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## Introduction

Loneliness and associated mental health issues result in increased contacts with primary care especially amongst older people but GPs can offer limited help due to restricted appointment times and referral options (Kellezi *et al*., 2019). It is thought that GPs spend about 20% of their time with patients who have predominantly social problems (Husk *et al.*, 2019). Social Prescribing (SP) is a means for primary health care professionals to refer patients to community-based activities such as arts, gardening or befriending, with a view to meeting their needs in a holistic way. There are several models for SP, most involving a (non-clinical) link worker, based at a GP surgery, who connects people with community-based activities. As such, SP is a form of integrated care between primary care and the community/voluntary sector. As Goodwin (2016, p.1) describes:

*"Integration is a coherent set of methods and models on the fundings, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life..."*

Whitelaw *et al.* (2017) highlight the importance of the charitable and voluntary organisations of the third sector in integrated care networks but suggest that little attention has been given to them in the literature which has tended to focus on acute clinical and care domains.

The NHS Long Term Plan (NHS, 2019a) set out the intention for a national rollout of SP schemes via the recruitment of 1000 trained social prescribing link workers aiming to handle around 900,000 patient appointments by 2023-24. As a result of rapid growth, practice has outstripped the evidence base concerning the effectiveness of SP (Husk *et al*., 2019). SP schemes have tended to grow from the 'bottom up' with little 'top down' guidance (Polley *et al.*, 2017) resulting in a heterogenous field, with inherent confusion about what constitutes SP (Husk *et al.*, 2019). This is exacerbated by a lack of contextual description of the drivers, mechanisms and processes of SP schemes. Whilst there is a growing body of evaluations, these have been criticised for poor design and lack of rigour (e.g. Bickerdike *et al*., 2017).

Between 2017-18 St Johns Winchester, a CQC-registered charity that runs a care home for people living with dementia and provides social housing for people across four sites in Winchester, undertook a period of planning and implementation ahead of launching the Hand in Hand (HiH) Service, a SP initiative designed to alleviate social isolation and loneliness amongst older people in Winchester. The service was launched in January 2019 with a planned 18-month pilot period. As part of the planning phase St Johns (authors GD and SW) commissioned research from the University of Winchester (authors EW, AL, GM) to inform service development. This article results from collaborative reflection on the impact of the research and the processes instigated by St Johns to plan, implement and evaluate the HiH service which has been locally recognised as an exemplar of good practice. The article defines the context of, drivers for and collaborative process followed (including commissioned research) to implement and evaluate HiH, reflects on challenges, facilitators and key points for transferable learning. Early evaluation findings are presented. It meets a gap in the extant literature and offers a novel contribution for those planning SP at the level of practice and policy and for the developing field of SP evaluation.

## Literature review

The SP literature is expanding alongside the proliferation of schemes. SP initiatives show promise with regards to enhancing service users' wellbeing, quality of life, patient activation, health related confidence, community involvement and experience of services, as well as to



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reduce anxiety, emotional problems, loneliness and healthcare use (e.g. Kellezi *et al*., 2019; Pescheney, *et al*., 2019). However, strength of evidence is hampered by a heterogeneity of schemes (aiming to achieve different things, making comparison difficult) and a majority of small scale studies, limited by poor design and reporting – in particular an absence of controlled designs and a reliance on qualitative data for positive outcomes (e.g. Bickerdike *et al*. 2017). Bickerdike *et al.* (p. 15) acknowledge that whilst methods for rigorous evaluation are well developed, the 'opportunity, time and resources needed to employ these in a service can be limited". A common outcomes framework for evaluating SP has recently been developed by NHS England which aims to improve consistency and comprehensiveness of monitoring, reporting and proof of effect across schemes (NHS England, 2019b).

A small but growing body of research has focussed on understanding the key enablers and challenges to success of SP schemes. Patients' beliefs about treatment options, the presentation of the scheme as well as its accessibility both psychologically and physically, the level of support given by the link worker and skilful, flexible leadership are identified as important components associated with achieving patients' enrolment and maintaining adherence (Lovell *et al.*, 2017, Husk *et al.* 2019). Other research has highlighted the pivotal role of link workers in determining success– particularly in their knowledge base and level of skill as a 'bridging agent' between sectors and individuals and in building relationships with patients (Martsolf *et al.*, 2018). Husk *et al*. (2019) conducted a realist review to ascertain what approaches to SP work, for whom and in what circumstances. They conceptualised SP as consisting of three key stages of enrolment, engagement and adherence. Their findings were in line with the other cited studies with regards to enrolment and engagement but they found that the evidence base was not sufficiently developed methodologically to draw conclusions about the effectiveness of specific models or approaches to SP.

Key ingredients for successful cross-sectoral ventures in delivering and implementing SP schemes have included: sharing a common vision and language; the presence of strong, tenacious leadership; trust between key players and time to build long-standing relationships; high levels of staff engagement and low levels of staff turnover; and having clear legal agreements in place (Pescheny *et al.*, 2018; Martsolf *et al.*, 2018). Conversely, identified barriers have included: a lack of resources amongst voluntary and community groups to deliver high-quality, sustainable services; as well as unclear patient expectations (Skivington *et al.*, 2018; Lovell *et al.*, 2017), a lack of 'buy in' from GPs, differences in understanding of the concept of 'health'; concerns around accountability of schemes, mistrust between key players and poor network connections (White *et al.*, 2017 Grills *et al.*, 2012).

## The Hand in Hand Service

In 2017, St. John's Winchester decided to expand its care into the wider community to support older people living in their own homes through the provision of a new community navigator 'Hand in Hand' service (HiH). HiH was designed to offer a mix of signposting and befriending services according to individual need. Wellbeing co-ordinators employed by St Johns would work alongside the individual older person to co-produce a Wellbeing plan to be monitored over time. The wellbeing plan would be underpinned by a bespoke database detailing local groups and activities that older people may wish to attend. Volunteers would provide additional support and befriending. An 18 month pilot phase began in January 2019 to trial the new service and evaluate its efficacy. HiH evolved over the first 12 months of the pilot phase, becoming integrated into the work of the GP practices and Proactive Care Teams. The approach taken to develop and implement the service is shown below.


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**The approach taken to develop and implement a new SP service**
To aid the design, development and governance of the new SPS, London Healthy Partnership's 'Steps towards implementing self care: a resource for local commissioners' (2017p. 5), were used as a guide. Each step identifies an important issue for focus:

1. **Needs**: Identifying the target population and local needs
2. **Assets**: Identifying local partners and community assets
3. **Funding and resources**: Working out funding, resources, contracting and governance and risk
4. **Structure, processes and value for money**: Setting out the business case for the investment, citing ethical, economic and practical arguments.
5. **National standards and governance**: Ensuring compliance with national standards and governance.

We outline the key processes involved in each of these steps and the cross-sectoral contributions below. We describe steps 4 and 5 together because on reflection the authors felt that these two elements in this case study were dealt with together. We therefore use a combined forth heading entitled *Processes, standards and governance*.

### 1. Identification of the target population and local needs

The development of HiH was informed by an assessment of local needs. Winchester has a higher proportion than the national average of people aged 65 years (21.5% in Winchester compared to 18.5% across England) (ONS, 2018). Predicted population growth anticipates exponential numbers of older people living longer often in poorer health, representing a significant challenge for overstretched health and social care services. Reductions in these services due to austerity, and increasing financial pressures have led to increased emphasis on a preventative approach to health and wellbeing. The Hampshire Joint Health & Wellbeing Strategy (Hampshire Health and Wellbeing Board, 2013) set out a key priority to encourage 'ageing well' by supporting people to remain independent, have choice, control and access to highly quality services. It highlighted the potential of SP to promote wellbeing and quality of life amongst older people through increasing their social connections.

Further rationale was the need to support the carers and families of older people living in their own homes so that they themselves can stay well. The Care Act (UK Government, 2014) highlights the statutory role of local authorities in promoting wellbeing within their communities by identifying unmet health and social needs, supporting community facilities, and providing/ quality information on health. Caring for carers and families is part of this new role which charities like St. John's Winchester can support. Another driver was the growing evidence-base on the links between social isolation and loneliness and adverse impacts on physical and mental ill-health (Cacioppo *et al.*, 2006; Holt-Lunstad *et al.*, 2010). Evidence shows that adverse impacts are reversible via improvements in a person's social networks and social capital which can improve resilience, promote recovery from illness and empower people to avoid risky lifestyle choices such as smoking (Pevalin and Rose 2003; Folland, 2008).

### 2. Identification of local assets and partners

#### *i) Identification of local partners*


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To identify a target group of those most likely to benefit from a new social prescribing service, St. John's held discussions with the local Clinical Commissioning Group (CCG) and local Proactive Care Teams (PCTs). The PCTs are embedded across the three GP surgeries in the city which form the Winchester City Primary Care Network and have a combined patient list size of 60,863 people, of whom 17.3% are aged over 65 years. PCTs integrate non-medical and medical services to support individuals over 70 years with complex health and social needs. Their main aim is to enable individuals to maintain their independence and quality of life and to include the individual's family and carers in this process. The development of care-plans and signposting individuals to beneficial community-based services inform this process. A lack of community-based services to signpost identified older individuals to was identified as a barrier to overcome. Filling this gap, HiH aimed to provide a seamless continuation of the service initiated by the PCTs in the community which became the main referral route onto the scheme.

### *ii) Identification (and creation) of local assets*

SP schemes are often shaped around local assets and resources in the community and voluntary sectors and, by building cross-sectoral partnerships, their capacity can increase over time (London Healthy Partnership, 2017). However, in 2017, the extent and level of service provision for older people in Winchester – particularly signposting type services which focused on alleviating social isolation and loneliness – were relatively unknown to St. John's. A large proportion of these services came from volunteers running small group activities or providing practical, individual assistance, which had not been formally identified or mapped out. St. John's therefore commissioned the local university to conduct the following research activities to shape the new social prescribing service:

1) Gather basic data on all services (including navigator services) within Winchester to relieve social isolation/loneliness and/or to support independent living amongst older people.
2) Perform a rapid evidence review of the effects of navigator/befriending services.
3) Identify gaps/opportunities in service provision for the benefit of the older population in Winchester.

The gap analysis and evidence-review were conducted between January-March 2018, comprising searches of peer-reviewed and grey literature from a limited number of databases and data-sources, guided by discussions with seven key stakeholders. These included a coordinator of a team of community navigators working for a local charity; two voluntary community navigators working in the community sector; two public health professionals; a Proactive Care Coordinator working in a local GP practice and a representative of local charity which supported older people living in the community. Detailed reporting of approach and findings is beyond the scope of this paper and is reported separately (Wilkinson *et al.*, 2018). In summary, the gap analysis identified a patchy landscape of signposting and other services with inadequacies in three main areas. Firstly, barriers to accessing services, such as a lack of transport for older people living in rural areas or the prohibitive cost of signposting and other services for those living on low incomes. Secondly, barriers to identifying and reaching out to the most isolated were highlighted; particularly men undergoing a crisis. Thirdly, general gaps in service provision included: a lack of reliable numbers of volunteers and befrienders to


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facilitate sustainable service provision; a lack of professional emotional support particularly at times of crises; a dearth of trust-worthy practical home-help and capacity-limitations in providing good quality signposting services due to time restrictions of link workers.

Additionally, limitations in the quality and scope of data-sources underpinning existing signposting services were noted. This included difficulties in keeping data-sources up-to-date in a context of fluctuating, transitory community-based service provision during times of austerity and challenges in keeping a comprehensive data-source infallible to omission. Competition between community-based service providers led to a lack of sharing of data-sources which in turn could compromise the quality and reliability of service provision for older people. Overall, the gap analysis identified a need for a bespoke database to underpin the signposting element of St. John's HiH. The evidence review informed the design of the database and a provisional framework for the database was outlined by researchers based on the Audit Commission's (2004) Better Government for Older People Strategy. A database expert was employed in spring 2018. Consideration of all likely users' needs was given and best accessibility principles followed. The database has been under development for two years and has grown into an online directory which can be accessed and updated by multiple users.

## 3. Funding and resources

Informed by findings from the evidence review, the capacity and resources to test and build a new SP scheme over an 18-month pilot phase were assessed by St. John's Winchester. When the service went live in January 2019, St. John's provided funding to employ two Wellbeing Coordinators who were supported by a team of trained volunteers. The need for longer term funding arrangements beyond the pilot phase was recognised and the importance of networking and building strategic, collaborative partnerships with commissioners and other local providers.

As described above, during the first year of the pilot phase, St. John's established a working relationship with the Mid Hampshire Locality Proactive Care Teams based in the three GP practices. This arrangement was supported by a joint operational protocol. In 2019, additional funding was received from the Primary Care Network for an additional Wellbeing coordinator/ social prescribing link Worker. St John's also funded a Volunteer Coordinator to enhance the capacity within the team to support volunteer recruitment and retention. The scheme was expanded in partnership with Community First Hampshire through the additional NHS funding to include social prescribing clinics in each of the three practices as well as the existing HiH home visiting service. In addition to the three full-time Wellbeing Coordinators, a team of trained volunteers, a Volunteer Coordinator and a range of resources were developed during the pilot phase. These resources included the development of the bespoke database and a range of support including: a Living well assessment; Living Well plans; a formal service description; information leaflets; a Volunteer handbook and induction process including training and regular reviews; referral forms and confidentiality agreements; risk assessments and policies and procedures to be adhered to. Agreements for monitoring and evaluating the HiHS were also drawn up with the Primary Care Network. This approach has potential for replication in other SP schemes, particularly when the NHS is subcontracting its SP work with a voluntary sector partner.

## 4. Processes, standards and governance.

During the pilot phase operational guidance was produced for staff and volunteers working within HiH, staff working within the wider St. John's services and partner organisations. This



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guidance included staffing support, recruitment and training policies; referral protocols and guidance on team working and communication; documentation and consent for scheme members which covered issues pertaining to safety, risk management and data protection; as well as guidance on HiH and its operational levels.

The HiH service model was developed further during the pilot phase and was shaped to operate at four levels – all of which included support from volunteers:

Level 1 – Signposting and service navigation, introducing scheme members with the ability to access solutions for themselves, includes telephone support but no face-to-face contact.

Level 2 – Supported signposting including the development of a short Wellbeing plan to assist scheme members to access services and solutions, limited to a maximum of 12 weeks. Includes telephone support but no face to face contact. Additional support may be required from a specially trained volunteer with expertise in time-limited interventions or Wellbeing coordinators to achieve wellbeing plan outcomes.

Level 3- Development of Wellbeing plans and support to scheme members from volunteers to deliver outcomes. Time limited intervention of up to 12 weeks and may involve referral to other partner organisations for ongoing volunteer/ befriending support. Time-limited face-to-face and telephone befriending from St. John's volunteers. Additionally, scheme members to be encouraged to attend a HiH social club, based in Winchester with a focus on group-based befriending activities.

Level 4 – Ongoing support to scheme members who due to their vulnerability and social isolation need ongoing volunteer support and befriending. St. John's volunteers and partner organisations to deliver care jointly at this level and to include face-to-face befriending. This group of scheme members have no or little other contact from family and friends and need ongoing input from a service.

A Memorandum of Understanding was drawn up between St. John's Winchester and the Mid Hampshire Locality Group for the Winchester City GP practices to scope out joint working arrangements for the delivery of the HiHS during its pilot phase. This was underpinned by the service description, operational guidance, confidentiality, data protection and privacy agreements. The process of developing the documentation and resulting learning developed with the Winchester GP practices has already been adapted by the Eastleigh Primary Care Network in the implementation of its SP which has been contracted through a voluntary sector provider.

## Evaluation design

During the pilot phase, operational standards and performance indicators were agreed to demonstrate impact and value for money for the new service (Table 1). Monitoring operational standards will allow for *process* evaluation and performance indicators for *outcomes* evaluation at the level of the person and the health and care system (NHS, 2019b). Evaluation will be based on the interrogation of routinely collected quantitative data and supplemented by qualitative testimonials.

**INSERT HERE:** Table 1: Draft performance indicators and operational standards

## Evaluation findings



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The evaluation of this new scheme is ongoing, and it is too early to demonstrate its full impact and value for money. However, qualitative testimonials from users and GPs have been favourable with testimonials indicating improvements in users' health and wellbeing following their engagement in the SPS. Two early examples are shown below:

*Example Testimonial 1*
*Mrs P – Surgery 3*
*Mrs P was referred to the service as she was socially isolated and needed support to remain active outside her home and some practical help. Mrs P who was widowed, lived alone in a small rural community and had minimal social contact. She had a domestic helper that came once a week and neighbour who checked on her regularly. The only time she was able to get out was for visits to the GP practice and regular hospital appointments. She did not feel safe going out because of her poor health and felt more secure at home.*
*Mrs P was matched with a volunteer who established a trusting relationship with her and they began to venture out, initially to a garden centre and then after finding they shared a love of ballet, a trip to the theatre and a day out at the seaside.*
*The volunteer has had a wide-ranging positive impact, assisting with her affairs in preparation for an impending move into a care home and liaising with other professionals who visit her. Mrs P also attended the Hand in Hand club, where on her first visit she celebrated her birthday.*

*Example testimonial 2*
*Mrs DB Surgery 2*
*Mrs DB was lonely and isolated and had lost all her confidence to venture out into the community. This was a change for her as she had always been an active and sociable person. After assessment it was agree that a part of her living well plan she would receive support from a volunteer for companionship and support and to access clubs and activities in her local community. The visits from the volunteer started with a hot drink and a chat and as the relationship and trust developed they ventured out into the community for short walks to the local shops. On these trips out she began meeting up with friends as she regained confidence she managed longer walks and trips into Winchester city and garden centres.*

These testimonials demonstrate increased social contacts and increased self-confidence which are outcomes that have been previously been associated with SP schemes. Data collated during the first year of the pilot phase showed that HiH received ninety referrals from PCTs and for each referral, there were multiple contacts from staff and volunteers from the HiH team.

## Discussion

The HiH service is still in its pilot phase with evaluation ongoing. Early signs from qualitative and basic data have been encouraging and the scheme has now been running as an integrated system for fourteen months.

Reflecting on the usefulness of the guidance around implementing Social Prescribing Schemes (London Healthy Partnership, 2017), the authors found that adopting a logical, incremental approach to developing and testing the service, based on best-known SP practice and principles to date facilitated the launch of the service and its operation during the pilot phase. Each of the four steps (*Identification of the target population and local needs; Identification of local assets and partners; Funding and resources and Processes, standards and governance*) contained vital elements that have been fundamental to operation thus far. For example, in terms of *local assets and partners*, we would highlight


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the vital role of the team of volunteers and volunteer coordinator and collaborative working with the key strategic partners of the CCG, GP practices and PCTs. Early involvement with partners for a year ahead of the pilot launch allowed a joint shaping of the service and building relationships of trust. Effective co-operation between partners facilitated the development of robust *Processes, standards and governance* – such as referral processes and operational standards; and also reinforced 'buy-in' and trust amongst partners. In particular, the role of a 'super navigator' (a consultant employed by St John's) with high-level expertise and knowledge across the health, care charity sector contributed to successful networking across the primary and third sector, which has been highlighted in the literature as sometimes difficult to establish (White *et al.,* 2017, Grills *et al.,* 2012). Following its success here, the role of the 'super navigator' has been replicated in another Primary Care Network to share learning and adapt the model to meet the needs of the practice population.

The online database has been an essential asset in equipping the Wellbeing coordinators with the relevant knowledge and information for developing Wellbeing plans and underpinning the signposting element of the service. However, keeping the directory up to date is a challenge, primarily due to limitations in volunteer capacity. The *funding and resources* available to St. John's Winchester – as an established 900-year old charity – particularly its strategic intent to support older people living in the wider Winchester Community, its physical resources and the commitment of a budget to pay for the pilot phase were also fundamental. All these features have ensured that some of the barriers to cross-sectoral working such as lack of buy-in from GPs and mistrust between key stakeholders appear to have been avoided and that the scheme is seen locally as an excellent exemplar of integrated care.

In view of criticisms levelled against the extant state of SP evaluation outlined above, it feels important here to highlight the inherent challenges of demonstrating the impact of this locally developed SP scheme. Polley *et al.* (2017) helpfully outline the costs associated with the evaluation of SP schemes. They suggest that for a budget up between £5000-£10,000 it is possible to achieve a single case study or the processing of existing data on who has used the social prescribing scheme and why, or basic analysis of outcomes data. They suggest that £30,000-£60,000 would allow external evaluator support for around three months. A mixed methods evaluation conducted by external evaluators over a longer time scale would cost in the region of £60,000 - £140,000. In view of this, the evaluation plan for the HiH scheme is mainly reliant on the processing of existing data via systems such as the electronic patient data recording system EMIS. Whilst gathering the 'basic data' and 'health service' data highlighted in Table 1 will be possible thanks to robust data sharing agreements and partnership working, gathering individual scheme member outcomes is proving challenging due to the absence of routinely collected data on patients' social and emotional wellbeing. This is an ongoing topic of discussion between St Johns and their partner organisations.

This absence has been recently recognised by NHS England (2019b, p.29). As part of their work on developing a common outcomes framework for social prescribing they state that they will investigate "whether it is possible to co-produce a new free wellbeing measure…that everyone can use to inform social prescribing, including small community groups". However, it seems unlikely that one wellbeing measure would be able to take into account the heterogeneity of aims of social prescribing schemes that has been identified above and there remains a disparity between the urgent need for rigorous evaluation data and the availability of resources and routine data required to produce this.


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## Conclusion

In this paper we have described the process by which St John's Winchester set up a social prescribing scheme and successfully integrated it into local service provision, informed by recent national guidance and commissioned research. We have not seen such a description elsewhere in the literature and believe that it will provide useful learning for others developing social prescribing schemes. We have also described the planned evaluation framework, informed by NHS work on a common outcomes framework and presented early findings. Despite the work by NHS England, we suggest that there remains a disparity between the urgent need for rigorous evaluation data and the resources available to produce it. This is both in terms of evaluation costs and data that is routinely collected within health and care systems.



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