- Bespoke assessment and intensive support, with more flexible and tailored approach being adopted only when there are clear signs that such level of support is required to improve client health and wellbeing. Ensuring that this level of support is offered appropriately should be monitored by the delivery provider and commissioner.

In addition, alternative approaches to using action plan should be explored as a way of enabling patients to take control of improving their wellbeing from the outset. Social prescribing providers should be encouraged to seek innovative solutions that they could offer to clients who consider action planning formalistic or do not meaningfully engage with it for other reasons.

**Social prescribing interventions – their intensity and nature**

In its description of the planned approach to supporting patients through social prescribing, the delivery provider stated that they envisaged to:

- Link patients with groups, services and activities that can help improve health and well-being including sources of social, practical and emotional support
- Link patients with existing providers of advice and information, for example on housing, welfare benefits, money advice and employment
- Apply for small grants for individuals for items that will support their health and well-being.

Evidence of interventions and support offered to clients suggests that the delivery approach was consistent with what was planned. Most clients presented a number of issues and the delivery partner was effective at resolving many of them using the strategies listed above.

There was a lack of clarity about how the decisions about different types of onward referrals and support were made; making sure in particular that those clients who needed it had sustainable mechanisms of dealing with issues in place, rather than relying on the community navigators or their GP practice. There did not appear to be a strategy for choosing between different types of social prescribing interventions for each client, such as art therapy; nature and eco therapy; exercise and physical activity; learning; mutual aid, befriending and peer support; self-help groups; programmes
based on the principles of cognitive behavioural therapy; and taking part in volunteering and community groups.\textsuperscript{12}

Selections of interventions were often client-specific, i.e. clients with the same needs and issues appeared to have be offered very different intervention types. This was again explained by the provider using a client-centred approach and listening to client preferences. It was not possible to assess the extent to which this was required, or how such choices were monitored to ensure consistency of client experience and quality of delivery, as well as whether the choices were most effective in supporting improvements to client wellbeing. We did not see evidence of accessing or developing community assets.

The number of meetings also varied between clients. Nearly three quarters of clients for whom data was available, had between one and three meetings with community navigators, which is similar to the levels of intensity of support noted in other social prescribing schemes. It is however important to highlight that some clients were also supported remotely, mainly over the phone. According to the provider’s monitoring data, there were over 2,000 contacts made with the clients during the pilot, suggesting an average of more than 20 contacts per client. These included face-to-face meetings, home visits and drop-in sessions, as well as phone, email and postal contacts. Despite encountering many challenges in implementing the service, for example the community navigators not being based in the GP surgeries as anticipated and therefore needing to allow time for travel to meet with clients, the delivery provider worked hard to ensure clients had personalised and tailored support, which was often resource-intensive.

In any future implementation of social prescribing, cost-effectiveness would need to be carefully considered and monitored. This might include developing a clear client support plan and discharge guidelines for social prescribing coordinators, with a standard number of support instances defined and variations planned for, if the complexity of client needs warrants it. Evidence from this projects and other schemes suggests that two or three face-to-face client contacts are usually sufficient.

Considering the location of client meetings might improve cost-effectiveness as well as efficiency of the service. Social prescribing coordinators being based at participating GP practices would be an obvious choice and is indeed part of many social prescribing implementation models. However, evidence from this project and other schemes suggests that this is not the only way to deliver social prescribing and ensure positive outcomes for clients since social prescribers can be based in the community or offer outreach support. Nor should social providers expect to be offered a place in GP surgeries, where space might be limited or – as one practice manager reported – the practice rents

\textsuperscript{12} See e.g. The University of York Centre for Reviews and Dissemination (2015) Evidence to inform the commissioning of social prescribing; Health Education England (2016) Social prescribing at a glance: A scoping report of activity for the North West.
the building and might reasonably expect to be reimbursed for any use of practice space. Consequently, in future commissioning potential providers should be asked to consider where their social prescribing coordinators will be based and how they will work with clients, how the necessary practical arrangements will be put in place for this to happen and what alternative arrangements would be pursued in case of obstacles.

**Social prescribing coordinator (community navigator)**

According to the service specification, the role of the community navigator was central to delivery of social prescribing. They were expected to support clients in accessing groups and activities in their local area. This should be achieved through assessing the individual’s needs, agreeing actions and providing feedback to GPs on progress. A full description of the community navigator’s knowledge and skills is given in the service specification. This covers the knowledge that navigators are expected to have such as understanding the range of community assets that are on offer in the local area and how these can help benefit one or more of the Five Ways to Wellbeing. Navigators are also expected to have knowledge of the welfare and advocacy services on offer locally as well as the circumstances in which clients can be referred on to them. Required skills include motivational interviewing, counselling skills, health coaching or mental health first aid and making every contact count (MECC) training. A lot, therefore, is expected of the community navigator role and, as a result, the navigators recruited to work on the pilot came from different professional backgrounds and had different skills and expertise.

In total, four navigators worked on the pilot. They took part in training, for example, Motivational Interviewing training was part of the Wellbeing Star training. However, there did not appear to have been a consistent approach to training new community navigators. This may be a reflection of individual navigators starting in post at different times. Shadowing of existing navigators was used to help new members of staff become familiar with the role.

Irrespective of the training that was received by individual navigators, each felt more skilled in some areas than others. This may be less of an issue when an individual is working as part of a team since they can support each other where knowledge or skills may be lacking. However, it does pose a question about whether one navigator working on their own can be expected to be in possession of all the skills and knowledge as set out in the service specification.

Navigators were supported by an Advice Manager. This role included overseeing the pilot and navigators’ performance and monitoring key performance indicators and quality assurance. Richmond AID’s approach to quality assurance was described in full in their bid for the social prescribing pilot and included purchase of AdvisorNet (an online resource which is also used by the
Citizen’s Advice Bureau) and the Disability Rights Handbook. In addition, Richmond AID developed an advice manual which covers how they record and manage casework.

The community navigators’ work was consistent with the service specification and bore many commonalities with social prescribing schemes implemented elsewhere. Similarly, the inputs and training that was offered to community navigators (e.g. Motivational Interviewing training and Wellbeing Star training), was broadly similar to what was available to people in similar roles in other social prescribing schemes.  

Compared to many other social prescribing schemes, community coordinators in the Richmond pilot offered more personalised, bespoke and intensive support to their clients, effectively ‘going an extra mile’ for them. There were clear instances when this led to long-standing issues experienced by clients being resolved, despite many previous unsuccessful attempts by other agencies and organisations. This suggests that there is a clear role for social prescribing coordinators as they can offer more than just sign-posting to clients. As stated before however, intensive support should be used where it is needed rather than a standard way of delivering social prescribing.

Equally, highly personalised delivery poses questions over quality and consistency of delivery. Finally, focusing on empowering patients rather than solving all their diverse problems might be a good way of balancing consistency and efficiency of service with it remaining person-centred which appeared to be a key feature of the delivery provider’s approach. When commissioning social prescribing service, potential providers should be asked to explain how empowering patients will be ensured through their delivery model rather than relying on individual, potentially tokenistic activities and outputs.

**Onward referral to community organisations**

Linking individuals who have non-clinical needs with appropriate community assets is a key component of social prescribing and is outlined as a requirement in the service specification. The delivery provider drew upon their existing relationships with local organisations as partners to whom they could refer their clients. Information regarding the number of organisations that the provider made new connections with as a result of the pilot was not available to the evaluation team.

The service specification stated that referral forms should be used to provide information about clients to community organisations. This raises the question of how secure information about an individual should be transferred between the service provider and partners and the responsibility

---

that the service provider has regarding storage of this data by the community partners. In practice, the referral of clients has been carried out over the phone with the least amount of information possible being shared, and where clients were signposted to an organisation referral forms were unlikely to be used. All community organisations said they would do their own assessment if someone was referred to them via social prescribing.

Overall, the process of onward referral remained informal throughout the pilot and flow of information between the delivery partner and community organisations was limited. In particular, no evidence related to patient engagement post their referral to them or outcomes data was requested or shared by the participating community organisations. This is appropriate for ‘social prescribing light’ and to some extent ‘medium’, as per Kimberlee et al’s typology. Yet, the service specification makes reference to the provider gaining feedback about clients from community assets as well as the service provider passing this, and any other relevant outcome information, back to GPs, suggesting that it wishes to see the process of the delivery provider working with community and charity organisations formalised.

Implementing this process would need careful consideration of a number of other areas. Currently community assets are not funded to participate in the pilot, which makes it harder to persuade them to invest the time needed to gather additional information on those clients referred through social prescribing. Furthermore, with potentially hundreds of community assets being involved in social prescribing, particularly in any scale up of the service, keeping track of the information received and checking it is in a consistent format could be time consuming for the service provider. It is therefore, important to decide whether formalising information sharing between community organisations and the social prescribing prover is required and if so if this can be limited to a small number of key organisations referred to.

Of the 70 individuals who received an onward referral, 63 per cent were referred to more than one organisation. The most common destination for referrals was Richmond AID (delivery provider) services with 16 per cent of the total number of referrals. This is followed by FiSH (11 per cent) and Age UK (7 per cent). The London Borough of Richmond received 5 per cent and Barnes Workhouse and Castelnau Community Centre each received 4 per cent.). There were also referrals to the Alzheimer’s Society, Richmond ARTS and Barnes Safer Neighbours Team. The types of organisations that clients were most commonly referred to suggests that greater attention might need to be paid in future provision to fully exploiting the breadth and diversity of all community assets that Richmond has to offer. Referrals should consider different types of social prescribing interventions (such as physical activity, art, learning, volunteering and others mentioned above) to precisely target client needs around sustainable improvements to wellbeing and reducing social isolation. At the same time, many of the organisations referred to offer a breadth of various groups and support options, meaning that clients could be referred to a small number rather than multiple
organisations, which can overwhelm clients\textsuperscript{14}. In future commissioning and delivery of social prescribing services these issues will need to be carefully considered.

**Partnership working between delivery provider and GP practices**

Partnership working, ranging from coordination and information sharing to integration of social prescribing into primary care settings, is core part of most social prescribing models. This was one of the key areas where the delivery of the pilot service encountered challenges, meaning that there were a number of aspects of the original delivery plan that had to be abandoned or changed.

According to the service specification, the provider was expected to support four meetings for GP staff and community organisations to discuss social prescribing and progress of the pilot as well as deliver at least one training session for clinical and non-clinical staff per GP practice. Training would be important to standardise, for example, processes such as referral form filling. In practice, no formal meetings or training took place between the service provider and GP staff, according to the GP practice managers. They felt GPs did not have sufficient time to devote to these activities because of their heavy workloads and competing priorities, nor were practices funded to take part in the pilot. As a result, social prescribing it was not seen as a priority, even if it might help reduce GPs’ caseloads in the long term. One practice manager commented that despite these limitations, they felt an expectation from the CCG that they should engage fully in it. The practice managers were aware of steering group meetings taking place in Twickenham but were unable to attend the meetings because of the travel time from Barnes.

The provider not having access to patient medical records and not being based at GP practices, also meant that the original delivery plan was not fulfilled.

Overall, GP practices taking part in the pilot appeared to have struggled to play the role that was designed for them within the service specification, due to their high workloads, lack of funding and needing to deal with other priorities. Not enough attention was given to securing their buy-in and carrying out an assessment of their capacity to perform the role that was designed for them and in the way that was specified. Equally, the available evidence suggests that not all aspects of their role were clearly communicated to them. For example, even in the final stages of the project delivery there was an element of confusion around the GP practices needing to assemble and share some of the data related to patient outcomes.

The service specification states that the responsibility of managing relationships and capacity lies with the delivery provider yet is ambiguous on the matter of securing initial engagement and buy in from GP practices, including GPs themselves, presenting their roles and nature of their involvement

as givens. Equally, no concrete strategies for putting partnership-working arrangements in place, apart from complying with the requirement to deliver training and hold meetings, were included in the service delivery proposal, with the provider quoting instead their experience of partnership working.

Whilst the importance of partnership working is referenced in the service specification, in reality, the nature of the relationships between the service provider and GP practices did not always allow this to run smoothly; something that was recognised by all parties involved in the evaluation. Practice managers were protective of GPs’ time, pointing out that they did not have any time ring-fenced or funded for delivering the social prescribing pilot. Practice managers also appeared to have struggled to comply with the requirements of their role as it was outlined in the service specification and as further expectations of them, e.g. around evidence gathering and sharing, unfolded.

Additionally, without direct access to GPs, the delivery provider could not fulfil all their commitments to work collaboratively with GPs as part of the service delivery.

These points all relate to key facilitating (or impeding) factors in delivering special prescribing emerging in the wider evidence. For example, a recent systematic review of facilitators and barriers of implementing social prescribing\(^\text{15}\) mentions amongst others the following factors, the importance of which was clearly demonstrated by the Richmond pilot:

- Developing relationships and communication
- Organisational readiness (GP surgeries becoming ‘navigator ready’)
- Developing a shared understanding between clinical and non-clinical staff
- General practice staff engagement.

Attention to these factors should be given in any future implementation of social prescribing services. This should not just involve the delivery provider and commissioner but also GP practices. As well as developing a shared understanding of the service, its delivery and expected outcomes, clinical and non-clinical staff in relevant roles should be actively involved in defining their own role and specifics of their involvement, so that it was consistent with their capacity, priorities and ways of working.

**Summary**

The evidence suggests that there was a lack of clarity about the experimental and exploratory nature of the project, including an expectation for a specific delivery model of social prescribing to

developed and tested. This had important implications for the pilot and needs to be considered in future commissioning.

The delivery approach that was used appeared to be effective at engaging clients and improving client outcomes. At the same time, the available evidence suggested that there might have been instances where a more structured approach would have been sufficient and achieved similar results.

Clarity is needed about whether and how the systems for different referral pathways can be integrated or aligned. A decision about whether a social prescribing service can become a single point of referral for GPs in future, or if there should be parallel mechanisms with their specific purpose and application clearly defined, needs to be made in consultation with relevant parties.

Future provision should look to fully exploit, and to build upon, the breadth and diversity of all community assets that Richmond has to offer. Referrals should consider different types of social prescribing interventions, while ensuring that clients are not referred multiple organisations, which can be overwhelming for some.

The focus on empowering patients’ needs to be foregrounded more in future delivery, including when considering evidence that needs to be collected as part of the project.

Partnership working was one of the key areas where the delivery of the pilot service encountered challenges. In particular, this related to community navigators’ and GP practices’ involvement in social prescribing and sharing information. To ensure successful delivery of social prescribing in the future, it will be important ensure enough attention is given to:

- Developing relationships and communication
- Organisational readiness (GP surgeries becoming ‘navigator ready’)
- Developing a shared understanding between clinical and non-clinical staff
- General practice staff engagement.
CONCLUSIONS AND RECOMMENDATIONS

The research presented in this report suggests that delivery of the Richmond social prescribing pilot has had a positive impact on many clients’ lives, for example through receiving help with housing, making social connections and attending counselling. For almost half of the patients for whom the data was available, the number of GP appointments had decreased in the period following the pilot. Monitoring whether this positive trend is sustained when the service is taken to scale would make it possible to confirm whether social prescribing can free up GP capacity and lower the burden on NHS. At this stage, the patient numbers and the variations in and limitations of the data make it difficult to draw firm conclusions. More information about the patients for whom the numbers of GP appointments and non-elective attendances had increased can shed further light on the reasons for this occurrence.

The available evidence suggests that there is a need to consider and develop the following areas if the existing model of social prescribing were to be continued to be delivered on this or a larger scale:

- Focus on empowering patients, i.e. working towards enabling them to manage their own needs, and look after their health and wellbeing in the long term, without depending on the service
- Optimise the delivery processes, focusing on consistency of experience between patients, efficiency and cost-effectiveness, and evidence gathering and sharing between the delivery provider and GP practices in particular
- Secure greater levels of engagement of GP practices in social prescribing, through co-design of the processes and mechanisms if at all possible, so that they take account of GP practices’ capacity, priorities and existing ways of working.

Recommendations

Outcomes

- Further evidence needs to be collected to better understand why some patients do not experience positive outcomes.
- The use of an externally validated measure when gauging the service outcomes should be supported with guidance on quality assurance for data capture and for ensuring GDPR-
compliant consent for data sharing is obtained at sign up. This will improve the volume, quality and rigour of outcomes data.

- Analysis of secondary data or other means of testing the counterfactual are required to attribute decreases in GP appointment numbers to patients’ involvement in social prescribing.

The model of social prescribing

- A clear description of the model to be tested should be required during the commissioning stage, with a plan of how it can be developed and adapted during any pilot. This should build a more structured approach to: developing criteria for identifying suitable patients for social prescribing; making referrals into the service and developing multiple referral points; engagement with the community navigator and assessing need; and making onward referrals and signposting to services.

- The model should also include reference to utilising and developing community assets. Future provision should look to fully exploit, and to build upon, the breadth and diversity of all community assets that the area has to offer. Referrals should consider different types of social prescribing interventions, while ensuring that clients are not referred to multiple organisations, which can be overwhelming for some.

- Access to clinical records has been shown to be important for information sharing and efficiency of social prescribing mechanisms. Evidence from other projects suggests that arranging this for social prescribing coordinators is possible and putting this in place is recommended as a preferred option. However, information sharing can be done in other ways, as the pilot demonstrated. Planning for information sharing is important and concrete details of this should be requested as part of the initial delivery plans.

- Clarity is needed about whether and how the systems for different referral pathways can be integrated or aligned. In particular, consideration should be given to how social prescribing and the Community and Independent Living Service (CILS) can complement one another. A decision about whether a social prescribing service can become a single point of referral for GPs in future, or if there should be parallel mechanisms with their specific purpose and application clearly defined, needs to be made in consultation with relevant parties.

- Sign-posting can be cost-effective and might be sufficient to achieve the desired outcomes for some of the clients referred to social prescribing. At the same time, clients not having further contacts with social prescribing coordinators might be a sign of ineffective approaches to client engagement. Greater attention would need to be paid to evidence gathering for such patients, ensuring that it is commensurate with their level of engagement. Again, understanding how a social prescribing service can work alongside CILs will be helpful to facilitate better outcomes.
• In any future implementation of social prescribing, cost-effectiveness would need to be carefully considered and monitored. This might include developing a clear client support plan and discharge guidelines for social prescribing coordinators, with a standard number of support instances defined and variations planned for, if the complexity of client needs warrants it.

• Similarly, for the majority of clients, a focused and structured approach to, for example, assessment should be used. Fully bespoke assessment and intensive support, with a flexible and tailored approach being adopted, should be used only when there are clear signs that such level of support is required to improve client health and wellbeing. Ensuring that this level of support is offered appropriately should be monitored by the delivery provider and commissioner.

• When commissioning social prescribing service, potential providers should be asked to explain how longer-term impacts can be achieved through their delivery model, including how patients are given strategies to improve their well-being once engagement with the service has ended.

• It will be important to ensure that the referral process is monitored for effectiveness and efficiency by the delivery provider and commissioner so that changes to the process can be made.

• Effective partnership working is required when delivering social prescribing in the future. In particular GPs and providers need to work closely to ensure that social prescribing services can be located in GP surgeries. This requires staff in all relevant roles to define and co-create the process so that it is tailored to be consistent with existing systems and ways of working as far as possible. Potential providers should be asked to consider where their social prescribing coordinators will be based and how they will work with clients, how the necessary practical arrangements will be put in place for this to happen and what alternative arrangements would be pursued in case of obstacles. GPs and providers need to work closely to ensure that a more proactive approach is taken to identifying patients as suitable for referral to social prescribing.
REFERENCES


APPENDIX 1: PRIMARY AND SECONDARY EVIDENCE CONTRIBUTING TO THE EVALUATION

Primary evidence

Primary evidence gathered by the evaluation team and used in the current report included interviews with a range of stakeholders involved in the pilot, specifically:

- 12 phone interviews with social prescribing users to explore their experiences in depth as recipients of the service.
  - Of the twelve interviewees, two were male and the remainder female.
  - Five interviewees, all female, were aged under 50 years (two in their 40s, two in their 30s and one in her 20s). The other seven were aged 60 or above (two in their 60s, three in their 70s and two who were aged 80).
- Two GP practice managers
- One GP, who was also a member of the CCG
- The service provider
  - Chief Executive of Richmond AID
  - three social prescribing community navigators
- Representatives of four community organisations suggested by Richmond AID for interview because they had worked closely with them on the pilot. These organisations were,
  - Castlenau Community Centre (CCC), a community hub where local people can access a wide range of activities and support
  - The Barnes Workhouse Fund (BWF), a grant-making body which supports local people and organisations
  - FiSH Neighbourhood Care, which provides services to older people such as befriending and help with shopping and
  - Age UK, a national charity which works with older people on various issue and has local branches throughout the UK.
A representative of the commissioning body, Kingston and Richmond CCGs.

There were a number of aspects of this evaluation where the evaluation team was unable to gather the evidence that was suggested in the original design. Specifically:

- The service provider advised against a user post-intervention survey on the grounds of many clients being unable to fill it in themselves and relatively low numbers of clients using the service. Increasing the number of user interviews was deemed a better way of securing a similar level of evidence.
- The number of user interviews was lower than the 20 that were specified: only 23 service users could be contacted by the research team and some of did not respond or were not well enough to take part.
- It was not possible to hold a GP online forum because practice managers were concerned about the demands on the time of the GPs in their practice.
- Interviews with stakeholders were fewer than expected as some participants did not attend scheduled interviews.

**Secondary evidence**

The evaluation team was also able to draw on a range of evidence gathered by other stakeholders and to perform its analysis and synthesis alongside primary evidence collected by the evaluation team. The main types of the secondary evidence were:

- Service and referral data provided by Richmond AID
- ‘Feedback to GP’ forms prepared by Richmond AID
- Wellbeing Star data (see definition below) collected and processed by Richmond AID
- Information on the number and types of participating patients’ GP and other primary and secondary care appointments, assembled by the GP practiced at the request by the CCG.

---

16 Online discussion forums allow individuals to log into a secure website in their own time and take part in discussions, tasks, polls etc related to a research topic. They are ideally suited to busy professionals who would, otherwise, be difficult to bring together for a face to face discussion group.

Richmond AID’s service and referral data and other relevant process-related documents

The evaluation team received referral and service data from Richmond AID. This included demographic variables, where individuals were referred from and to, and information about the nature and volume of support received by individual clients. The data was provided in a combination of raw data and summary data format. In a number of instances, updated versions of the datasets were shared with the evaluation team during the final stages of reporting. Where most recent evidence was made available to us, the team drew on it but this was not possible everywhere and partly explains the different bases used throughout the report. Incomplete and partially complete records at Richmond AID, reflective of the nature of the clients’ engagement with the service, their personal preferences and gaps in the data shared with the service provider by the participating GP practices, explain other instances of different bases within the report.

‘Feedback to GP’ forms prepared by Richmond AID

In the final stages of this evaluation Richmond AID shared with the evaluation team a set of feedback forms, designed to be sent to the relevant GPs in order to inform them about the patients’ involvement in the service, the nature of their needs that have emerged during the assessment stage and the extent to which they have been addressed. All forms were specific to individual clients and were based on the internal records and notes held for each of the clients by Richmond AID.

Overall, 90 anonymised feedback forms were shared with the evaluation team, covering almost all of the patients taking part in the pilot (the total number was 94). One record was removed from analysis by the evaluation team as it was identical to another patient’s record but the patient reference numbers were different. Evidence for 89 patients was coded by the evaluation team to determine the patterns in their needs and the extent to which these were addressed as part of the pilot.

Wellbeing Star

The Wellbeing Star is a tool which can be used with individuals who have a long-term health condition, to establish their current needs, design action plans and goals and measure their progress and outcomes over time. It promotes a person-centered and strengths-based approach to working with clients and covers the following areas; your lifestyle, looking after yourself, managing your symptoms, work, volunteering and other activities, money, where you live, family and friends and feeling positive. The outcomes star is a tool to be used in frontline services, on a one-to-one basis with clients. Other social prescribing schemes and pilots have used a variety of well-being and health outcome tools and the Wellbeing Star was not noted to be used commonly (Bickerdike et al., 2017).
Within the Richmond social prescribing pilot, the Wellbeing Star was administered during a one-to-one conversation between a patient and a community navigator. The initial assessments were made shortly after a patient was referred to the service, during the period between October 2017 and June 2018. All post-treatment assessments were made in July. According to Richmond AID, most baseline assessments were carried out face-to-face whereas most post-treatment ones were done of the phone. It is possible that the quality of the second data collection was negatively affected by the delivery provider attempting to get all the assessments completed over a short period of time. For example, 44 (out of 57) assessments appear to be completed on the same day (20 July 2018) which, given that there is currently only one community navigator, poses questions about the level of rigor with which assessments were carried out. There were three instances of baseline assessments being completed retrospectively, at the end of the project. These were removed from the analysis by the evaluation team, along with one incomplete record.

Richmond AID explained that where the Wellbeing Star records were blank, patients either refused to complete the Wellbeing star assessment(s) or only one out of the pair of assessments was available. Overall, Wellbeing Star assessments for 57 out of 94 patients were available for analysis illustrating that nearly 60% of the patients successfully completed the assessment.

This contrasts with the social prescribing scheme in East Merton which also utilised the Wellbeing Star tool and an evaluation (Healthy Dialogues, 2017)\(^\text{18}\) of the project revealed that out of the 206 patients referred, 186 completed a Wellbeing Star assessment resulting in 90% successful completion rate of this assessment.

**Information on the number and types of participating patients’ GP and other primary and secondary care appointments**

The participating GP practices were requested to provide data related to numbers of GP appointments and non-elective attendances pre and post client involvement in the social prescribing pilot as well as data related to the numbers of prescribed medications and patients’ smoking behaviour.

Records were prepared for a total of 82 patients. Seven patient records had to be excluded from analysis as they were incomplete, due to for example, patients moving out of the area. This left a total of 75 patients.

Prior to sharing the data from the GP practices with the evaluation team, Richmond AID standardised the datasets as they were submitted in different format and added notes

---

contextualising the information assembled by the practices, for example explaining increases in the numbers of GP appointments for some of the patients.

Overall, the evaluation team believes that the resulting primary and secondary evidence set is limited but is nevertheless of sufficient quality to enable us to make some conclusions about the effectiveness of the pilot.
APPENDIX 2: DEMOGRAPHICS\textsuperscript{19}

Barnes (population 10,340)  Clients (94 referred)

\begin{figure}
\centering
\includegraphics[width=\textwidth]{demographics.png}
\caption{Gender distribution of the Barnes population and referred clients.}
\end{figure}

\textbf{Age of population in Barnes and referred clients}

NB for Barnes, under 65s is those aged 16-64 years, for client population it includes those aged 18-64

\begin{figure}
\centering
\includegraphics[width=\textwidth]{age_distribution.png}
\caption{Age distribution of the Barnes population and referred clients.}
\end{figure}

\textsuperscript{19} Data from Office of National Statistics Census, 2011 and Greater London Authority, 2016
Ethnicity of population in Barnes and client profile

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Client profile</th>
<th>Barnes population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefer not to say/unknown</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Other White</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>White Irish</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>White British</td>
<td>42</td>
<td>66</td>
</tr>
<tr>
<td>Mixed</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Black or Black British</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>4</td>
<td>7</td>
</tr>
</tbody>
</table>
## APPENDIX 3: WELLBEING STAR ANALYSIS SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th>Time 2</th>
<th>Mean diff</th>
<th>SD diff</th>
<th>t stat</th>
<th>t critical, two tail</th>
<th>SE diff</th>
<th>Confidence level (95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>lower limit</td>
</tr>
<tr>
<td><strong>Lifestyle</strong></td>
<td>2.93</td>
<td>3.89</td>
<td>0.97</td>
<td>0.68</td>
<td>10.71</td>
<td>2.00</td>
<td>0.09</td>
<td>0.78</td>
</tr>
<tr>
<td><strong>Looking after yourself</strong></td>
<td>3.28</td>
<td>4.26</td>
<td>0.98</td>
<td>1.01</td>
<td>7.35</td>
<td>2.00</td>
<td>0.13</td>
<td>0.71</td>
</tr>
<tr>
<td><strong>Managing symptoms</strong></td>
<td>3.18</td>
<td>4.02</td>
<td>0.84</td>
<td>0.75</td>
<td>8.47</td>
<td>2.00</td>
<td>0.10</td>
<td>0.64</td>
</tr>
<tr>
<td><strong>Work, Volunteering</strong></td>
<td>2.95</td>
<td>3.89</td>
<td>0.95</td>
<td>0.98</td>
<td>7.23</td>
<td>2.00</td>
<td>0.13</td>
<td>0.69</td>
</tr>
<tr>
<td><strong>Money</strong></td>
<td>3.30</td>
<td>4.32</td>
<td>1.02</td>
<td>1.06</td>
<td>7.24</td>
<td>2.00</td>
<td>0.14</td>
<td>0.74</td>
</tr>
<tr>
<td><strong>Where you live</strong></td>
<td>3.63</td>
<td>4.30</td>
<td>0.67</td>
<td>0.95</td>
<td>5.29</td>
<td>2.00</td>
<td>0.13</td>
<td>0.41</td>
</tr>
<tr>
<td><strong>Family &amp; Friends</strong></td>
<td>3.88</td>
<td>4.35</td>
<td>0.47</td>
<td>0.78</td>
<td>4.58</td>
<td>2.00</td>
<td>0.10</td>
<td>0.27</td>
</tr>
<tr>
<td><strong>Feeling positive</strong></td>
<td>3.12</td>
<td>4.12</td>
<td>1.00</td>
<td>0.80</td>
<td>9.4</td>
<td>2.00</td>
<td>0.10</td>
<td>0.79</td>
</tr>
</tbody>
</table>
APPENDIX 4: CLIENT CASE STUDIES

Client story – Cathy

Cathy is in her late 70s and lives with her adult son, who suffers from depression and anxiety. Cathy lives in a second floor flat and, partly due to heart-related problems, struggles to get in and out of her home. She needs to move to more suitable housing but has been on a waiting list for nine years for a new home.

She saw her GP to discuss her mobility and within days she had a call from the SP navigator. Although initially Cathy wasn’t sure who the navigator was – she didn’t know she had been referred to SP – she was quickly reassured and realised that the navigator was there to help.

Following the first call, Cathy has met with the navigator twice and also spoken on the phone. They have discussed her son’s problems and her home circumstances, and she has been referred to local services FiSH and Mind. Cathy has also had a call offering her a home on the south coast. She says that her navigator has been an incredible support. “She’s very on the ball. You just have to mention something and she’s on it”. Not only has SP addressed her housing need, but the navigator liaised with the vet to fix her dog’s broken leg for an affordable sum, which means that her son has a vital companion again.

Cathy believes the navigator has listened to her, understood her circumstances, and provided direct help. She can’t talk highly enough of the service she’s received. "I find [Richmond AID] absolutely wonderful. I think it's badly needed...At the moment as far as I am concerned, they are gold."
Client story – Jane

Jane is in her 40s and has a history of depression, eating disorders and panic attacks. She does not currently work although she is enjoys doing regular voluntary work. Jane receives excellent support from her GP and hospital.

She has been experiencing noise disturbance from a neighbour in her block of flats. He often plays loud music late at night and verbally abuses her. She had been in touch with her housing association but had made little progress with the issue and she was aware that it was affecting her state of mind. Her GP mentioned the social prescribing pilot and suggested Jane try it as a means to address the problem since it was clear how much it was affecting her.

At their first couple of meetings, Jane described the steps she had taken so far to try and resolve the problem. They then discussed what needed to be done next. She felt the moral support she had received from the navigator was important, “Having someone to talk to and making you feel like you aren’t a drama queen, and that it’s something very, very real, and very, very upsetting. And there was someone there to help, listen”. The navigator made phone calls to the housing association on her behalf, checked she was receiving the correct benefits and has managed to secure funding so she can get sound insulation in her flat. She does not feel the situation with her neighbours is fully resolved; they seem to go quiet for a while and then will have a big “blow out” but she was very complimentary about the service, “I have nothing but the highest praise really”. She wishes that she could receive support from her navigator for longer.
Client story – Monica

Monica is in her 60s, has diabetes and is the main carer for her husband who has Alzheimer’s. She finds her role of carer to be a particular burden as she has to do everything for her husband, “it’s really killing, physically and emotionally, it’s too much really”. She was not sure who had referred her for social prescribing, or why, but thought that her social worker had made the referral because of her caring role. It was a surprise when she received the initial call about social prescribing, but she was happy to meet with the navigator in a local coffee shop.

She meets her navigator every fortnight and they have had four meetings so far. The navigator told her about FiSH and the kinds of services she could access there. The navigator has found a carer and befriender for her husband so that Monica is able to go out for longer periods of time on her own. She has also been referred for counselling which she is finding very helpful. Funds were secured through the BWF to pay for it as she is on a low income. The navigator is also providing support on her housing situation as she and her husband live on the upper floor which she is finding increasingly difficult to access.

She appreciates that the navigator listens to her, gets things done and has provided both emotional and practical help, “To me, it’s made a lot of difference... at least I know there’s someone who is ready to really do things if they can. That does make a lot of difference to the way I feel.”