
EVALUATION OF THE PILOT MENTAL HEALTH SOCIAL PRESCRIBING PROGRAMME

Final Report
for Mind Cymru

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EXECUTIVE SUMMARY

Mind Cymru commissioned the Welsh Institute for Health and Social Care to evaluate a new social prescribing service for people with mental health problems, to enable these people to get the support they need, when they need it. The study has analysed and reported data collected from a range of data sources across the study. The project commenced in Autumn 2018, but due to delays in receiving ethical approval, data collection began in Autumn 2019 and ran for up to five months. In this summary, findings from all the data collected is summarised and framed against the four key questions of the study.

HOW EFFECTIVE IS THE SOCIAL PRESCRIBING MODEL?

What worked well

- Positive elements of the model were that clients were included in discussions about the available support services, feeling heard and valued, through active listening via the ‘what matters’ conversation.
- For clients the model offers a timely intervention, particularly in the context of long waiting lists for primary care mental health services.
- Link workers are a key feature of social prescribing services and their role is highly valued by Mind Cymru staff, local Mind managers, referring and receiving organisations. They help facilitate buy-in and engagement of stakeholders and enable client participation and attrition (see Table 7.3 for *skills of link workers*).
- Uplift funding had been used to provide a number of services and in some cases, had been used for link workers’ capacity.
- The core of the Mind Cymru social prescribing programme worked and was adaptable (as highlighted by the change to the model as a result of COVID-19), (see Table 7.3 for *the impact of COVID-19*)

What worked less well

- The peer navigator role, as it had been intended to work, has not been realised. Challenges included the delays to implementing this aspect that were associated to the research trial and the infrastructure of local Minds to support and deliver a volunteer programme, and local Minds’ concerns about safeguarding.
- In respect of uplift funding, challenges included the confidence and experience of local Minds to sub-contract services, and governance as, for example, the quality of reporting of the use of uplift funding from local Minds was variable.

Overall

- The service model developed by Mind was effective in delivering the service. The role of the link worker is a core component to the model and its delivery. There are evident advantages

of this service model for clients, although limitations on our ability to speak directly with clients and analyse robust data provided by them means that we have to rely on proxies for this assessment.

- That being said, placing people at the heart of the social prescribing service has been a key and constant consideration for those directly involved in providing the social prescribing service. For clients of the service, benefits include the provision of a timely intervention, and feeling valued, heard and regarded via the ‘what matters’ conversation. The model was especially adaptive under the pressures brought to bear by the COVID-19 pandemic, but there are learning points around the need to continually support front-line link workers and local Minds to ensure that the model continues to be as effective as it possibly can be.

WHAT WERE THE BARRIERS AND ENABLERS TO IMPLEMENTING THE SOCIAL PRESCRIBING SERVICE?

Enablers to successful implementation

- Strong, effective relationships are crucial (with and between referrers, patients/clients, link workers, and the social prescribing activity).
- The link worker is highly valued in developing and maintaining relationships with health partners.
- The inclusion of health partners in the design and delivery of social prescribing may alleviate challenges to buy-in and contribute to the success of the referral.

Challenges to successful implementation

- The wider context that social prescribing is operating in, for example:
 - Time and capacity of GPs, which was a factor highlighted as affecting referrals to the social prescribing service
 - Duplication or provision of other similar social prescribing programmes (e.g. well-being coordinators employed by primary care, and the ‘well established’ community connector role)
- High use of locums and branch surgeries can interrupt relationships and affect the awareness of the service.
- Frustration experienced by link workers with confusion in the referral process (e.g. lack of communication with practices, lack of familiarity with the referral process, missing information to clients, missing referral forms). This is connected to the local Mind relationships with practices (e.g. communication) and referrers’ knowledge of the project.
- The impact of research trial conditions, which included:
 - The potential burden of the trial on clients
 - Preparation and training for a trial to help manage understanding of the requirements, and managing a dual role of link worker (as both service provider and researcher) and meeting the duties to the trial

- The considerable planning and work to prepare and manage the complexity of a research trial, including ethics, its impact on implementation and delivery
- The perceived reluctance of GPs to engage due to the added complexity of a trial and the availability of easier referral pathways elsewhere

Overall

- Central to this question has been the ability of the service to build and maintain effective relationships, and manage resources in a challenging and complex environment. The trial itself was a feature highlighted as influencing the implementation of the service, such as the additional activities to plan and prepare and the dual role of the link workers to deliver a social prescribing intervention whilst managing a trial.
- Given the unforeseen and unprecedented changes that have been brought to bear during 2020, overall, the project has worked well under pressure to implement and embed an adapted social prescribing service effectively.

WHAT FACTORS INFLUENCED ENGAGEMENT WITH THE SOCIAL PRESCRIBING PROGRAMME?

Factors influencing social prescribing participation and sustainment rate

- The skills of the link worker are key to enabling participation and sustainment. Core features include:
 - Their role in supporting clients, and clients feeling listened to and valued
 - Developing and maintaining trusting, reciprocal relationships with partners
- Link worker knowledge of third sector and community provision
- Link worker training, development, and support is important to enable link workers to perform their role effectively. Important considerations are:
 - Link worker well-being and the importance of informal peer and management support (e.g. supervision)
 - A ‘link worker’ only space/network, to share best practice and knowledge exchange
 - Established route of information sharing between local Minds and link workers
 - Needs training analysis, tailored, co-produced training programmes
 - Manager time to support link workers fully costed into the model
- Securing and maintaining the buy-in of GP practices and health partners contributes to the success of referrals. Aspects include:
 - Effective feedback loops between partners, providing updates about patients’ progress
 - Good relationships and feedback helps to sustain buy-in
- Impacts associated with the buy-in and relationships with GP practices and health included:
 - Low numbers of referrals to the service (with the exception of one local Mind)
 - Concerns from GPs about the sustainability of the service
 - Perceived lack of recognition/confidence of third sector skills

- Link worker frustration and confusion in the referral process (e.g. information packs not being provided to clients, difficulties with room availability and bookings, lack of knowledge of the model)
- Relationships with receiving organisations were highly valued and strong reciprocal partnerships were evident. Link workers are central to sustaining these relationships. However, communication/feedback about clients could be improved.
- The COVID-19 pandemic led to the suspension of the trial and a change to the delivery of the model to open referral pathways and the provision of telephone and online support. These changes led to increased referrals (with exception of one local Mind who experienced a drop in referrals) and had advantages and disadvantages:
 - The move to online and telephone support was regarded as positive, enabling more convenience and flexibility to the client
 - The provision of telephone and online support offered link workers more efficiency and increased capacity to support more clients
 - There are some disadvantages to online and telephone support (e.g. digital exclusion, poverty)
 - Increase of referrals from opening of referral pathways led to workload for link workers increasing and an increase in inappropriate referrals for some local Minds
 - An acceleration of client issues (COVID-19 related)

Overall

- This question is multi-faceted, and has accordingly a multi-faceted response. There are very many reasons to assert that this social prescribing service has worked effectively in increasing and encouraging participation, and sustaining people throughout the programme. The service was agile in their response to the COVID-19 pandemic, and demonstrated positive new ways of working via online and telephone support.

WHAT IS THE ROLE OF SOCIAL PRESCRIBING ON THE WIDER HEALTH SYSTEM?

Social prescribing is an important provision, particularly given the often complex and interrelated needs of clients. As such, social prescribing offers a broader, holistic support compared to traditional mental health services. In some circumstances, social prescribing may be more easily accessed in the community. However, where it is successfully integrated within the health system, the service could also benefit from widening the referral pathways beyond GPs to include a broader range of health professionals including community mental health teams and other mental health specialists.

Overall

- It is difficult to be definitive about this question based on the data that is available to the study. It may well be the case that there are positive system effects of social prescribing, but evidencing that is not possible within this study.

RECOMMENDATIONS

As with all studies of this kind, there are important learning points that have emerged. The recommendations are made to Mind Cymru and the local Minds, and focus on future projects like this one, thinking about how to optimise the service model:

1. Effectiveness of the social prescribing model

- Priority must be given to ensuring the perspectives of the clients is captured to better understand their experience of the social prescribing model given the limitations of this study.
- Based on the experience of this study, careful thought should be given before Mind Cymru engages in a randomised controlled trial on social prescribing. Notwithstanding the challenges around COVID-19, there are logistical and other methodological issues to be considered.
- Project elements like peer navigators and the use of uplift funding should be co-designed with local Minds in respect of the infrastructure, resource and expectations so as to identify potential gaps and determine how they can best be addressed.

2. Barriers and enablers to implementing the social prescribing service

- Developing and sustaining effective working partnerships is crucial to the success of the service. Key stakeholders (clients, local Minds, link workers and their managers, health service partners, community and third sector partners) should be involved in all aspects of the design, development and continued delivery of the model to sustain buy-in and engagement.
- Should another randomised controlled trial be deemed necessary, a sufficient resource to manage the trial need to be identified. In addition a more robust package of preparation and training needs to be provided to all staff to ensure understanding of the requirements and management of a trial.

3. Factors influencing engagement with the social prescribing programme

- Training, development, and support is important to enable link workers to perform their role effectively, especially given the increased workload of link workers and the acceleration of issues clients are presenting with as a result of the COVID-19 pandemic. Individual link worker training needs should be analysed and co-produced development plans enacted.
- Regular supervision of link workers is needed, and more resource made available to local Minds to ensure that they are able to do this.
- A practice network or a shared, confidential space for link workers to share ideas, experience, best practice, and receive informal peer support needs to be developed and nurtured.
- More needs to be done to ensure effective feedback and communication between the social prescribing service and referring and receiving organisations.

4. Role of social prescribing on the wider health system

- Widening the referral pathway to include a broader range of health professionals including community mental health teams and other mental health specialists should be implemented as this has the potential to increase referral rates to social prescribing programmes.
- Professional registration of link workers should be considered in order to offer greater awareness and recognition of the role amongst all stakeholders.

1. INTRODUCTION

Mind Cymru commissioned the Welsh Institute for Health and Social Care, University of South Wales, to evaluate a new social prescribing service for people with mental health problems, to enable these people to get the support they need, when they need it.

This service was offered by social prescribing 'link workers' at one of four local Mind partners (referred to as Sites 1-4 in this report) located within three health board areas, for people experiencing mild/moderate mental health problems and/or emotional wellbeing disorders, aged 18+. Individuals were referred by GPs and other healthcare professionals from one of the three health boards. Detail on the service model and associated activity date is presented in chapter 3 below.

The study has analysed and reported data collected from a range of data sources across the study. The project commenced in Autumn 2018, but due to delays in receiving ethical approval, data collection began in Autumn 2019 and ran for between three and five months.¹

The study began as a randomised controlled trial (herein referred to as the 'research trial' or the 'trial') with patients being randomised to one of two arms after referral from primary care. The first group were to be seen immediately after an initial set of outcomes measures were collected and engaged in a 'what matters' conversation with the link workers. Whereas for the waitlist arm, people were delayed for four weeks after that initial data collection before they would have their 'what matters' conversation. The idea behind this stepped wedge study design was to control for the influence of the link worker in shaping goals and working to support people in the early stages of the pilot. This required an application to the NHS Research Ethics Service, and the trial was given permission centrally, and then subsequently by the Research and Development Offices of the three health boards in the pilot study.

RE-SPECIFYING THE PROJECT

However, in the light of the coronavirus outbreak and associated lockdown, all non COVID-19 research was stopped by the NHS in April 2020. It came at a time when only n=65 people had been recruited into the research trial. There was therefore a need to re-program the study away from the trial to focus on capturing learning from the design and implementation of the model to inform the effective commissioning of future social prescribing projects and services.

Having re-specified the study, there were four key questions identified, to which data from this report contributes:

1. How effective is the social prescribing model?
2. What were the barriers and enablers to implementing the social prescribing service?

¹ This was dependent upon the start date for the trial in the three health board areas as this varied.

3. What factors influenced engagement with the social prescribing programme?
4. What is the role of social prescribing on the wider health system?

STRUCTURE OF THE REPORT

The report begins with 'meta-narrative' which is based on six key review papers and provides a broad context within which the findings need to be situated. A methodology chapter is then followed by a detailed description of the service model and associated activity data. After this, the key dataset that has been gathered for this study – the 'thematic synthesis' – is the substantive findings chapter which includes an analysis of a number of different sources of data, but most importantly in-depth interviews with a range of different participants. The next chapter provides a realist evaluation of the reflective diaries that were completed by staff members within the programme. This is followed by the conclusion and associated recommendations, which offers a summary of findings against the four key questions above.

2. META-NARRATIVE

A tailored narrative overview using six realist and systematic reviews was developed specifically for this study. The purpose was to provide a context for the study, and to consider the wider evidence-base of social prescribing together with the specific influencing factors on this project, with a focus on the process of establishing a social prescribing programme. The reviews included preceded or ran parallel to the study, but were not derived from the findings.

APPROACH

Systematic and realist reviews provide a robust evidence base of the existing literature. Both types of review are a reliable synthesis of evidence that adhere to a strict scientific design. Systematic reviews prescribe explicit, reproducible, and transparent processes for collating the best available evidence in answer to specific questions (Sage, 2020) and therefore, conclusions are more reliable and accurate than single studies (Greenhaigh, 1997). Realist reviews present evidence from diverse sources, selected according to relevance and rigour, to explore how a complex intervention works, for whom and under what circumstances (Booth et al, 2019).

The meta-narrative benefits from the inclusion of two unpublished reviews by USW academics, offering a unique insight into the most current and up-to-date literature. These were augmented by four other published systematic or realist review papers:

Unpublished realist reviews:

1. Roberts T., Erwin C., Pontin D., Williams M. and Wallace C. Social prescribing and complexity theory: A systematic review (*manuscript under review*).
2. Elliott M., Davies J. and Wallace C. What methods for evaluating social prescribing work, for which intervention types, for whom and in what circumstances? A realist review. (*manuscript in preparation*).

Published systematic reviews:

3. Pescheny J.V., Pappas Y. and Randhawa G. (2018a) Facilitators and barriers of implementing and delivering social prescribing services: a systematic review.
4. Bickerdike L., Booth A., Wilson P.M., Farley K. and Wright K. (2017) social prescribing: less rhetoric and more reality. A systematic review of the evidence.

Published realist reviews:

5. Tierney S., Wong G., Roberts N., Boylan A., Park S., Abrams R., Reeve J., Williams V. and Mahtani K.R. (2020) Supporting social prescribing in primary care by linking people to local assets: a realist review.

6. Husk K., Blockley K., Lovell R., Bethel A., Lang I., Byng R. and Garside R. (2019) What approaches to social prescribing work, for whom, and in what circumstances? A realist review.

Reference lists of these papers were examined to identify additional literature, and where relevant to the factors identified by Mind Cymru were included. The meta-narrative included peer reviewed publications – grey literature (e.g. reports) was excluded.

The aim of the meta-narrative is to set the wider context for this study by considering the wider evidence-base on social prescribing together with influencing factors on this social prescribing model, particularly focusing on the following issues around as identified by Mind Cymru:

- Reputation of the provider organisation;
- Skill of link workers and training;
- Buy-in of GP practices and experience of stakeholder engagement;
- Appropriateness of referrals;
- Length of intervention and activities undertaken during intervention;
- Referral pathways and relationships with referred-to organisations; and
- Wider context that services are operating in, including duplication and competition with similar services.

As the factors above indicate, the focus of the meta-narrative was the process of social prescribing and not client benefits. Findings are presented in two sections:

1. Commissioning of social prescribing programmes and the existing evidence base; and
2. Enablers and barriers in social prescribing.

Wherever appropriate, there is an indication against the headings and sub-headings as to which of the four key questions the evidence in this meta-narrative addresses.

COMMISSIONING OF SOCIAL PRESCRIBING MODELS AND THE EVIDENCE-BASE THAT SUPPORTS THEM (Q1, Q2)

In spite of social prescribing being widely advocated and implemented (Bickerdike et al (2017), good quality evidence to inform its commissioning is limited in quality and extent (Polley et al. 2017) and there is limited agreement regarding appropriate outcome measures (Rempel et al 2017). Limitations affecting the evidence base on social prescribing interventions have been attributed to gaps regarding the effectiveness of programmes, the referral and delivery process, its suitability for different health conditions, and its impact on GP workload (Husk et al 2019).

Issues affecting the quality of studies on social prescribing include small sample sizes, high risk of bias due to sampling strategies, high levels of participant drop off and a lack of transparency in reporting (Roberts et al under review; Bickerdike et al 2017). Issues of methodological rigour, for example, the absence of transparency in reporting methods and results creates challenges in

evaluating the quality of evidence (Roberts et al under review) and creates difficulties to assess 'who received what, for what duration, with what effect and at what cost' (Bickerdike et al 2017, p.14). Variation in results reported have also been attributed to the type of study undertaken with qualitative methods identifying consistent positive trends and quantitative studies results being inconsistent in measuring health and wellbeing outcomes (Roberts et al under review).

Within their realist review, Elliott et al (in preparation) developed a sub-case of 21 qualitative methodology papers, which highlight the range of methods and analytical approaches used to evaluate social prescribing programmes. For example, data collection methods included in-depth and semi-structured interviews, opens surveys, and case studies analysed using approaches such as thematic analysis, grounded theory and realist evaluation. Echoing issues raised above, the quality of these studies were considered as low to moderate, and reporting on the methodology and methods limited.

A theme identified by Elliott et al (in preparation) was that some studies included in the qualitative sub-case were embedded within a larger mixed methods studies but had not integrated their findings or triangulated between the components of the larger studies. This has consequences for understanding the impact of the social prescription and hindered interpretation of the findings in the context of other available data.

A 'complex intervention' (Tierney et al 2020; Roberts et al under review), social prescribing includes a range of components such as educating and empowering individuals, multiple stakeholder involvement (patients/clients, health, third sector, link workers) and a range of variable outcomes (Tierney et al 2020). Given the breadth of these factors, evaluating social prescribing programmes is challenging (Elliott et al in preparation).

Nonetheless, in order to the inform commissioning of social prescribing models, good quality, robust evidence is required regarding what constitutes effective social prescribing practice and its process, especially given the range of components (Husk et al 2019) and to determine how social prescription may impact individuals and in what way. For commissioners and policy-makers, a reliance on outcomes evaluations in isolation can be at the expense of addressing other important questions; effect sizes does not offer information about implementation (enablers, challenges, processes) or contextual factors that can influence delivery and outcomes of interventions (Pescheny et al 2018a). Similarly, Roberts at al (under review) refer to the large number of studies included within their review that focussed on whether the intervention or service worked rather than how it worked.

Summary

In the context of commissioning social prescribing models and the evidence base that supports them, key findings from the literature are:

- The quality of social prescribing evaluations is lacking; studies are hampered by poorly reported methodologies, limited or missing information about sampling strategies and the process of collecting and analysing data (Pescheny et al 2018a)

- Some qualitative studies do not integrate or triangulate findings between components of larger mixed-method evaluations in which they are embedded (Elliott et al in preparation).
- These issues lead to difficulties in evaluating the quality of evidence and determining ‘*who received what, for what duration, with what effect and at what cost*’ (Roberts et al under review; Bickerdike et al 2017, p.14).
- Consequently, the evidence base for the benefits of social prescription remains ‘*largely inconclusive*’ and there is a need to increase the methodological rigour of studies in relation to their design, analysis, as well as the transparency in their reporting (Roberts et al under review; Pescheny et al 2018a)
- There is an emphasis within evaluations as to whether social prescribing programmes ‘work’ and not ‘how’ they work (Roberts et al under review), which is problematic given the complexity of social prescribing interventions.

ENABLERS AND BARRIERS IN SOCIAL PRESCRIBING (Q2, Q3)

Pescheny et al (2018a, p.10) provide a summary of identified facilitators and barriers to the implementation and delivery of social prescribing services:

Table 2.1: Facilitators and barriers (after Pescheny et al, 2018a)

Facilitators	Barriers
A phased roll out implementation approach	A ‘go live date’ approach to implementation
Realistic planning of ‘lead in’ time to set up a social prescribing service	Lack of partnership and service level agreements
Workshops to design and discuss social prescribing services prior to implementation	A collaborative approach to project management, which results in the lack of a targeted approach to strategic and robust project management
Standardised trainings, briefings, and networking events for involved partners	Absence of a robust risk management systems
Flexibility during the development, implementation, and delivery of a social prescribing service	Volunteers as navigators
Shared understanding, attitudes, and perspectives of stakeholders	Staff turnover
Good relationships and effective communication between stakeholders within and across sectors	Limited financial resources to fund service providers or secure a high salary for employed staff
Social prescribing champions in CCGs and general practices	Lack of shared understanding among stakeholders and partners

Facilitators	Barriers
Navigator ready general practices	General practice staff disengagement
A general practice culture that supports the biopsychosocial model of health	Patient disengagement
General practice staff engagement	A reduction in available and suitable service providers in the third sector
A wide range of good quality third sector based service providers	

Skill of link workers and training (Q3)

Bickerdike et al (2017 p.13) referred to key factors that support successful implementation of social prescribing programmes. These include:

- The central co-ordination of referrals;
- Resources and training to support link workers/coordinators; and
- Enabling networking with the voluntary and community sector.

Working directly with clients, link workers are a key feature of social prescribing services. Tierney et al (2020 p.12) programme theory proposes that: *'...through meeting with a link worker, social capital (e.g. new skills, confidence and links) is developed, prompting patients to feel able to manage their health; individual activation levels are stimulated by engaging with social networks. Desired outcomes may then transpire, such as improved well-being and reduced reliance on a GP'*

Important aspects referred to by patients/clients are: trusting relationships with link workers; the provision of personalised appointments that are not time limited (Wildman et al 2019; Woodall et al 2018); the person-centred approach of the link worker; and feeling listening and valued (Pescheny et al 2018b).

Despite the important and valued feature of the link workers in social prescribing programmes, there is a lack of consistency about their roles and duties, which can vary between projects. For example, Roberts et al (under review) identified a range of duties frequently undertaken such as 'signposting', 'action planning', 'supporting access', and 'home visits to clients'. The authors note that whilst the training and experience of link workers varies, a core requirement of the person specification was knowledge of local community and third sector services, which resonates with the third success factor above outlined by Birkdale et al (2017). Nonetheless, with a variety of skills set, training and knowledge, it is difficult to ascertain what is required to effectively fulfil the link worker role (Bickerdike et al 2017).

For link workers to be a *'credible source for patients'* (Tierney et al 2020, p.9), appropriate training and supervision should be provided. Doing so ensures the link worker feels confident and equipped to perform their role, whilst supervision provides the space to explore and discuss

difficulties or anxieties. If a link worker's capabilities and capacity is overstretched, this can have implications for retention, which in turn, can affect the delivery of the social prescribing model due to the requirement to recruit and train new link workers (Tierney et al 2020).

Buy-in of GP practices and experience of stakeholder engagement [incl. relationships with referred-to organisations] (Q2, Q3)

In previous studies that have included the perspectives of healthcare professionals (including GPs), social prescribing programmes are generally viewed as a potentially helpful means to support for non-medical issues and concerns (Roberts et al under review). For these groups, enabling mechanisms associated to the role and skills of the link workers (as identified by Roberts et al under review) include:

- Knowledge of community services (e.g. Brown et al 2016)
- The provision of flexible and longer appointment times (e.g. Wildman et al 2018)
- The co-productive nature of the role (e.g. Whitelaw et al, 2017; Wildman et al 2018)
- Developing trust between staff and patients/clients (e.g. Brown et al 2016; Woodall et al 2018)

The buy-in and engagement of health workers (GPs, health professionals, and practice staff) is a core facilitator of the implementation and delivery of social prescribing programmes (Pescheny et al 2018a). Factors influencing buy-in and engagement from health include time constraints during busy consultations, lack of confidence to discuss social prescription, forgetting about the availability of social prescribing, and doubts about patient/client take up and adherence once referred (Pescheny, et al 2018a). The authors suggest approaches that may encourage and maintain the engagement of health (p.10):

- Regular education events and training sessions;
- Encouraging link worker attendance at surgery staff meetings;
- Information stalls within practice reception areas; and
- A brief and easy to complete referral form to reduce the workload for prescribers.

Strong partnerships and shared understanding of the social prescribing programme between stakeholders (health, third sector, link workers, and patients/clients) is essential to manage expectations and alleviate pressures during its implementation and delivery (Pescheny et al 2018a). An enabler for the successful implementation of social prescribing programmes is effective communication between stakeholders (GPs, third sector, patients/clients and link workers) and the development of reciprocal partnerships (Pescheny et al 2018a; Birkdale et al 2017). This includes the provision of feedback from link workers about patient/client progress and outcomes, which encourages support for social prescribing (Bickerdike et al, 2017) and promotes shared delivery and partnership working amongst stakeholders and partners (Pescheny et al 2018a).

However, difficulties persist in establishing and maintaining a robust and consistent means of feedback between link workers and referrers (Bickerdike et al 2017, Whitelaw et al 2017). Roberts et al (under review) refer to further challenges to stakeholder engagement that link to concerns about funding, the sustainability of social prescribing initiatives (e.g. Skivington et al 2018), and limited capacity of services and link workers from increased referrals (e.g. Bertotti et al 2019).

Concerns about funding and sustainability also extends to the potential impact of social prescribing on third sector and community services; that services and activities may be reduced below the level of patient/client needs and impact the delivery of social prescribing programmes (Pescheny et al 2018a).

Appropriateness of referrals [inc. uptake and adherence, and activities undertaken during intervention] (Q3)

Where reported, a client's attendance at the first appointment with their link worker ranged from 50% to 79% and that individuals' attendance at activities they were referred on to by their link worker varied from 58% to 100% (Bickerdike et al 2017). Through accessing, developing knowledgeable activities and assisting transitions between services, link workers have the potential to contribute to the successful uptake of social prescription (Husk et al 2019). However, the authors acknowledge that social prescribing is not '*a single intervention but a pathway with many interacting elements*' (p.319). They further highlight the importance of effective, functioning relationships (with and between referrers, patients/clients, link workers, and the social prescribing activity) in order to meet client need and to contribute to the success of the referral.

Factors found to influence client enrolment, engagement and adherence to a social prescription (Husk et al 2019; Pescheny et al 2018b; Bickerdike et al 2017) include:

- Patient's trust in their GP
- The prescription and referral (perceived to be of benefit and the referral is presented and understood in a way that meets their needs and expectations, with any concerns addressed)
- The skills and support of the link worker
- Accessibility of the activity [Inc. literacy and travel issues]
- Interest in, and appropriateness of activities offered
- Skills and knowledge of the provider of the social prescription

Less positive aspects to social prescribing for patients/clients as identified by Roberts et al (under review) are feelings of being overwhelmed (Carnes et al 2017), confusion about the service being referred to (e.g. Bertotti et al 2018; Pescheny et al 2018a), and being unable or unwilling to commit due to unsuitability of referral or fluctuating health (e.g. Wildman et al 2019, Carnes et al 2017). Other reported barriers to uptake and adherence include patients' fear of stigma of

psychosocial problems, patient/client expectations and the short-term nature of some social prescribing programmes (Pescheny et al 2018b).

There is a wide scope of activities provided as part of a social prescribing referral, which can include practical information, advice, physical activities, community activities, and befriending services (Bickerdike et al 2017) – for example art therapy, volunteering, exercise classes, walking and reading groups, support with employment, debt and housing (Pescheny et al 2018b). The most frequent types of social prescriptions identified by Roberts et al (under review) were fitness and exercise classes, arts groups, social groups, support groups, and financial/housing advice.

Summary

When thinking about the development, implementation and delivery of future models of social prescribing programmes in the context of participation and attrition, key considerations highlighted from the literature are:

- **Role, skills and experience of link workers (Q2, Q3)**

Throughout the literature, link workers are identified as a fundamental element to the successful implementation and delivery of social prescribing interventions. Their role is extensive, helps facilitate the buy-in and engagement of health partners, stakeholders, and enables patients/client participation and works to minimise attrition rates.

For health professionals and stakeholders, link workers provide knowledge of local third sector and community services, offer flexible and longer appointments, and help build trust between staff and patients/clients.

For patients/carers, the person-centred approach provided by link workers enable the development of trust, and feeling listened to and valued. Positive, trusting relationships, coupled with knowledge of activities and supporting patient/clients between services can aide patient/client uptake to an intervention.

However, there is inconsistency with regards to the role, duties and training of link workers. With the exception of link workers requiring knowledge of local community and third sector services, there is a lack of an agreed job description or training and development plan within social prescribing programmes. Ongoing training and supervision is an important feature that can support link workers in their role and provide the space to explore and discuss difficulties or anxieties. Overstretching link workers capabilities and capacity can have implications for retention, which in turn, can affect the delivery of the social prescribing model due to the requirement to recruit and train new link workers.

Given the lack of person specification and skills required, link workers may bring a variety of skills and knowledge to the role. Therefore, understanding training and development needs might be supported through consultation and tailored, co-produced training programmes.

Furthermore, despite the clear advantage of the link worker role for health, stakeholders, patients/clients, social prescribing is not a single intervention. The complex nature of social prescribing means its success is not dependent on one intervention but the numerous interacting elements such as the inclusion of multiple stakeholders). Therefore, effective relationships and partnerships are essential.

– **Relationships and partnerships (Q2, Q3)**

Strong, effective relationships and partnerships (with and between referrers, patients/clients, link workers, and the social prescribing activity) were highlighted within the literature as being crucial to the success of social prescribing programmes. The development of partnerships and securing buy-in and engagement from stakeholders during the development of social prescribing interventions contribute to the success of the referral. Establishing effective feedback loops between all partners and maintaining communication ensures all stakeholders are informed and included promotes a shared partnership approach. In particular, this relates to feedback from link workers about patient/client progress, which was a problematic feature referred to within the literature that can affect partnerships.

The inclusion of health services in the design and delivery of social prescribing programmes may help alleviate some of the challenges to their buy-in and engagement that were highlighted in the literature (e.g. lack of confidence, forgetting about the availability of social prescription).

– **Barriers to participant uptake and adherence (Q3)**

Barriers to patient/client uptake and adherence to a social prescribing intervention include confusion about the service, accessibility, and patient/client expectations. Hence, there is a clear need to provide reassurance, information (in accessible formats) about social prescribing itself, its potential benefits, the role of stakeholders (link workers, health, third sector and community services) and the programmes available. Consultations and co-production of information with stakeholders (including patients/clients) (e.g. preferred formats, dissemination) may raise awareness of social prescribing and help alleviate anxieties.

3. METHODOLOGY

The study used a mixed methods approach to collect and analyse data to evaluate the Mind Cymru social prescribing programme. In order of their inclusion in the report here, methods used were:

1. Production of a meta-narrative wherein published and unpublished systematic and realist reviews of social prescribing were considered;
2. In-depth interviews with a variety of key stakeholders, undertaken both pre-and post-lockdown, reflecting on the key learning points from the service development;
3. Analysis of project documentation which included an analysis of the project steering group minutes and reports;
4. Service data analysis of both trial and pre-trial data centred on service activity data, and a consideration (albeit limited due to the issues with the research trial being indefinitely suspended) of the outcome data from service users; and
5. Realist evaluation of reflective diaries which were completed by staff members throughout the project.

STAKEHOLDER INTERVIEWS

Telephone and online interviews were undertaken with stakeholders of the social prescribing project with the aim of understanding their experiences of the programme. Stakeholders invited to take part included:

- Mind Cymru programme staff who were involved with the design, development, and implementation of the service;
- Local Mind managers and link workers, who were involved in the design of the social prescribing service, then managing and delivering the service in one of the four sites;
- Referrers into the social prescribing service, namely general practitioners and others in the health system such as cluster leads, who made referrals into the project; and
- Receiving organisations from a range of community groups to whom link workers from the social prescribing service made referrals.

There were two data collection periods. Interviews were undertaken before the research trial came to an end in Spring 2020, and a second set of interviews were undertaken after the trial had ended during Autumn 2020. In total, across the two data collection time periods, n=32 interviews were completed with n=33 interviewees (see below). Interview schedules are provided in the Appendix.

Table 3.1: Total numbers of interviews across both data collection periods

Locality	Number of interviews
Mind Cymru	3
Site 1	5
Site 2	8
Site 3	9
Site 4	7
Total	32

Table 3.2: Total numbers of interviewees across both data collection periods

Locality	Number of interviews
Mind Cymru	3
Site 1	5
Site 2	10
Site 3	9
Site 4	7
Total	34

Table 3.3: Interviews by role across both data collection periods

Role	Number of interviews
Mind Cymru programme staff	3
Local Mind Chief Officer	4
Local Mind Service Manager	3
Local Mind Senior Co-ordinator	2
Local Mind link worker	9
Referring organisations	4
Receiving organisations	7
Total	32

Table 3.4: Interviews by stakeholder type and health board across both data collection periods

Stakeholder type	Number of interviews		
	Health board 1	Health board 2	Health board 3
Local Mind project staff	6	6	6
Referring organisations	1	1	2
Receiving organisations	2	5	0
Total	9	12	8

Qualitative data was transcribed verbatim and anonymised and transcripts analysed using thematic analysis (Braun and Clarke, 2006). Developing themes were synthesised with the project documentation and service data.

PROJECT DOCUMENTATION

A series of key papers from the project were provided to the research team. These mainly consisted of meeting notes and reports as follows:

- Minutes of meetings (n=8), December 2018 to May 2020
- Uplift funding documentation (n=13)
 - Uplift criteria and process for agreement; allocation of uplift funding – 2019/21; uplift reports from local Minds (n=8)

Documents were analysed using a thematic analysis approach (Braun and Clarke, 2006). These key themes were then triangulated and synthesised with the stakeholder interviews and service data, and are presented in the thematic synthesis chapter. Findings from across the datasets were triangulated and considered against the four key questions of the re-programmed study. The process of triangulation refers to the fact that findings from multiple methods were combined to mutually corroborate one another (Creswell and Plano-Clarke, 2011). Triangulation offers a variety of datasets to explain differing aspects of a phenomenon of interest (Noble and Heale, 2019).

SERVICE DATA - TRIAL AND PRE-TRIAL DATA

Data from both the pre-trial and trial phases of the study was supplied for analysis. The pre-trial data was presented as categorised data, and a series of descriptive statistics (mainly frequencies) was produced based on this. Table 3.5 describes the amount of data collected in the pre-trial and trial phases of the study:

Table 3.5: Amount of data collected

	TOTAL	Pre-trial	During trial
Referrals received	413	350	63
No. clients proceeding to What Matters conversation	299	276	23
No. referrals made to other services	559	510	49
No. inappropriate referrals	15	14	1

Wherever possible, data series that carried from the pre-trial into the trial phase have been analysed alongside one another. There was a limited quantum of data from the trial phase of the study, as described in Table 3.6. This was due to the indefinite suspension of the research trial by the NHS Research Ethics Service in April 2020, but the consequence of this was that it was not possible to undertake an analysis of the participant outcome data with any statistical significance or confidence.

Table 3.6: Quantum of data provided from the research trial

	TOTAL	Site 1	Site 2	Site 3	Site 4
Baseline outcome measures recorded	65	0	32	26	7
Second baseline outcome measures recorded (<i>for waitlist group</i>)	7	0	3	4	0
Demographic info collected	22	0	10	11	1
Details about referrals collected	18	0	8	9	1
Second set of outcome measures recorded (<i>after link worker intervention but before participant benefitting from referral to other services</i>)	12	0	1	10	1
Third set of outcome measures recorded (<i>link worker following up a month after initial intervention</i>)	4	0	0	4	0

REFLECTIVE DIARIES

The aim of collecting reflective diaries was to understand the experiences of those staff members working with people with mental health problems to deliver the Mind Cymru social prescribing programme.

Reflective diary entries were collected from three of the four local Mind sites between May 2019 and March 2020. Those diary keepers who chose to provide feedback produced eighty-nine diary entries across forty-six pages. The time-period of the reflective diaries provides a unique perspective, capturing experiences prior to the COVID-19 pandemic and subsequent closure of the research trial. Detail of the diary entries analysed is provided in Table 3.7:

Table 3.7: Numbers of diary entries per site²

Sites	Total entries	Total pages
Site 1	25	17
Site 2	18	11
Site 3	46	18
Total	89	46

All of those associated with the delivery of the programme were invited to complete the reflective diaries as part of their role in the social prescribing service. A number of people took

² It is not possible to be absolutely sure how many diary keepers these entries reflect, because some of the entries are that are not attributable – entries weren't always labelled in such a way that allowed us to see whether the diary keeper had submitted a previous entry or not. However, we can only say that there are two diary keepers in Site 1, probably one diary keeper in Site 2 (the entries are not labelled so we assume it is one person), and at least two diary keepers in Site 3 (it may be more than this as some entries are not attributed).

up that opportunity, but people were free to not do so. Diary keepers submitted their entries to a central person at Mind Cymru who anonymised them before sharing them with the study team for analysis at University of South Wales. A reflective diary template was given to all participants to follow (see Appendix for details).

The qualitative data from the reflective diary exercise was analysed using a realist evaluation approach – the six steps as outlined by Wong and Papoutsi (2016) (see Appendix for details). Realist evaluation was used to analyse this data because the role of the link worker in social prescribing is a complex one working at the interface of health (often primary care), social care, housing and the voluntary sector.

The realist evaluation approach involves consideration of relevance of the data, interpretation of meaning, judgments about Context-Mechanism-Outcome Configurations (CMOCs), judgements about programme theory and consideration of the rigour of the data. Each of the three sites was analysed separately initially and then triangulated to provide the results. As the reflective diaries were anonymised when they were returned to the team, the participants are referred to as ‘Diary Keepers’ in the chapter below.

ETHICS

Ethics permission for this study was secured from the University of South Wales’ Faculty of Life Sciences and Education Ethics Committee in March 2019 to collect data and undertake analysis against all of the elements of the methodology as described above. Permission to interview NHS stakeholders was sought through the three individual health boards. All three health boards provided service evaluation permissions. However, there were challenges over the timeline to secure permissions in one of the three health boards, and therefore a low take-up of the opportunity from NHS referrers to contribute to the study. Detail of the timelines associated with the ethical approvals is provided below:

Table 3.8: Key dates in securing ethical approval

	Date achieved				
	OVERALL STUDY	Site 1	Site 2	Site 3	Site 4
USW Ethics Committee permission	March 2019	-	-	-	-
NHS Ethics submission	April 2019	-	-	-	-
NHS Ethics review	May 2019	-	-	-	-
NHS Ethics approval	June 2019	-	-	-	-
Local health board Research and Development Office approval	-	November 2019	December 2019	August 2019	November 2019
Trial site file sign off	-	December 2019	January 2020	September 2019	December 2019

LIMITATIONS

There is no perfect study, and this project was faced with a number of challenges that impacted on the overall quality of data collection. Delays in achieving ethical approval from the NHS and associated permissions from local health boards took at least six months longer than had been anticipated. Quantitative data collection (especially around quality of life outcomes) therefore didn't begin until Autumn/Winter 2019. With the onset of COVID-19 and the subsequent suspension of the research trial in April 2020, this meant that the quantitative aspect of the study was compromised. In addition, whilst a number of the interviews were indeed in-depth, a number with receiving organisations were quite brief, often based on small numbers of referrals having been sent from the Mind social prescribers. As such, the answers given were limited in scope and depth. Given the change in circumstances, it was not possible to hear directly from clients, which is an obvious limitation of the study.

4. SOCIAL PRESCRIBING MODEL AND SERVICE DATA

In 2018, Welsh Government awarded Mind Cymru a Social Prescribing – Mental Health Pilot grant. The aim of the grant was to support the development of a more robust evidence base for social prescribing services to inform future planning and commissioning decisions. Mind Cymru were given funding to develop and deliver a model of social prescribing suitable for adults with mental health problems; and undertake a randomised control trial (RCT) of the effectiveness of this model.

The service was offered by social prescribing ‘link workers’ at one of four local Mind partners (referred to as Sites 1-4 in this report), chosen to represent a range of communities with high levels of deprivation (rural, urban and valleys) across Wales. The local Minds were located within three health board areas. Individuals were referred by GPs and other healthcare professionals from three designated clusters within those three health boards.

Ethical approval was secured for the trial and arrangements had been put into place in the three health board areas. However, in April 2020, the NHS stopped all research trials not related to COVID-19. At that point, Welsh Government agreed that Mind Cymru could continue to deliver an adapted service, but with a new methodology for the study.

DEVELOPING THE SOCIAL PRESCRIBING MODEL

Mind Cymru developed the model of social prescribing used in this project in collaboration with the four local Minds through a series of co-design workshops.

The model also took into account the experience from previous services, and requirements of the funder. This experience suggested that people with mental health problems might find it difficult to engage with the services to which they were referred and so need additional support to do so. It also identified that they might need to deal with complex sets of circumstances that would require access to a range of services and support, rather than a single social prescribing pathway.

Project Values

The service specification identified a number of collective values and principles, and committed to deliver a service that is: embedded in the principles of supportive and reflective practice; holistic, empowering, person-centred and based on individual need; and collaborative and strives to deliver best practice for participants, staff, volunteers and stakeholders.

Client Criteria

Social prescribing is a service that connects people to a range of community services that can enable them to improve their mental and physical health and emotional well-being. The service can help those who are isolated, lonely and at risk of poor mental health by nature of their socio-

economic circumstances and/or health condition. Social prescribing can also help to prevent the deterioration of mental health problems and improve well-being.

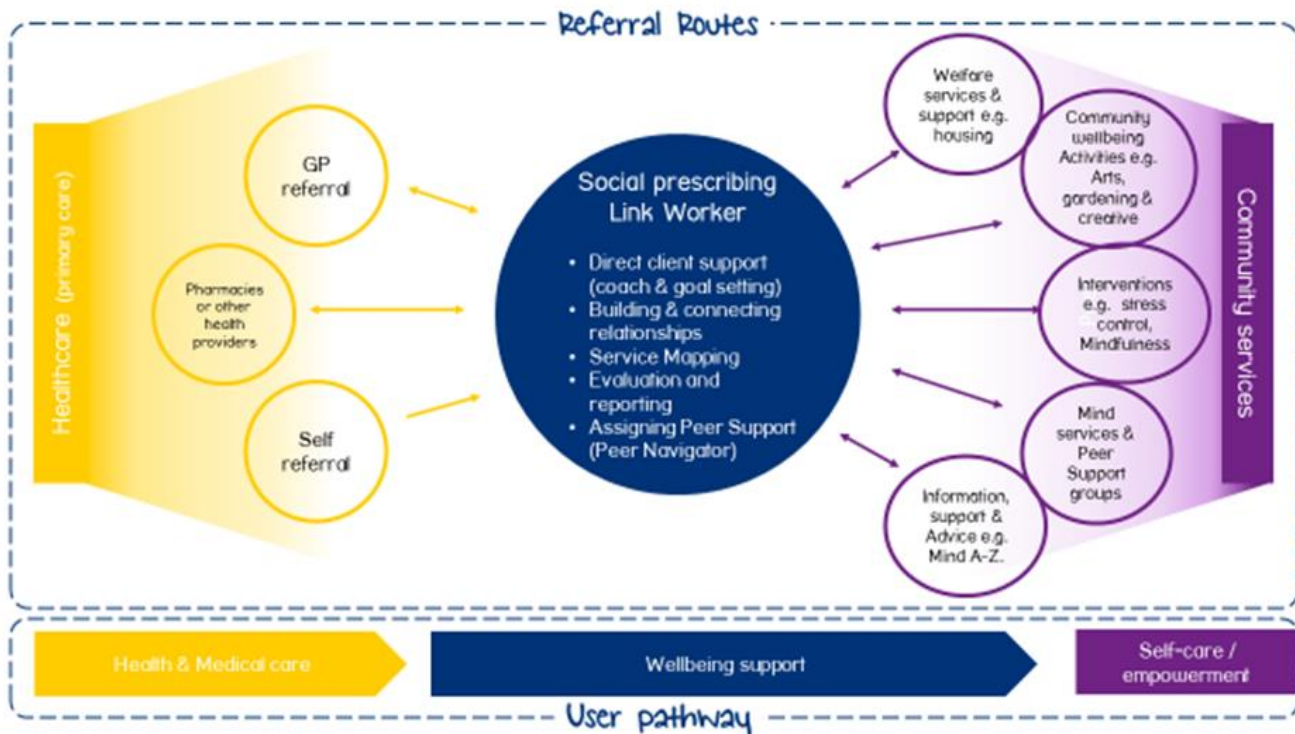
This project was aimed specifically at people who are aged 18+, registered with a GP, and experiencing mild to moderate mental health problems (such as anxiety or depression) and/or low emotional well-being, and who may also meet one or more of the following criteria:

- Frequently or regularly attending primary care services due to their mental health needs
- Experiencing known risk factors for poor mental health (e.g. isolation, loneliness, unemployment, bereavement, housing difficulties)
- Suitable for, or may benefit from, alternatives to clinical and/or drug treatment
- Struggling to manage significant life change or health conditions

REFERRAL ARRANGEMENTS

The terms of the protocol for the research trial specified that all referrals must come via GP practices that had agreed to be part of the project. The route to referral could be made via a GP or another primary care worker within the practice. Participants were allowed to self-refer. However, they were not able to refer themselves directly into the service but had to make a request to be referred by the GP practice – see Figure 4.1.

Figure 4.1: Referral routes as set out in the Mind service specification



As soon as NHS stopped the trial, the service adapted by opening up new referral routes. This meant that other organisations, such as third sector organisations, were now able to refer, and people could also refer themselves directly into the project.

LINK WORKERS

Referrals are made to a local link worker. Local Minds were responsible for employing and managing link workers in their areas. Most areas employed two to three link workers, but no one was full time. The service specification identified the following in relation to the link worker role:

Local Mind delivery partners will employ suitably qualified link workers who will report to, and be supported by, an appropriate Manager at each local Mind. The link workers will need to have good local knowledge of services and activities, with direct or indirect lived experience of mental health difficulties.

Link workers will be involved in the design phase of the project, working collaboratively with other link workers, Mind Cymru and other stakeholders, to complete detailed mapping work of services and referral pathways available locally... They will work in partnership with the full range of community, wellbeing or social care organisations in their local area to support participants and achieve the project aims and outcomes.

Link workers will also have a key role in promoting the service and building confidence with GPs and other primary care staff. They will act as the central point for managing social prescribing referrals from GP surgeries.

KEY ELEMENTS OF THE MODEL

The service model has the following key elements:

- The link worker spends quality time with the client (in a ‘What Matters’ conversation) and they work together to identify the client’s needs and what they want to achieve (‘My Goals’). They also identify any underlying mental health issues. Establishing a good relationship between the link worker and the client is crucial;
- It is integral to the model that all link workers have a good knowledge about mental health;
- They also have a strong knowledge of the range of services and groups available in the local community. The service model enables referrals to a wide range of community services designed to improve social engagement, mental health and well-being, address other underlying issues (e.g. loss, trauma and abuse) and enhance life skills;
- Link worker and client work together to co-create a plan for the client to access various services and groups that will help them with root causes of mental health problems. The link worker will also help to identify any barriers (e.g. anxiety, lack of self-confidence) that might prevent the client from engaging and support them to address these; and
- The link worker will arrange a final meeting to review client progress towards their goals. At this meeting, the aim is to check client progress in accessing the appropriate community services and support, and to prepare them to exit the link worker element of the intervention. However, if the client is still experiencing difficulties, the link worker may need to provide further assistance.

Link workers carried out an initial mapping exercise in each of their areas to identify the range of local services available for clients in each of the referral pathways, for example welfare services and support, and community well-being activities. These varied from small local community activities or services to nationally available programmes. The ability to draw on a wide range of services is vital to be able to meet a given individual's needs. To be effective, link workers keep this service mapping up-to-date for their local areas and develop local 'intelligence' about delivery – this has been particularly important since COVID-19 regulations were put in place.

Uplift funding

Knowledge of local services provides the information needed to inform clients' action plans. It has also provided information to support requests to draw down uplift funding. As part of this project, local Mind delivery partners were provided with a budget to help uplift services in their locality, in order to improve the availability of these services and activities for clients, where demand for support outstripped supply. Uplift funding was never intended to fund the main onward referral services and activities. However, it recognised the demands that social prescribing would place on local services to which referrals were made. It could be used to increase existing capacity within a service or to fund a service that was not currently available (e.g. mindfulness courses).

During the set-up phase of the project (2018-19), uplift funding was used to provide additional link worker capacity to carry out the initial mapping of services and establish the referral routes. However, once the service was in place, it was used as originally intended for uplifting services.

Volunteer 'peer navigators' with lived experience

The original model included provision for each local Mind delivery partner to recruit, train and manage volunteer peer navigators. These are people with lived experience of mental health difficulties, who have accessed support directly through the social prescribing service, and subsequently volunteer to support clients to engage with services and activities. It was intended that peer navigators would enable greater engagement in services by providing additional one-to-one support for programme clients, whilst also providing a volunteer opportunity for those who were exiting the service. This could include providing a point of contact for clients in addition to that of the role of the link worker, and helping clients to access social prescribing options by attending the first appointment or activity with them. Local Minds were in the process of making arrangements to recruit peer navigators when the COVID-19 restrictions came into force which meant that local Minds could not put this element of the model into place.

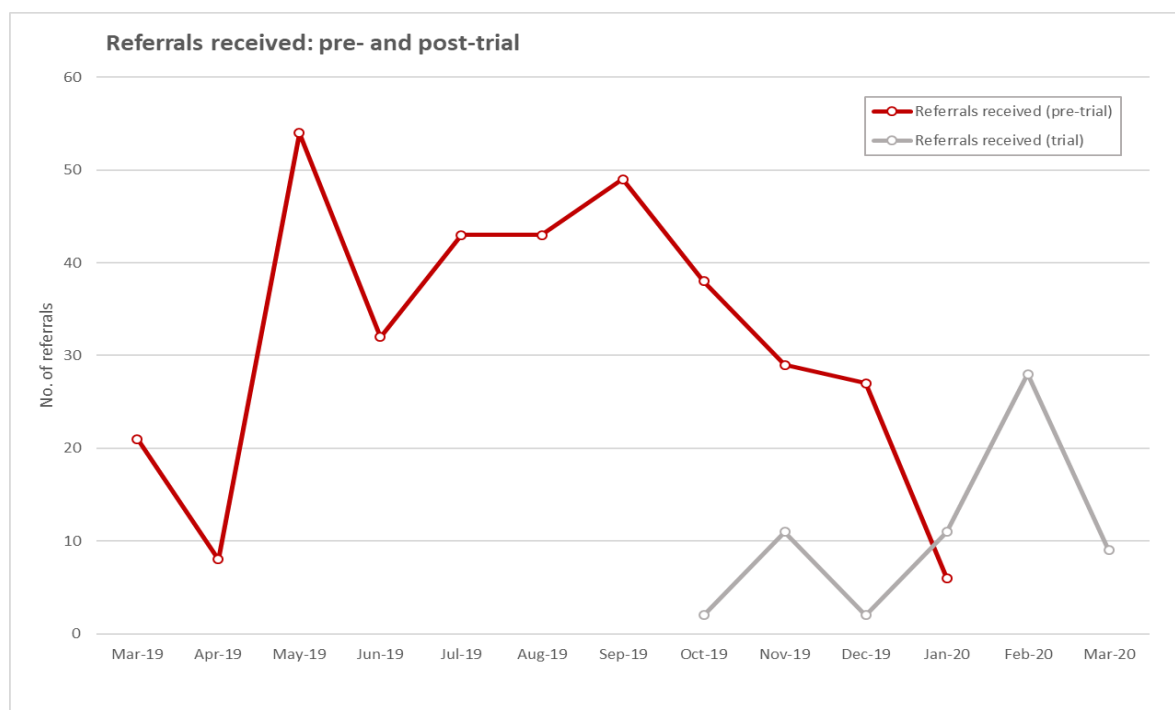
SERVICE AND ACTIVITY DATA

In order to provide context for the description above, below is a presentation of service and activity data. In particular, there are three metrics that cross-over between the pre-trial and trial phases of the study. There was not one single 'go' date for the commencement of the trial – it varied across the four sites depending on the decisions made by the three health board Research and Development Offices. Accordingly, in the three charts that follow, two lines are presented

which overlap. The red line presents the position as represented by the pre-trial data (which covers the period from March 2019 to January 2020).³ The silver line on the charts represents the trial data (which covers the period from October 2019 to March 2020).⁴ Given the nature of such programmes, it is sensible perhaps to consider that the pre-trial data is at its most stable (and therefore most ‘accurate’) place between May 2019 and November 2019) and that the trial data from January to March 2020 should be considered over the early months of getting the trial established (October-December 2019).

Figure 4.2 represents the number of referrals received, by month. It is difficult to be conclusive about the data presented because we did not see a long time-series in the trial dataset, but it shows that there was a significant drop-off in numbers of referrals when the research trial commenced. This is especially the case if we place less value on the pre-trial data from March-May 2019 and after November 2019.

Figure 4.2: Number of referrals received: pre- and post-trial



A similar pattern is observed in Figures 3.3 and 3.4 (overleaf). These data represent the fact that the local Minds had established a pattern of work that was routinely ensuring that >25 people per month took up the offer of a ‘What Matters’ conversation in the pre-trial phase (which dropped to a maximum of <10 in the trial phase). Similarly in respect of onward referrals made during the pre-trial phase, the data represents four months when referrals were >40 per month, and another four months when referral were >60 per month. These numbers were a good match for the number of referrals coming in. This contrasts starkly with referrals in the trial phase. Time

³ Although as explained above, by January 2020, two of the three sites had commenced recruitment into the trial.

⁴ The research trial was indefinitely suspended in April 2020 by the NHS Research Ethics Service when the first national lockdown took place.

is a factor here in that many people who began their 'journey' in the trial phase did not proceed very far before lockdown came along.⁵

Figure 4.3: Number of clients proceeding to 'What Matters' conversations: pre- and post-trial

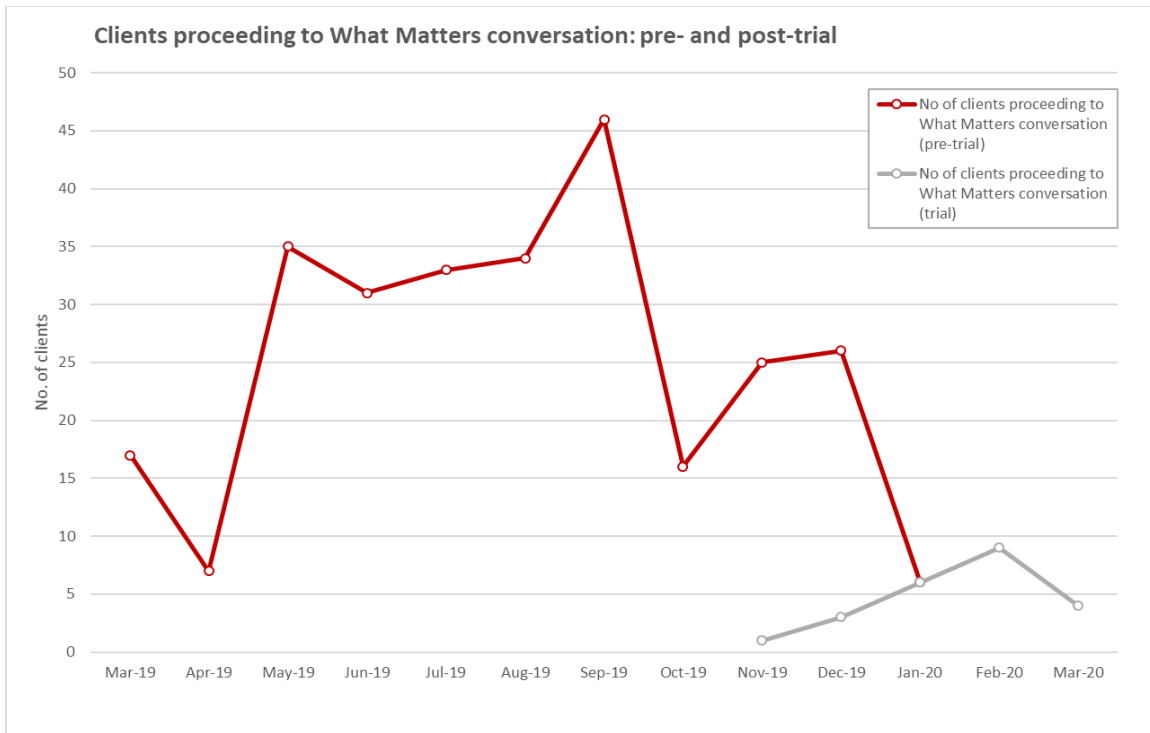
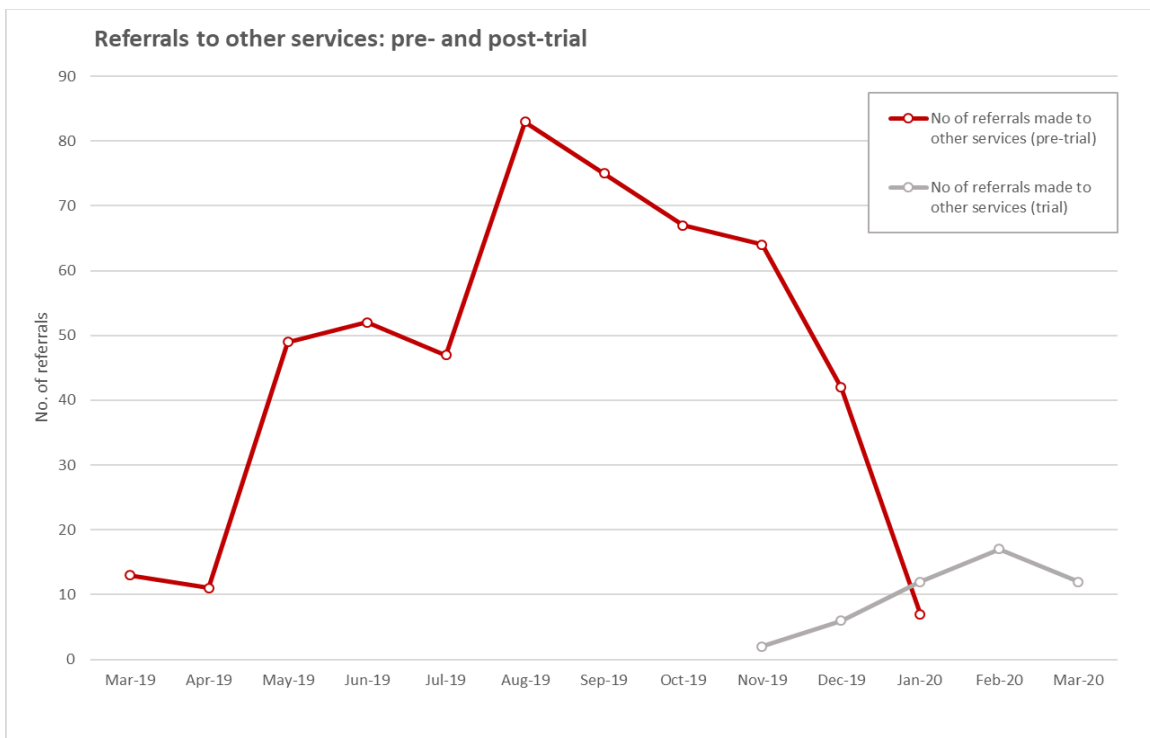


Figure 4.4: Number of referrals made to other services: pre- and post-trial



⁵ It is instructive that it has not been possible to calculate an average length of support in the trial phase because no-one had enough time to complete the intervention before lockdown, and a new form of support was offered.

5. THEMATIC SYNTHESIS

This section of the report presents a thematic synthesis of data analysed from three data sources. The key source is the stakeholder interviews, and this is augmented wherever appropriate with project documentation and service data.

It is important to note that the quantum of evidence is much greater in respect of the interviews than either of the other two sources. The project documentation and service data are synthesised here in supporting the themes identified through the interview findings. Findings are presented below using four overarching themes, which are then aligned with the four key study questions in the Conclusions chapter below.

1. Elements of the Mind Cymru social prescribing Model
2. Role of the link worker
3. Relationships
4. The impact of COVID-19

Each overarching theme heading specifies the data source that supports it, and which of the four key Mind Cymru questions the theme contributes to addressing. Where quotations are provided as supporting evidence, the stakeholder type is provided. However, names, organisations, and the geographical locality are not provided to ensure the anonymity of all participants.

ELEMENTS OF THE MIND CYMRU SOCIAL PRESCRIBING MODEL

(Addressing Q1, Q2, Q3, drawing on service data; interviews with Mind Cymru programme staff, local Mind managers and link workers; project documentation)

Benefits of the model – partners

The Mind social prescribing service was seen to be particularly helpful by primary care practices as it allowed patients to be supported to access support as *'not everyone has the level of confidence they need to go up to find information or engage with others'* (Referring organisation/GP practice). One participant referred to the Mind social prescribing service as leading to a decrease in frequent attenders, with patients contacting the surgery less after they had been supported by the social prescribing service.

Thinking about how patients may perceive the service, feedback received by referring organisations commented on the importance of social prescribing offering a timely intervention, particularly in the context of long waiting lists for primary care mental health services:

'It was timely, that they could speak to someone when they needed that support, so often when we refer to the primary care MH team there would be a good 2-3 month waiting list'. People would mention 'I've spoken with link worker, and it's been so helpful'. So the timely factor was a positive' (Referring organisation/GP practice).

Organisations receiving referrals from the social prescribing service also reflected on feedback they had received from clients:

‘The feedback I’ve been getting from the participants is that they’ve really valued that connecting together, the sense of belonging, they felt safe and they felt nurtured and cared for and it set them up for the weekend. They went away feeling uplifted and calmer’ (Receiving organisation).

In the context of COVID-19 and the restrictions of lockdown, referrers recognised the need to make adaptations to the social prescribing to ensure patients continue to benefit: *‘it feels like more and more people are struggling with COVID. Most of them that come into the surgery with other things will have some type of mental health problem’ (Referring organisation/GP practice).* The sustainability of the social prescribing service was an issue of concern, with participants keen for the service to be maintained: *‘We would be devastated if this service came to an end in our surgery’; ‘Please don’t pull the service’*

Benefits of the model – clients

In terms of the benefits of the model, there are important considerations in respect of the clients of the service. Table 5.1 provides an account of the time spent supporting clients in the phase of link workers’ role prior to the formal intervention whereby they worked alongside and collected data from 31 clients, and during the intervention when they collected data from 12 of these 31 clients:

Table 5.1: Time spent supporting clients: prior to, and during the intervention

Type of activity	Prior to intervention (minutes) based on data from 31 clients		During the intervention (minutes) based on data from 12 clients	
	Total time	Average per client	Total time	Average per client
Face to Face contact	1035	33.4	660	55.0
Telephone contact with the person	530	17.1	85	7.1
Time spent in other ways supporting this person	165	5.3	300	25.0
Admin (other tasks, including data entry)	425	13.7	240	20.0
Travel	0	0	16	1.3
TOTALS	2155.0	69.5	1301.0	108.4

Within link worker interviews, developing trust and building trusting relationships with clients was described as a central feature of their role. Enablers to successful working with clients were identified as:

- Offering flexibility around appointments in both times and delivery (e.g. offering home visits, telephone calls, emails, video calling);
- Providing information about the social prescribing service;
- Identifying needs and tailoring support *‘many of the issues don’t become evident until few meetings later’ (Link worker)*; and
- Listening and valuing clients.

One participant emphasised the importance of building trust and allaying fears about their involvement to clients: *‘When working with older people who despite wanting support, were fearful that disclosing or accepting help might mean having to live in a care home’ (Link worker)*.

In respect of the outcomes of the service, data collection and analysis was compromised by the closure of the research trial ahead of time. Table 5.2 presents Time Point (TP) 1 data gathered from participants on entry to the social prescribing programme against the three key outcome measure for the study: Recovering Quality of Life (ReQoL), the Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS), and UCLA Loneliness Scale (UCLA-3). This is then compared with TP 2 data (the second data measurement). Unfortunately, the number of data items collected (n=60 at TP1, and n=7 at TP2) means that there is no statistical significance in these data, but they are included here for the purposes of completeness. The message from this data is that when defined by the outcome measure scores given at both TP1 and TP2, there are considerable similarities between Sites 2 and 3, whereas Site 4 is dissimilar to these other two.

Table 5.2: Time Point 1 and Time Point 2 data for the three key outcome measures

	TP1 Mean	TP2 Mean
ReQoL	33.1 (n=60)	44.4 (n=7)
SWEMWBS	20.4 (n=60)	19.0 (n=7)
UCLA3	6.6 (n=59)	7.1 (n=7)

Service delivery and research in partnership – the research trial

In relation to the issues of pre-trial and post-trial data, it is important to note that this project was a partnership with the research team throughout, perhaps more than is typical for such relationships. The nature of running a research trial (in this case a waitlist, or steeped wedge trial) meant that local Minds were not free to act unilaterally when it came to the implementation of the service model. Consideration had to be given to the conditions laid out by the NHS Research Ethics Service.

Constraints associated with the trial, for example in respect of the referral pathway, meant that there would be limited referrals for some local Minds. In addition, concerns were raised about the potential burden of a trial on clients and the reluctance of GPs to engage:

I think the service model is a good idea, and there is a place for it but in terms of referral pathways, they would need to be set up differently because GPs might have been reluctant to engage because it was an RCT (Mind Cymru programme staff).

The considerable planning and work required to prepare and manage the trial itself was also referred to by Mind Cymru programme staff as was the tension between what is needed for a robust evidence base that imposed constraints versus the flexibility that the link workers wanted which was: *'to be able to receive self-referrals before entering GP surgeries'* (Mind Cymru programme staff).

For link workers, challenges of the RCT were associated with the roles and responsibilities of the trial itself combined with the link worker role. To manage these roles effectively, emphasis was given for the need to be organised and allocate time between appointments. Duties included:

- Working with and building relationships with clients;
- Building relationships with organisations (referrers and receivers);
- Time to complete the research passports;
- Adjusting the client pack from what had been originally produced to fit the requirements of the RCT;
- Administrative tasks including collating and collecting data was described as a *'heavy burden'*; and
- Ongoing data input.

All of the above were felt to have impacted on the service delivery and time spent with clients and some link workers felt a lack of support in their role: *'It has been hard to support everyone and balancing the need to complete the paperwork. It's been draining, and there hasn't been much support'* (Link worker).

Link workers reflected that it would have been advantageous to have had a better understanding about the responsibilities connected to the trial from the outset *'we have felt like we were launched into the deep end'*, and that more training would have helped.

The process of securing ethical permissions via the NHS Research Ethics Service to undertake the research trial, affected the ability to *'to respond to good ideas that come along'*, and coupled with the timescales of this process, were attributed to delays in the implementation and delivery of the social prescribing service by Mind Cymru programme staff:

'The biggest challenge which has impacted some of the time scales was the process of securing ethical approval. I think we perhaps didn't build in, well it was a mandated element of the contract that we needed to do a RCT, and it was a 3 year contract. I think just by the nature of that, the length of time that it took, and I think the complexity of it as well, to secure ethical approval was challenging' (Mind Cymru programme staff).

When the situation around COVID-19 led to the closure of the RCT and the subsequent removal of trial restrictions, this was seen by some as an enabler for the social prescribing service: *'Keeping them [link workers] engaged was difficult so allowing them to switch to focussing on as many people as you can, resonated more with their core purpose'* (Mind Cymru programme staff). For others though, it meant that the opportunity of 'proving' the worth of their work in a robust manner had disappeared.

Peer navigators

The peer navigator element of the social prescribing model had been anticipated to support sustainability of the social prescribing service. However, Mind Cymru programme staff acknowledged that this element had not been realised as it had been intended to work, and there had been delays to implementing the role that were associated with the processes of the RCT. Challenges referred to fully implementing the peer navigator role highlighted by Mind Cymru programme staff were:

- The capacity of local Minds *'some local Minds don't have infrastructure to support volunteers like other larger local Minds'*;
- The *'resource intensive nature of running a good volunteer programme'*;
- Concerns and anxieties about safeguarding from local Minds who do not have an effective volunteer programme already embedded; and
- Low numbers of referrals meant this element of the model kept getting delayed and *'pushed to the next stage'*.

In some cases, local Minds who were due to commence the peer navigator element were prevented from doing so by COVID-19. Being unable to test the peer navigator element was described as *'a big frustration'*.

However, for local Minds who had effective volunteer programmes, one Mind Cymru programme staff participant acknowledged the peer navigator was *'a good idea'*, yet, in recognising all of the challenges highlighted above, noted they would not include it in a future social prescribing model within Mind.

Uplift funding

Mind Cymru project documentation advised that uplift funding was used to provide a number of different services identified through a mapping exercise of existing provision undertaken by local Minds, and evidence of need. Services provided to clients using uplift funding included mindfulness, counselling, 'My Generation' (a Mind resilience and well-being programme for over 50s), mindful meditation, and creative writing. The provision of these additional services offered additional support options for clients accessing their local Mind. Initially, and in some cases, uplift funding was used to provide extra capacity for link workers, described on local Mind uplift reports as helping to *'ensure the project was up and running by February 2019'*. For example, mapping and scoping organisations and relationship building with partners such as GP surgeries.

– Uplift funding for services

Interviews with Mind Cymru programme staff highlighted that despite its intentions to relieve potential additional demand placed on local third sector and community services via the social prescribing service, uplift funding had *'not being used as intended'* and that the project had not put undue pressure on local service as initially envisaged (attributed to low-referrals to the social prescribing service). Issues associated to uplift funding included:

- The infrastructure of local Minds - local Minds are not set up as *'grant giving organisations'*, the uplift element *'relies on local Minds being sub-contractors of services which isn't part of their organisational function'*;
- A lack of confidence and experience of local Minds to let a contract with another organisation;
- *'Local Minds were broadly identifying needs that the local Minds were best placed to provide themselves'*. Examples provided were courses for anxiety, counselling;
- Too small an amount of funding for local Minds to really engage fully with; and
- Individual cost of uplift has been higher than originally anticipated.

Nonetheless, project documentation (from December 2018 to May 2020) and interviews with Mind Cymru programme staff show that all of the local Minds submitted business cases to draw down their uplift allocations each year. The Steering Group then approved these proposals in line with the agreed guidance for use of Uplift. These included proposals to deliver counselling and anxiety support and some local Minds had bought in services and run extras sessions of Mind courses such as *'My Generation'*. In this way, local Minds drew down the majority of the funding allocated for this purpose on an annual basis. Any annual uplift allocation that local Minds did not draw down was also not claimed from Welsh Government.

In terms of effectiveness, the quality of reporting from local Minds of the use of uplift funding for services is varied. Uplift funding reports were limited to information on spending and participant attendance, and in some cases, this information was not provided as soon as the funded activity ended. Auditing and accountability with regards uplift funding was referred to as requiring improvement at the Mind Cymru steering group meeting (7.5.20): *'more robust arrangements in place for auditing and accountability so that we could keep a better track on how funding was being used'*. Similarly, difficulties associated to governance were also highlighted by Mind Cymru programme staff with some local Minds providing more information than others. However, local Minds subsequently submitted closure reports for all completed activity, and revised arrangements were put in place to track spend and delivery on a quarterly, rather than annual, basis from 2020-21, in line with the Steering Group decision.

Closure reports from 2018-2020 show that target figures for client attendance and actual numbers achieved varied across local Minds. For example, one local Mind reported that numbers had *'exceeded anticipated engagement'*, whilst in another local Mind, from a target of 84 clients over a 12 month period, 16 attended. In this case, low attendance was attributed to a *'lack of referral to the social prescribing service and to the course'*. However, reasons for attendance

targets were not consistently provided via reports. Where outcomes/benefits for clients were reported, these included:

'Uplift funding provided speedier access to support for physical and emotional issues'.

'Clients who have attended have engaged well and left positive feedback with reduced scores on the recovery model'.

Client feedback was provided by one local Mind:

'Gained 'tools to help me re-programme a lot of long standing issues'.

'Helped me separate my problems instead of being one huge mess'.

'Feel better after talking and gave a different way of looking at problems'.

'Thank you for listening and not judging me'.

'Talking helped me sort out things in my mind'.

'Thanks for giving me an understanding of anxiety and how it works, so I realise I am not going mad'.

– Uplift funding for link worker capacity

Mind Cymru programme staff noted that in early stages of the social prescribing service, requests had been received from local Minds to uplift staff resource rather than uplifting services, with Welsh Government approval, in recognition of the extra burden that trial conditions placed on the link worker resources. Uplift funding documentation advised that two local Minds requested uplift funding to provide extra capacity for link workers. For one local Mind, these funds were used in part to pay for TOIL hours accrued by link workers to *'prevent pressure on service delivery if leave was taken instead'* and the remainder of the funding set aside to pay for future toil accrued as delivery entered the research phase. This raises the issue of link worker capacity/workload, plus the additional duties associated with the trial.

ROLE OF THE LINK WORKER

(Addressing Q1, Q2, Q3, Q4, drawing on interviews with Mind Cymru programme staff, local Mind managers and referring organisations)

Value of the link worker

Link workers were seen as being fundamental to the social prescribing service by Mind Cymru programme staff, local Mind Managers, and referring organisations. Link workers were described as having gone *'above and beyond'* (Mind Cymru programme staff) in their work with clients:

'Link workers are really tied into a whole breadth of potential treatments or solutions in their areas' (Mind Cymru programme staff).

The skills and experience of link workers were highly valued by local Mind managers and seen as integral to the social prescribing model. Key features of the role referred to by local Mind managers included:

- Their role in developing ‘excellent’ partnerships with third sector stakeholders;
- Knowledge of and mapping third sector and community services;
- Maintaining positive working relationships with third sector and community services: ‘we have a database of more than 150 organisations and they [link workers] personally contacted them and explained the service so that people were really keen to say ‘yes’; and
- Their relationships with clients.

Indeed, the link worker skills and experience in their work with clients and building and maintaining trusting reciprocal partnerships, afforded referring organisations the confidence to make referrals to the social prescribing service:

‘The link workers are amazing, and they balance the dependency, they recognise that people want someone to have a conversation with and it’s the one-to-one to get them onto the next step’ (Referring organisation/GP practice).

‘The GP surgeries and the practice managers have been overwhelming in their praise of what the social prescribing workers have achieved, yeah, so I think it’s that combination of specific people recruited specifically for that person purpose and therefore passionate’ (local Mind Manager).

There was an acknowledgment that the link worker role requires professional recognition, with a proposal for registration, so that clients and other organisations have greater awareness of the role and what it offers:

‘It would be good as a profession that it had a clearer understanding of what they are doing and recognition, that would help with cementing it as a role, it would be good if it had a higher recognition both for clients and other orgs to be aware of the role and the offer’ (Mind Cymru programme staff)

‘Link worker registration would be a real positive in terms of recognition for that role’ (Mind Cymru programme staff).

The expertise and skill set of link workers was seen to be essential to recognising the role: *‘Having a strong mental health practitioner background was key and that link worker role was really key to the effectiveness because it’s not just about signposting, it’s about supporting people through what matters to them’ (Mind Cymru programme staff).*

Training, development and support

To support and maintain the valued contribution of the link worker role in the effectiveness of the social prescribing service, Mind Cymru programme staff referred to the importance of providing link workers the space and time to undertake their role. For example, the space and time for link workers to build trusting effective relationships with clients and support them to find the right services is crucial to help clients achieve good outcomes and central to the success of a social prescribing service.

The complex and interrelated needs of clients of the Mind social prescribing service was recognised from the outset in the model's design. Acknowledging that immediate needs like finance, housing needed to be addressed first to help reduce the barriers to engaging in the service was a *'key aspect that the project was seeking to address'* (Mind Cymru programme staff).

Mind Cymru programme staff recognised that link workers frequently support clients with complex high-level issues. Therefore, it was important to ensure that link workers themselves are fully supported through for example, supervision with their managers. This led to some to reflect on the difficulties inherent in dealing with the burden of delivering support: *We've been trying to do our very best for people, but it's felt like a conveyor belt to be honest* (Link worker).

However, the social prescribing programme had taken up a substantial element of local Mind managers' time: *'There had been a disproportionate amount of manager time invested in this project'* (project documentation) and that local Mind managers supporting link workers in their role had taken *'a lot more time than anticipated'* (Mind Cymru programme staff). Furthermore, the design of the social prescribing model had not costed enough managers' time resulting in *'a lack of budget'* (Mind Cymru programme staff) to enable local Mind managers' time to fully undertake this work with their link workers.

Other challenges associated to capacity and staffing within the social prescribing service was the retention of link workers, referred to in the project documentation:

'It is important to note that link workers are leaving because they are getting despondent with the lack of referrals'

'There has also been a turnover of link workers and some link workers have not received the initial training'

RELATIONSHIPS

(Addressing Q2, Q3, Q4, drawing on interviews with Mind Cymru programme staff, local Mind managers, link workers and receiving organisations, service data and project documentation)

Primary care

Within the Mind Cymru meeting notes and across interviews with Mind Cymru programme staff, local Mind managers, and link workers, relationships with primary care was a recurrent theme. Establishing and maintaining the buy-in and ongoing engagement of primary care was seen as a factor that impacted referrals to the social prescribing service. Early reports in recorded minutes about the arrangements and service delivery from two of the local Minds referred to *'issues'*, for one local Mind these had been resolved but for another, issues were persisting with two GP practices. Relationships between local Minds and primary care were described as *'variable and patchy'* (Mind Cymru programme staff) and low referrals from primary care to the social prescribing service was an issue for all but one of the local Minds.

Factors reflective of local Mind feedback (summarised by Mind Cymru programme staff) as affecting the number of referrals received from primary care included:

- The time and capacity of GPs *'they are so busy it can be difficult to consider or discuss social prescribing'*;
- High use of locums in some clusters was attributed to difficulty maintaining awareness of the social prescribing service and its criteria, and maintaining relationships;
- Concerns about sustainability of the social prescribing service. An example provided was the de-commissioning of 'Active Monitoring', which was reported to have good buy-in and engagement. It was suggested that this might have led to a reluctance on the part of GPs to commit to the new service in the event it is not sustained;
- Initial buy-in and commitment from GP surgeries and had not followed through into practice;
- Concerns from GPs *'about the funding period and building up a demand for something that would subsequently not be funded'*, which impacted buy-in;
- The *'crowded market place'* of social prescribing – the availability of other social prescribing services that are not connected to an RCT which have easier referral pathways; and
- The *'more traditional pathways for mental health need where they can refer directly to the mental health team'*.

Additional issues within project meeting notes reported that the referral process that was *'too complicated'*, and there were uncertainties linked to *'confusion between the service and trial'* and *'confusion with Active Monitoring and counselling'*.

Local Mind manager and link worker interviews reflected similar challenges as those outlined above, which included the provision of other similar social prescribing services such as well-being coordinators employed by primary care and working in the same area. One local Mind manager also referred to the *'extra layer'* of complexity of the trial and the restrictions of the referral route from primary care and the contrast this had created from the service which had been *'a go to as a first source of support for mental health rather than the GP'* (local Mind Manager).

The issue of low referrals being received by local Minds throughout the delivery of the social prescribing service was a regular matter of concern within meetings and prompted an *'extraordinary meeting'* to be called in March 2020 in which the issue was described as an *'urgent need'*.

Meeting notes referred to actions intended to alleviate uncertainties and increase referrals rates from practices such as:

- The development of *'a statement articulating the distinction between data gathering for the trial and the service that local Minds can use to progress this conversation'*;
- The development of *'a flowchart for use by surgery staff in view of large number of locum GPs'*;

- Raising the profile and awareness of service via newsletters, leaflets, and workshop for GPs;
- Letter from the Chief Medical Officer;
- Social media campaign; and
- Uniforms for link workers.

Throughout the duration of meetings, some improvements to referral rates were noted, yet problems in some local Minds persisted. Despite these challenges, interviews provided examples of positive relationships between local Minds and primary care, which was viewed by one local Mind manager as key contributing factor to receiving good numbers of referrals: *‘A good relationship [is a key to success] with the GPs who actually understand what we're trying to achieve’ (local Mind Manager).*

Link workers also provided examples of positive effective relationships, which highlighted important components to developing and maintaining reciprocal partnerships with GP practices:

‘We developed a fantastic relationship with our practices very early on. We actually physically face to face met them, spoke to them, supported them in to know what we required from them, and we had we continued that support with them both ways. I regularly get in contact and say how's things going you know or we pop into surgery after we were visiting clients are doing home visits, would just pop in the surgeries and say how's things going? Just keeping in touch you know keep sending through you're happy with what's going on and we did that quite a lot’ (Link worker).

Important features also included the provision of regular feedback about the progress of clients/ patients:

‘We have a constant update with them and let them know what's going on, how it's going on and the feedback about the clients as well. Monthly we send them feedback on people, but we obviously don't put personal details in. I think it's just that two way relationship makes it’ (Link worker).

‘When you have a service like this, it has got to be integrated into the environment [...] we have got to feedback and tell them what we have done and this is why they are improving. They [surgeries] are all very grateful [for the feedback]’ (Link worker).

The importance of primary care receiving feedback about the patients they have referred to the social prescribing service is further reiterated in the examples below:

‘The team built up a good relationship with the link workers. We got monthly feedback as we needed to know how it had impacted on patients positively or otherwise with their connections’ (Referring organisation/GP practice).

‘In terms of improvement, it would be good to have feedback on patients. It is possible that we get this in the surgery, but it would be an improvement if we could get some information scanned in and part of the patient's notes’ (Referring organisation/GP practice).

However, despite one local Mind manager highlighting ‘*genuine buy-in*’ and having ‘*really good relationship with the cluster*’ this did not always lead to referrals from primary care. In these cases, factors influencing referral rates were considered to be:

- The time constraints of GPs as ‘*a central barrier*’;
- Use of locums and ‘branch’ surgeries – interrupting communication and awareness of social prescribing; and
- A general feeling from primary care that social prescribing is better situated in the community, or signposting by a person outside of the room of the GP.

In addition, establishing relationships with practices was an ongoing challenge for most local Minds: ‘*It proved to be very difficult to get into the GP practice. We try to communicate, but we kept getting inappropriate referrals, and it’s not gone anywhere*’ (Link worker).

In closing, some local Mind managers felt a lack of recognition of the skills of the third sector by statutory services such as health leading to the sector not being valued or utilised: ‘*[the] statutory often associate the third sector with amateur*’ (local Mind Manager). In one local Mind, link workers being provided with uniforms helped aid acknowledgment from practice staff and helped the ‘*link workers to fit in better*’ (local Mind Manager) and gave credibility to the link worker role.

Stakeholders – third sector and community organisations (receiving organisations)

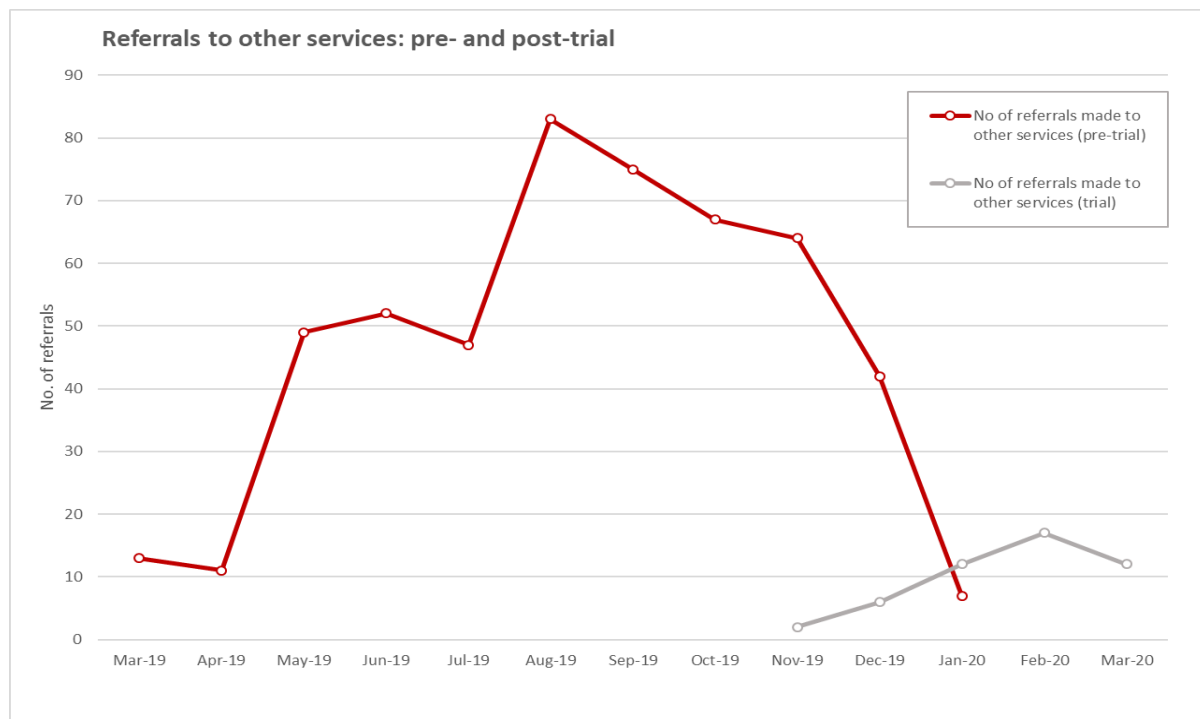
Between November 2019 and March 2020 during the trial period, forty-nine referrals were made by link workers to receiving organisations, primarily in the third sector – Table 5.3 provides detail on the different domains to which these referrals were made during the trial.⁶ In addition, Figure 5.1 offers analysis of the referrals made to other services for both the pre- and post-trial periods, demonstrating similar patterns to those represented above whereby there was a significant drop off when the trial began.

Table 5.3: Detail on domain of referral – during trial

Domain of referral	November	December	January	February	March	TOTAL
Clinical	0	0	0	1	0	1
Community well-being	0	2	4	7	6	19
Information	0	0	1	2	1	4
Non-clinical	2	4	6	5	2	19
Welfare	0	0	1	2	3	6
TOTALS	2	6	12	17	12	49

⁶ It is not possible to provide comparable data to this for the pre-trial period as no such comparable data on domains of referral were collected.

Figure 5.1: Referrals to other services: pre- and post-trial



Positive working relationships with third sector and community organisations who were receiving referrals from the social prescribing service were considered an essential component. A ‘willingness’ (*local Mind manager*) to work together as well as knowledge of third sector and community organisations were described as ‘essential’ (*local Mind manager*) and strong partnerships were highly valued:

‘We have really good supportive, reciprocal relationships with community and third sector organisations that have been embedded over many years’ (local Mind Manager).

Link workers had spent considerable time mapping third sector and community organisations, which helped them acquire in-depth knowledge of local services and develop effective, trusted partnerships that provided link workers the confidence to refer their clients onto these services. Local Mind managers discussed the in-depth approach taken to map third sector and community resources this included internet searching and face-to-face conversations with services. Attending third sector and community organisations and speaking to those running the support as well as those attending helped local Minds build relationships, understand what was being offered, the potential benefits, and inform what might work and ensure they were the ‘right services for their clients’ (*local Mind manager*).

Yet, short-term funding of third sector and community service was recognised as being problematic and the need to continually revisit and update their ‘map’ of services to take account of new services and services no longer available was acknowledged. However, ‘trying to balance community assets and patients’ needs is a challenge’ (*local Mind manager*) given the time required to do this effectively. The issue of sustainability was highlighted by a receiving

organisation: *'As projects have finished, we haven't been able to start any new projects, partly because of not getting the funding and partly because of COVID, so it all sort of put a stop to that. So in that respect, the support and ability of [name of service] to take on and support referrals from the social prescribing has been limited'* (Receiving organisation).

Interviews with organisations receiving referrals from the social prescribing service reported largely positive relationships with their local Minds and Link workers: *'Teams have good relationship with support staff they've worked with'* (Receiving organisation).

Other positive aspects to relationships with link workers included good joint working, particularly where there are clients with complex needs, and the flexibility and commitment of link workers: *'they will always try to source an appropriate avenue of support'* (Receiving organisation).

Awareness of the Mind social prescribing service was mostly attributed to interaction with link workers, and via meetings with local Minds rather than promotional materials:

'Links were pretty much established with the support workers on the ground' (Receiving organisation).

'We had a very thorough introduction to what its aims were' (Receiving organisation).

Close working with link workers was highlighted and one participant referred to the similar role they undertook to that of the Mind social prescribing link workers. However, a primary advantage to the Mind social prescribing service was seen to be their ability to be able to work with clients for a longer period. Nonetheless, a *'blurring of boundaries'* (Receiving organisation) between the roles amongst the third sector to whom both services refer into, coupled with the *'well established'* (Receiving organisation) community connector role was acknowledged as potentially impacting referrals to the Mind social prescribing service.

Aspects seen as benefitting from improvement were linked to communication with local Minds and feedback about clients' progress:

- The benefit for opportunities for the teams to meet up and *'share the types of clients that we work with and identify a more appropriate pathway'* (Receiving organisation);
- *'From a team perspective, there was more that could have been done'* (Receiving organisation); and
- Some participants described having *'some'* or *'limited'* feedback about clients' progress.

Stakeholders – Mind Cymru

There were mixed views and experiences in relationships with local Minds and Mind Cymru. Positive features included:

- The provision of regular meetings such as contract meetings were referred to as facilitating discussions about issues being faced and to share ideas for change which was *'very helpful'* (local Mind manger).

- Information sharing worked *‘really well’* (local Mind manager).
- Local meet ups of all local Minds that were involved in the research was also seen to be helpful, allowing sharing of best practice, and knowledge exchange.

Less positive features referred to included:

- Over involvement of Mind Cymru which was felt as leading to a *‘lack of involvement from the people on the ground and their experiences in developing the model’* (local Mind manager).
- Despite co-produced approach felt *‘top down’* (local Mind manager).
- Feelings that the expertise of local Minds was not fully recognised.
- *‘Completing the spreadsheet [sometimes] seems to be more important than the people’* (Link worker).

Decision-making processes were sometimes seen as lacking clarity, and a slow process: *I will say that we think the pathway to decisions is, it's not very successful basically. [There are] quite a lot by the amount of people you have to go through to get a decision made [...]. The main thing that we are frustrated with is the lack of speed* (Link worker).

As a means for link workers to meet and share good practice, a *‘practice network’* referred to in the Mind Cymru project meeting notes, had received *‘positive feedback’*. However, the discontinuation of the network in its *‘current form’* was agreed (30.4.19), citing issues of *‘demands on time, the cost and the location’*. Instead, the following proposals were agreed:

- A space for link workers to share good practice to be integrated with national events;
- Remote networking (e.g. ‘OpenHub’);
- A move from quarterly to six monthly meetings; and
- The space for sharing to be *‘opened up to managers and chief executives as well as link workers so that there was a united approach’*.

Link worker interviews noted that opportunities to meet with other link workers were welcomed, yet these meetings were: *‘arranged by other managers, they would come along and dictate what would be on the agenda’* (Link worker). Consequently, some link workers felt there was a *‘limited’* space to openly discuss and share practice with other link workers and local Minds: *‘it seemed very much like as another meeting for managers’* (Link worker). One link worker described feeling *‘quite isolated from other local Minds on the project, although there was good support from our own manager and [some in Mind Cymru]’* (Link worker).

THE IMPACT OF COVID-19

(Addressing Q1, Q2, Q3, Q4, drawing on interviews with Mind Cymru programme staff, local Mind managers and link workers, and project documentation)

As a consequence of the COVID-19 pandemic, changes were made to the Mind Cymru social prescribing model. Mind Cymru project documentation specify these changes were a move:

- To open referral pathways to the social prescribing service (including self-referrals or referrals from any agency); and
- From face-to-face support for clients accessing the service to online or telephone support.

Open referral pathways

Within interviews, these changes were largely seen to be positive enabling the removal of parts of the project that were seen as working less well. For example, the original referral pathway that had been limited to GP practices was highlighted as negatively affecting participation rates. The move to extend referral pathways, market the social prescribing service directly to clients for self-referral, and receive referrals any agency had led to local Minds receiving a *'significant increase in referrals'* (Mind Cymru programme staff). These changes were described as *'exciting'*:

'I thought great, let's get rid of what doesn't work and free up the local Minds to concentrate on the bits that really work for them and that they really care about' (Mind Cymru programme staff).

In addition, changes to the social prescribing programme as a result of COVID-19, reinforced the perspective that the core of the model *'still worked'* and was *'adaptable'* (Mind Cymru programme staff). The increase of referrals experienced by some local Minds was described as *'skyrocketing'*, and a welcome shift from receiving *'extremely low'* numbers of referrals.

However, others saw the primary care referral route as central aspect of the model: *'I do think that the route for the research project was right. They come and then they have the what matters conversation and suddenly we are able to provide both practical help emotional help referrals that have proved that the research model works and self-referral is not working nearly as well. Key is a GP referral so I think the model was right'* (local Mind manager).

For local Minds who had an established referral pathway with GP practices and who were receiving referrals, COVID-19 was recognised as resulting in *'a drop'* in referrals that was attributed to referral pathways having *'broken down since COVID'* (Mind Cymru programme staff).

In some cases, self-referrals had led to an increased number of inappropriate referrals that was attributed to clients not being assessed before accessing the service. Link workers echoed the sentiment of increased numbers of inappropriate referrals since the change in the referral pathway. In addition, higher referral rates had led to link worker workload increasing *'massively'* (link worker). This increase, combined with being not being able to work together face-to-face due to COVID-19 restrictions, meant at time, link workers felt they were not fully supported: *'People assume we are invincible. We are not'* (Link worker).

Receiving organisations referred to having supported clients with *'more complex needs since COVID'*. Local Mind managers and link workers echoed these experiences, reporting that COVID-19 had accelerated issues experienced by clients, for example, agoraphobia, isolation, and led to an increased range of difficulties (e.g. bereavement, financial hardship, redundancy, shielding). In

particular, link workers noted they were supporting *'more people in crises'*. An example referred to an increased number of Personal Independence Payment applications (due to the closure of the benefit office), that was described as *'quite demanding'*. Project documentation further highlighted a change to issues reported by clients, which included (but were not limited to): isolation, loneliness, lack of exercise, and a fear of going outside.

Telephone and online support

The move from face-to-face support to telephone and online support was referred to offering convenience to clients and initial apprehensions about this change had not been realised:

'Since COVID, we have video link and telephone offers are really convenient for people, we though they [clients] would be disappointed not seeing people face-to-face, but what we have found is that's not true and it's more convenient' (Mind Cymru programme staff)

For local Mind managers and link workers, the ability to be *'agile'* (local Mind Manager) and respond quickly to the pandemic to be able to continue delivering the service was important. Changes in the delivery of service provided via uplift funding were reported by local Minds within the project documentation. They included the provision of Mindfulness sessions being recorded and added to YouTube, and online delivery of counselling, and creative writing sessions.

There were advantages and disadvantages to online/telephone support reported by local Mind managers and link workers:

- Digital exclusion (e.g. clients not having access to laptops, poor broadband, knowing how to make use of online resources);
- Poverty and accessibility (e.g. clients not being able to 'top-up' their mobile phones);
- Challenges of not being able to meet clients face-to-face, can make it more difficult;
- Opportunity to be more *'flexible'*; clients have welcomed not having to come into the service;
- More efficient to do the 'what matters' conversation via telephone; and
- Able to support more people via telephone.

For link workers, providing online and telephone support was more flexible and freed up more time in-between appointments. Mind Cymru programme staff also highlighted the change had enabled more flexibility; with clients being able to access a lower level of help rather than having more complex needs requiring longer forms of support.

SUMMARY – REFLECTIONS ON SOCIAL PRESCRIBING AND THE WIDER SYSTEM?

(Addressing Q4, drawing on interviews with Mind Cymru programme staff, referring organisations, and receiving organisations)

Reflecting on the social prescribing service overall and its future within the wider system, Mind Cymru programme staff questioned where social prescribing might be best placed; whether

primary care is the right location for social prescribing, or whether it would be best placed in the community, *'before they access the GP or linked to primary and mental health in the community'*:

'How do you deliver a non-clinical service either in a clinical setting successfully or how so you take it out of a clinical setting so that you reduce the pressure on GPs and primary care' (Mind Cymru programme staff).

However, some referring organisations felt that social prescribing is better situated within primary care: *'When the doctors make the referral into the social prescribing service, it works better' (referring organisation/GP practice)*. For referring and receiving organisations, the complex needs of clients highlights the importance of social prescribing as a means to provide a broader, holistic suite of support beyond traditional mental health services and treatment:

'People need to be fully engaged with their community, it's not just about knowing people, it's about knowing what services are out there to help people. If we look at mental health services, secondary mental health services, the pressure being placed upon them, and GPs, primary services are ill equipped to actually give people the empowerment by knowing what support services are out there, especially in the third sector' (Receiving organisation).

'Social prescribing is very important. As GPs we are wanting to step away from over-medicalising, over-diagnosing all the time, I don't think that is anything we have done consciously but it's almost like we have fallen back on medication [...]. But actually, the social stuff and the lifestyle stuff, even though it's harder it's going to solve your problems longer term and it's difficult to do the lifestyle and social intervention within the ten minute consultation that we have, but it's vital to patient health and well-being' (Referring organisation/GP practice).

'A benefit [of social prescribing] is that it takes pressure off health services and hopefully people's dependence on prescription drugs. If you can improve people's lives through having these channels for people to go and have that extra helping hand to access those opportunities themselves, that is a definite benefit' (Receiving organisation).

This was a perspective echoed by Mind Cymru programme staff: *'[social prescribing] has a massive role, the system still tend to view issues as a mental health problem and then only mental health services are offered. But people arrive with very complex problems, for example, domestic violence, housing, debt, employment and an intervention that includes unpicking those, that holistic approach is important beyond the standard paths like counselling and CBT etc.'* (Mind Cymru programme staff).

Proposed changes and recommendations to the social prescribing model offered by Mind Cymru programme staff focussed on the initial referral route and relationships with primary care.

- The referral pathway was envisaged to include a range of practitioners from primary care and not just GPs. Widening the remit and engaging other health professionals earlier was

considered to have had the potential to have made a difference in terms of referrals *‘we felt the front door was in the wrong place’ (Mind Cymru programme staff).*

- Engagement with the GP and cluster from the outset was referred to as being essential and the challenges of doing so were acknowledged: *‘were we were trying to push a non-clinical service into a clinical setting’ (Mind Cymru programme staff).*

Other proposals included the provision of social prescribing services for adolescents: *It would be really good if there was more for adolescents, they really seem to fall through the gaps [...]. People who are 14 and upwards, they’ve got quite adult types of mental health issues and it would be so useful if they could have that service as well (Referring organisation/GP practice).*

6. REFLECTIVE DIARIES

This chapter presents findings from the reflective diaries that were provided by those staff members who chose to be diary keepers within the social prescribing programme. A realist evaluation approach was taken to this aspect of the study which aimed to understand the experiences of staff members working with people with mental health problems in providing and co-ordinating the social prescribing service. In the section below, reference is made to the different diary keepers. In order to preserve their anonymity, the reference notes which site they worked in (S1, S2 or S3), and differentiates Diary Keepers by number (DK1, DK2, DK3 etc.). The diary entries that were analysed captured a range of experiences across the three sites from May 2019 to March 2020.

The research question was: *What were the experiences of staff members expressed within the reflective diaries?*

PROGRAMME THEORY

One of the key outputs from the realist approach is the generation of ‘programme theory’. The programme theory describes how the intervention is expected to lead to its effects and in which conditions it should do so. The purpose of a realist evaluation is to test and refine the programme theory as it is to determine whether and how the programme worked in a particular setting.

Four mid-range theories were identified from analysis:

1. *‘Link worker frustration with confusion in the referral process’*
2. *‘What matters to me in a complex case’*
3. *‘Managing workload and link worker well-being’*
4. *‘Training, knowledge and skills’*

Each of the four mid-range theories are discussed in the following section and are accompanied by which of the Mind Cymru key questions (Q1-Q4) the data contributes to addressing.

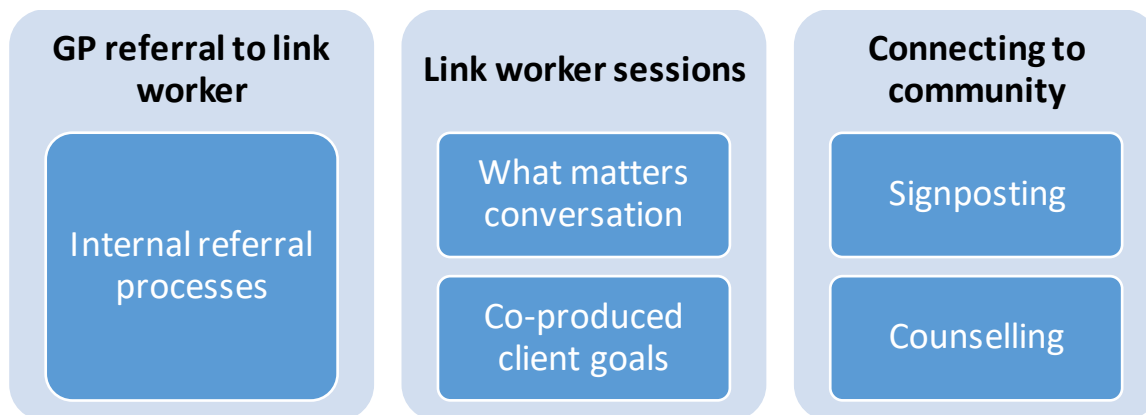
Social prescribing recognises that people’s health is determined primarily by social, environmental and economic factors. It aims to empower the individual to manage their health and well-being. Link workers often work in primary care and the community. Together with the client, link workers have a ‘what matters’ conversation, develop personal goals and signpost them to community groups (Figure 6.1 overleaf).

The programme theory (or how the programme is understood to work) has three parts, a referral to a link worker, link worker sessions (including what matters conversation and co-produced client goals), connecting to the community via signposting and most often including counselling.

In answer to the overarching question, the explanations have been built from their Context, Mechanism, Outcome (CMO) relationships identified within the diaries and are provided in the summary tables below. The *context* includes the resource, the *mechanism* includes the behaviour

which has triggered an *outcome*. The CMO configurations are operationalised by ‘If/then’ statements.

Figure 6.1: Presenting the initial overview of the programme theory (blue) with later theory development about the link worker and manager experiences during the pilot



THEORY 1: LINK WORKER FRUSTRATION WITH CONFUSION IN THE REFERRAL PROCESS (Q2, Q3, Q4)

This theory describes the link workers’ frustration with confusion in the referral process as they commenced the social prescribing project.

Table 6.1: CMO configurations and if/then statements, which underpin the explanations for theory one: Link worker frustration with confusion in the referral process

Context (Resource)-Mechanism (Behaviour)- Outcome		
Theory one: Link worker frustration and confusion in the referral process		
Lack of induction at site for project and primary care reception staff	Creates confusion	Communication issues, no initial safety procedures, ignorance around referral process, lack of consistency and issues around capacity (numbers)
No organised site and staff introduction	Irritation	Repeatedly asking surgery staff for information
Starting pilot before agreeing paperwork	Frustration	Constantly managing change
‘If/then’ statements		
<p><i>If there is lack of induction at site for both project and primary care reception staff then this will lead to confusion and result in communication issues, no initial safety procedures, ignorance around referral process, lack of consistency and issues around capacity (numbers).</i></p> <p><i>If there is no organised site and staff introductions then this leads to frustration and link workers repeatedly asking surgery staff for information.</i></p> <p><i>If you start pilot work before staff feel that the paperwork has been finalised then this leads to frustration and project staff having to constantly managing change.</i></p>		

This was due to both surgery staff's lack of communication about surgery processes to the link workers and their lack of knowledge about the project. When the link workers first presented themselves (as planned and requested) to the GP surgery prior to commencing the social prescribing project they didn't have an induction on site, for example, providing them with the building layout and safety procedures. In addition, receptionists and GPs were not familiar with the referral and appointment processes (S1 DK1; S1 DK2; S3 DK2). Other issues included:

- Missing client referral forms
- Information packs not being provided to clients
- Clients not reading the packs before the call
- Clients not turning up for appointments
- Clients being directed to Mind instead of the link workers
- Difficulties with room availability and bookings
- Providing the wrong information to the client regarding an appointment; some resulting in the link worker reporting that they were made late for a client (S1 DK1; S1 DK2; S3 DK1; S3 DK2):
 - *'I wasn't told what clients I was seeing and when, had to keep asking the receptionist for information' (S1 DK1). 'I feel as if we are hitting a brick wall as we have done all we can to ensure the GP practices know the process from their side' (S3 DK1).*
- Sometimes there was a drop in referrals or there were more referrals than agreed (e.g. four clients in 2.5 hours):
 - *'I felt that I was potentially rushed with some clients and was concerned that they didn't get the full involvement of the project that they needed' (S1 DK1).*

This situation continued and was frustrated by the link workers not able to communicate with the practice manager (S1 DK1) and repeatedly having to ask reception staff for information. In one area frustration was felt in the loss of GP surgeries participating in the pilot, some friction had occurred, but a proactive approach by Mind helped: *'small doses of quality communication and our good working relations with other GP practice, has helped smooth this over'* (S3, unidentified DK).

THEORY 2: CLIENT COMPLEX PROBLEMS (Q2, Q4)

This theory gives some explanation about the client complex problems, their needs and the role of the 'what matters to me' conversation in this context. The client referrals included in the diaries appear to represent a broad age range from late teens (19) to very elderly (90s). They sometimes visited the client in their own homes (S2 DK1), met in a coffee shop (S3 DK3), and accompanied them to hospital appointments, podiatrist, bank, and post office using the link worker's car for transport.

Their presenting problems were either appropriate (and often required several sessions) or were inappropriate and referred back to the GP. The former included clients presenting with the symptoms of anxiety and depression, stress, postnatal depression, challenging personal circumstances around health and relationships (for example relationship breakdown), workplace issues such as discrimination or assault, loneliness and social isolation, agoraphobia, increased caring responsibilities.

Table 6.2: CMO configurations and if/then statements, which underpin the explanations for theory two: What matters to me in a complex case

Context (Resource)-Mechanism (Behaviour)- Outcome		
Theory two: What matters to me in a complex case		
Client presenting with complex problems	Feeling alone and anxious	Client requiring concise and correct information and reassurance about the service being offered in order to make an informed decision
What matters conversation	Active listening by link worker	Client felt heard (understood and not being judged)
Including relative(s) in the conversation	Client change behaviour, tone and posture	Client voice becomes unheard or defensive
Nervous client unable to express feelings experiences more than one session required with link worker	Client feels increasingly calmer and more relaxed	Increased ability to describe the problems in more depth
<p>‘If/then’ statements</p> <p><i>If a client presents with complex problems then link workers perceive that they will feel alone and anxious and require concise and correct information (and reassurance) about the service being offered in order to make an informed decision.</i></p> <p><i>If a link worker creates the ‘what matters conversation’ then it provides opportunity for the link worker to engage in an active listening process which results in the client feeling heard.</i></p> <p>If relatives are included in the conversation, then clients can change behaviour, tone and posture resulting in the client voice becoming unheard or defensive.</p> <p>If a nervous client requires more than one session with the link worker then the client feels increasingly calmer and more relaxed, which results in the client gaining an increased ability to describe the problems in more depth.</p>		

These were complicated sometimes by suicidal thoughts, intrusive thoughts, homelessness, lifelong illnesses, inherited debt, experiences of violence, trauma or bullying as a child resurfacing, unemployment, coping with children who have witnessed domestic violence, relatives wanting to speak on their behalf during the consultations (S1 DK1), PTSD, night terrors, falling behind in university studies, sleep issues. As a consequence of these experiences, the client often found themselves feeling alone and anxious (S3 DK1; S3 DK2). One link worker commented on a first meeting: *‘the client was very nervous and questioned if we were there to*

put her in a home' (S2 DK1) and had to further explain they were there to *'encourage independent living'*. Consequently, they realise *'the importance of the initial telephone contact'* and that clients will require *'correct and concise information'* about the service before they are able to make an informed decision (S3 DK2).

The inappropriate referrals included police matters, health problems, requiring sick notes (S1 DK1), and clients under the influence claiming illegal drug use (S1 DK2). Key to all the referrals was the conversation, which included active listening and an opportunity for the client to talk and express what they thought they needed. The link worker offering a list of options for the client to consider often followed this, including counselling, yoga, mindful meditation, classes in the community, citizen's advice, women's groups to build confidence and assertiveness, domestic abuse services. The link workers often mention that they found it *'quite difficult to get this client to talk'* (S1 DK1) and *'couldn't make eye contact'* (S1 DK1) or they were *'quite nervous'* (S1 DK1) or the client wasn't comfortable *'showing his concerns'* (S1 DK2). Generally the conversation resulted in the client *'feeling heard for the first time in a long time'* (S1 DK1) also understood and not being judged (S1 DK1) and signposted to an agreed service.

There is mention of repeated sessions with the link worker with the client described as less nervous or *'calmer today than in recent sessions. They were open to discussing how they had been feeling and how they felt the process was helping them'* (S3 DK1). This resulted in the client demonstrating an increased ability to describe the problems in more depth.

There were occasions when the link worker had felt pressured into including a relative(s) in the *'what matters conversation'* or realised that the relative (as opposed to the client) had secured the referral. This led to the client's needs being perceived as ignored or the client behaving differently, feeling aggravated, presenting a change in tone and/or posture whilst the relative told the link worker what the client needed (S1 DK1; S3 DK3). The link worker noted (in the relatives' presence) that *'the client whispered to me that they wanted to feel better about themselves first'* (S1 DK1).

THEORY 3: MANAGING WORKLOAD AND LINK WORKER WELL-BEING (Q2, Q3, Q4)

This theory describes the mixed emotions experienced by the link workers/managers when managing the workload and their well-being. They were often excited, had *'a positive attitude'* about the developing service, and enjoyed seeing the clients achieve goals and promote independence (S2 DK1). The follow up appointments enabled the link workers to see how the clients had progressed. They felt *'passionate about what I do'* (S3 DK2), a sense of satisfaction when a client thanked them for sitting and listening (S2 DK1). Enjoyable working relationship with clients were reported which generally led to a sense of success but also sadness when bringing a case to closure (S3 DK2).

Link workers could see right from the beginning that there was a need for the service to help a *'stretched NHS in our area'* and *'I think this project is going to be very successful'...* *'it will reduce the impact on GP time'* (S1 DK1; S3 DK2). They reported occasions when they identified a need

for a new aspect of the service for example managing homelessness, anxiety depression, family support (S2 DK1). They felt the pressure to succeed in the role, wondering at times if they were strong enough emotionally (S2 DK1; S3 DK2). They often felt emotionally exhausted from thinking and listening, phone ringing, answering the door and trying to read 'a 50 page protocol'.

Table 6.3: CMO configurations and if/then statements, which underpin the explanations for theory three: managing workload and link worker well-being

Context (Resource)-Mechanism (Behaviour)- Outcome		
Theory three: Managing workload and link worker well-being		
Worrying whether strong enough emotionally to cope with the issues presented- balancing competing responsibilities of seeing patients, completing service stats and the research process	Feeling stressed, low morale, and sometimes taken for granted	Informal peer support and manager support to self-care and self-manage the workload. Link worker turnover Taking work home and/or working on days off
Supporting client achieve goals to promote independence	Enjoying a lovely working relationship and sense of satisfaction	Closing the case leads to both sadness and a sense of success
Too many new clients booked in a day and paperwork to complete	Link worker feeling 'drained' going home and recognise that they need to maintain their own health	Collaborative decision-making New workload strategy Co-productively reviewing workload and agreeing to 1 new client only per day and opportunity for peer support
'If/then' statements		
<p><i>If link workers are worrying whether they are strong enough emotionally to cope with the issues presented by the clients in addition to balancing competing responsibilities within the service then they will feel stressed, low morale and sometimes taken for granted. As a result, they will need informal peer and manager support to self-care/self-manage the workload in order to avoid issues such as taking work home, link worker turnover or working on days off.</i></p> <p><i>Where you have clients achieving goals to promote their independence then link workers enjoy a lovely working relationship and gain a sense of satisfaction. This results in mixed emotions of both sadness and a sense of success when closing a case.</i></p> <p><i>Too many clients booked in a day in addition to their paperwork leads to link workers feeling drained and recognising that they need to maintain their own health. As a result, a process of co-production and collaborative decision making in the team can lead to reviewing workloads and new workload strategy.</i></p>		

In addition to often having too many clients booked in during the day, unable to say no 'we do not want to say no to someone suffering'; and the paperwork left them feeling drained and alone, 'I am one person' (S2 DK1). They struggled with managing the competing responsibilities of client appointments, completing service statistics and the research process itself (S3,

unidentified DK). They sometimes felt stressed, defensive, angry and sometimes taken for granted, taking work home or working on days off. At other times, they reported feeling empowered to develop a new workload strategy to redress their work-life balance or address their own personal wellbeing through exercise, diet and computer breaks (S2 DK1, S3 unidentified DK). This was often supported by informal peer support and manager support.

THEORY 4: TRAINING, KNOWLEDGE AND SKILLS (Q3, Q4)

This theory explains the link worker/manager training, knowledge and skills expressed in the diary.

Table 6.4: CMO configurations and if/then statements, which underpin the explanations for theory three: link worker training, knowledge and skills

Context (Resource)-Mechanism (Behaviour)- Outcome		
Theory four: link worker training, knowledge and skills		
Link worker training needs analysis is conducted	Reassurance that funding is spent effectively	Link worker buy-in to the training allocated
Regular keep reflective diary	Reflexivity reveals training needs	Recommendation to address the identified gaps in knowledge to manage required cultural change
Understanding the equal importance of the link workers V evaluator roles is clarified at the beginning	Greater understanding of the benefits for clients and the service in the short and long term	Helps link workers with no previous experience of working with research better understand each element
'If/then' statements		
<p><i>If a link worker training needs analysis is conducted then link worker feel reassured that the funding is spend effectively, resulting in them buying into the training allocated.</i></p> <p><i>If a link worker keeps a reflective diary then the reflexive process provides opportunity to reveal training needs resulting in recommendations to address the identified gaps in knowledge to manage required cultural changes.</i></p> <p><i>If there is a clearer understanding of the equal importance of the link worker role and the evaluator role in practice then this will help link workers with no previous experience of working with research better understand each element, which results in greater understanding of benefits for clients and service in the short and long term.</i></p>		

There was a clear sense of link worker purpose, which was expressed by one link worker as 'I want the client to benefit from my guidance, listening and signposting. I want the client to feel safe that they do not fear their own emotions' (S1 DK1). Link workers identified that they had numerous skills such as listening, ability to put a client at ease, signposting skills, marketing/ promoting the new service and a broad knowledge of community services/connections. However, they occasionally identified gaps in knowledge e.g. how to manage client behaviour, how to successfully close a client case, waiting times, values training, data coding for the project

for Mind and data coding for the research project (Mind and USW), managing client dependency, link worker worrying that they may have said the wrong thing in certain situations, study role and process (S1 DK1, S3 DK2).

Training experiences included delivering positive social prescribing training to college students (S2 DK1), the mandatory 'what matters conversation' (had a mixed reception), NVQ qualification, the paperwork, stress management and mindfulness. These were formal and informal experiences e.g. class based or observation (S1 DK2; S3 DK1). However, one of the link workers thought that they should have been asked about their needs and qualifications prior to booking the training and were concerned that it was a waste of public money (S1 DK2). There was also mixed feelings about the WIHSC training sessions, for some the discussion about whether the service was a crisis intervention or not led to confusion for the link worker because of the type of complex referral they were receiving (S1 DK2), although it had been explained to GPs that referrals should only be mild/moderate cases. For others, the session was enjoyable and '*very informative and reiterated that what we are doing is correct*' (S3 DK1).

There were occasional comments in the diaries which suggested that mandatory training may be needed by the link workers around values specifically dignity and respect. Two comments reveal the specific training needs '*all clients I see will receive the same approach as I feel that everyone needs to be treated the same irrelevant of their needs*' (S2 DK1). In addition to '*it was very confusing to visit a client of 92 years old. We both questioned the requirement for the possibility of meeting goals for the future at that age.*' Although it must be noted, that the experience of working with the older client altered the link workers original perception (S2 DK1). A recommendation for values based training (dignity and respect) about addressing individual client needs along the lifespan should address these expressed gaps in knowledge and support cultural change. Link workers clearly had an awareness of safeguarding and the need for two of them to attend a vulnerable client at home.

In May 2019, one diary had reflected a greater understanding for a clear understanding of the equal importance of the link worker role and the evaluator role in practice:

'For the link workers to have a good understanding on how our link workers roles feed into and more importantly support the evaluators with their research requirements [...] that our roles are just as important to supporting the research elements of the project and possibly in some aspects, even more important that delivering the service itself' (S3 unidentified DK).

It was felt that training would help link workers with no previous experience of working with research to have a better understanding of each element of the role, how they fitted together and benefitted clients and services in the short and longer term. Nevertheless, there were comments scattered within the three sites about having to manage the role of the link worker and the study requirements. For example, the frustration of research passports getting approval, a date for the research to start (S1 DK2; S3 DK2): '*feel as though we are not being listened to*' when discussing client mild/moderate criteria, reading the research protocol, and feeling nervous about the research phase (S1 DK2).

SUMMARY

What were the experiences of staff members expressed within the reflective diaries?

In this final section, we discuss the relationship between the context and the mechanisms identified. In realist evaluation, we surmise that altering the context has an effect on the mechanisms and the outcomes. For example, in theory 1 **'Link worker frustration and confusion in the referral process'** there were variable experiences recorded with the referral process including confusion, irritation and frustration which triggered communication issues, issues around capacity and constantly managing change. Changing the planning context to include a joint induction and timeline agreements on the paperwork before project start would likely alter the link worker experience.

In theory 2, **'what matters to me in a complex case'**, we found that link workers were working with a variety of complex cases and experiences would enrich for both link worker and client where:

- Clients had standardised correct and concise information on the 1st phone call to help them make an informed decision about whether they want to take up their link worker sessions;
- The 'what matters conversation' is identified as an important context for the client to be heard and the link worker to practice 'active listening';
- The client is interviewed alone and not with family or friends if they are to be heard; and
- The link worker practice professional judgment with regards to the number of initial client sessions required (as opposed to just one) to feel relaxed and calm enough to express what matters to them.

In theory 3, **'managing workload and link worker well-being'** link workers were passionate and excited about the role and understood the need for the service in primary care. However, we found that link workers worried about managing the balance between their own well-being (strong enough emotionally to manage the caseload) and the competing responsibilities of the client appointments, collecting service statistics and the research process itself. Promoting and formalising the peer support across the services, promoting and strengthening co-productive practices and collaborative decision making in daily practice with the teams and stakeholders (where appropriate) would help link workers with this challenge.

In theory 4 **'training, knowledge and skills'** identified multiple link worker skills but three contextual issues, the first where there was an expressed need for a local training needs analysis to ensure 'buy-in'. The second where the actual use of the reflective diary identified a training need for mandatory training and the third where there were conflicting experiences of the understanding of the study process and its importance.

7. CONCLUSION

This study has analysed and reported data collected from a range of data sources across the study. In this concluding chapter, findings from triangulation of all the data presented in this report is presented the tables overleaf, which are framed using the four questions of the re-programmed proposal. Tables presented in this section overlap and should be considered together rather than in isolation.

HOW EFFECTIVE IS THE SOCIAL PRESCRIBING MODEL?

Table 7.1 triangulates data from the evidence base collected throughout the study, which focused on the effectiveness of the social prescribing model.

Table 7.1: Summary of findings - How effective is the social prescribing model?

How effective is the social prescribing model?		
Meta-narrative	Thematic synthesis	Reflective diaries
<p>Benefits of the model <u>Length of intervention and activities undertaken during intervention</u></p> <p>-Wide scope of activities including information and advice, physical and community activities and befriending. E.g. art therapy, volunteering, exercise classes, walking and reading groups, employment, debt, housing support</p>	<p>Benefits of the model <u>Clients</u></p> <p>Client outcomes for uplift funding limited, where reported, they include increase in subjective wellbeing scores. Client feedback provided by one local Mind – importance of be being valued and listened to.</p> <p>-Identifying needs and tailoring support -Listening and valuing clients -Reduction in frequent attenders to GP surgery -Timely provision of support</p> <p>[project documentation, interviews]</p>	<p>Benefits of the model <u>Clients</u></p> <p>Theory 2: Client complex problems [active listening via the ‘what matters’, ‘feeling heard’ and valued, included in discussions for support services]</p> <p>Theory 3: Managing workload and link worker well-being [satisfaction from clients progression, clients achieving goals]</p>
<p>Role of the link worker</p> <p>Link workers are a key feature of social prescribing services e.g. helps facilitate the buy-in and engagement of health, stakeholders, and enables patients/client participation and attrition.</p>	<p>Role of the link worker</p> <p>Link worker role highly valued by Mind Cymru staff, local Mind managers, referring and receiving organisations [interviews]</p>	
	<p>Use of peer navigators</p> <p>Peer navigator as intended to work had not been realised. Delays to implementation associated to RCT and there were issues to implementing fully e.g. infrastructure of local Minds to support volunteers, anxieties from local Minds about safeguarding [interviews]</p>	

How effective is the social prescribing model?		
Meta-narrative	Thematic synthesis	Reflective diaries
	<p>Uplift funding</p> <p>-Used to provide a number of services, and in some cases, capacity for link worker time</p> <p>-Issues included, need identified were ones that local Minds could provide themselves, a lack of confidence/experience for local Minds to sub-contract</p> <p>-Quality of reporting for uplift inconsistent and mostly limited to spend and attendance</p> <p>-Uplift funding for link worker capacity req. by two local Minds, one local Mind not used as intended and instead used to pay for link worker TOIL hours</p> <p>[interviews, project documentation]</p>	
<p>Referral pathways and relationships with referred-to organisations</p> <p>-Effective feedback loops between all partners and maintaining communication promotes a shared partnership approach. In particular, feedback from link workers about patient/clients progress</p>	<p>GP referral pathways affected client participation</p> <p>[interviews, project documentation]</p> <p>Relationships with receiving organisations</p> <p>-Strong, reciprocal partnerships described (deemed essential to the social prescribing service)</p> <p>-Communication/feedback about clients could be improved</p> <p>-Link worker key to enabling and sustaining these relationships [interviews]</p>	
	<p>Views on the core model itself – evidence-based framework, whether this is scalable/flexible/adaptable</p> <p>-Changes to the social prescribing model as a result of COVID-19 showed the core of the model worked and was adaptable</p> <p>[interviews]</p>	

What worked well

- Positive elements of the model were that clients were included in discussions about the available support services, feeling heard and valued, through active listening via the ‘what matters’ conversation.
- For clients the model offers a timely intervention, particularly in the context of long waiting lists for primary care mental health services.
- Link workers are a key feature of social prescribing services and their role is highly valued by Mind Cymru staff, local Mind managers, referring and receiving organisations. They help facilitate buy-in and engagement of stakeholders and enable client participation and attrition (see Table 7.3 for *skills of link workers*).

- Uplift funding had been used to provide a number of service and in some cases during project set-up had been used for link workers capacity.
- The core of the Mind Cymru social prescribing programme worked and was adaptable (as highlighted by the change to the model as a result of COVID-19), (see Table 7.3 for *the impact of COVID-19*)

What worked less well

- The peer navigator role, as it had been intended to work, has not been realised. Challenges included the delays to implementing this aspect that were associated to the trial and the infrastructure of local Minds to support and deliver a volunteer programme, and local Minds concerns about safeguarding.
- In respect of uplift funding, challenges included the confidence and experience of local Minds to sub-contract services, and governance as, for example, the quality of reporting of the use of uplift funding from local Minds was variable.

Overall

- The service model developed by Mind was effective in delivering the service. The role of the link worker is a core component to the model and its delivery. There are evident advantages of this service model for clients, although limitations on our ability to speak directly with clients and analyse robust data provided by them means that we have to rely on proxies for this assessment.
- That being said, placing people at the heart of the social prescribing service has been a key and constant consideration for those directly involved in providing the social prescribing service. For clients of the service, benefits include the provision of a timely intervention, and feeling valued, heard and regarded via the ‘what matters’ conversation. The model was especially adaptive under the pressures brought to bear by the COVID-19 pandemic, but there are learning points around the need to continually support front-line link workers and local Minds to ensure that the model continues to be as effective as it possibly can be.

WHAT WERE THE BARRIERS AND ENABLERS TO IMPLEMENTING THE SOCIAL PRESCRIBING SERVICE?

Table 7.2 triangulates data from the study, which focused on the barriers and enablers to implementing the social prescribing service.

Enablers to successful implementation

- Strong, effective relationships are crucial (with and between referrers, patients/clients, link workers, and the social prescribing activity).
- The link worker is highly valued in developing and maintaining relationships with health.
- The inclusion of health in the design and delivery of social prescribing which may alleviate challenges to buy-in and contribute to the success of the referral.

Table 7.2: Summary of findings – What were the barriers and enablers to implementing the social prescribing service?

What were the barriers and enablers to implementing the social prescribing service?		
Meta-narrative	Thematic synthesis	Reflective diaries
<p>Relationships with local health board/cluster</p> <p>-Strong, effective relationships and partnerships (with and between referrers, patients/clients, link workers, and the social prescribing activity) crucial to the success of social prescribing programmes; contributing to the success of the referral</p> <p>-Including health in the design and delivery of social prescribing may alleviate challenges to buy-in and contribute to the success of the referral</p>	<p>Relationships with local health board/cluster</p> <p>-Establishing and maintaining relationships with primary care</p> <p>-High use of locums, branch surgeries</p> <p>-Good relationship seen as key receiving referrals</p> <p>- link worker a valued role in developing and maintaining relationships</p> <p>[interviews, project documentation]</p>	<p>Relationships with local health board/cluster</p> <p>theory 1: Link worker frustration with confusion in the referral process [lack of communication, no induction, lack of familiarity with referral process, missing information to clients, missing referral forms]</p>
<p>Context service operating in</p> <p><u>Capacity of GP practice</u></p> <p>-Time constraints during busy consultations can influence buy-in from health</p>	<p>Context service operating in</p> <p><u>Capacity of GP practice</u></p> <p>-Time and capacity of GPs a factor impacting numbers of referrals</p> <p><u>Wider context social prescribing service is operating in</u></p> <p>-the ‘crowded marketplace’ of social prescribing</p> <p>-Well-being coordinators employed by primary care</p> <p>‘well established’ (Receiving organisations) community connector role [interviews]</p>	
	<p>Impact of trial conditions</p> <p><u>Clients</u></p> <p>Potential burden of the trial on clients</p> <p><u>Staff</u></p> <p>Considerable planning and work to prepare and manage complexity of RCT, including ethics, and its impact on implementation and delivery</p> <p>-Time spent undertaking link worker role and RCT requirements and its perceived impact on delivery</p> <p>-Effective management of link worker role and RCT responsibilities for link workers</p> <p>-Better preparation and training of link workers for an RCT to manage both roles</p>	<p>Impact of trial conditions</p> <p><u>Staff</u></p> <p>theory 3: Managing workload and link worker well-being [too many clients booked in, competing responsibilities of appointments, service statistics and the RCT]</p> <p>theory 4: Training, knowledge and skills [managing the link worker role and RCT requirements]</p>

What were the barriers and enablers to implementing the social prescribing service?		
Meta-narrative	Thematic synthesis	Reflective diaries
	<p><u>GP practices</u></p> <p>Reluctance of GPs to engage due to RCT, added complexity, easier referral pathways elsewhere [interviews, project documentation]</p>	
<p>Time and resources required (staff)</p> <p>-Overstretched link workers capabilities and capacity can have implications for retention, which in turn, can affect the delivery of the social prescribing model due to the requirement to recruit and train new link workers</p>	<p>Time and resources required (staff)</p> <p>-Uplift funding used by one local Mind to pay for link worker TOIL hours</p> <p>-Time spent mapping receiving organisations, mapping as a continual process</p> <p>- Local Mind managers time to support link workers not fully costed into the model</p> <p>[interviews, project documentation]</p>	<p>Time and resources required (staff)</p> <p>theory 3: Managing workload and link worker well-being [too many clients booked in, competing responsibilities of appointments, service statistics and the RCT]</p> <p>theory 4: Training, knowledge and skills [managing the link worker role and RCT requirements]</p>

Challenges to successful implementation

- The wider context that social prescribing is operating in, for example:
 - Time and capacity of GPs, which was a factor highlighted as affecting referrals to the social prescribing service
 - Duplication or provision of other similar social prescribing programmes (e.g. well-being co-ordinators employed by primary care, and the ‘well established’ community connector role)
- High use of locums and branch surgeries can interrupt relationships and affect the awareness of the service.
- Frustration experienced by link workers with confusion in referral process (e.g. lack of communication with practices, lack of familiarity with the referral process, missing information to clients, missing referral forms). This is connected to the local Mind relationships with practices (e.g. communication) and referrers’ knowledge of the project.
- The impact of trial conditions, which included:
 - The potential burden of the trial on clients
 - The considerable planning and work to prepare and manage complexity of a research trial, including ethics, its impact on implementation and delivery
 - Preparation and training for a trial to help manage understanding of the requirements, and managing a dual role of link worker and meeting the duties to the trial
 - The perceived reluctance of GPs to engage due to the added complexity of a trial and the availability of easier referral pathways elsewhere

Overall

- Central to this question has been the ability of the service to build and maintain effective relationships, and manage resources in a challenging and complex environment. The trial itself was a feature highlighted as influencing the implementation of the service, such as the additional activities to plan and prepare and the dual role of the link workers to deliver a social prescribing intervention whilst managing a trial.
- Given the unforeseen and unprecedented changes that have been brought to bear during 2020, overall, the project has worked well under pressure to implement, and embed, the service effectively.

WHAT FACTORS INFLUENCED ENGAGEMENT WITH THE SOCIAL PRESCRIBING PROGRAMME?

Table 7.3 presents evidence from the study on the factors that influenced engagement with the social prescribing programme.

Table 7.3: Summary of findings – What factors influenced engagement with the social prescribing programme?

What factors influenced engagement with the social prescribing programme?		
Meta-narrative	Thematic synthesis	Reflective diaries
<p>Skill of link workers and training</p> <ul style="list-style-type: none"> -Link workers are a key feature of social prescribing services e.g. helps facilitate the buy-in and engagement of health, stakeholders, and enables patients/client participation and attrition -Importance of clarity around job description, or training and development plan -Understanding link worker training and development needs might be supported through consultation and tailored, co-produced training programmes 	<p>Skill of link workers and training</p> <ul style="list-style-type: none"> -Working with and supporting clients effectively -Developing and maintaining trusting, reciprocal relationships with partners -Information sharing amongst local Minds and link workers is helpful enabling knowledge exchange -Space for link workers 'practice network' discontinued -Limited space of link workers to meet without inclusion of managers - Importance of a supportive environment for link workers via supervision - Local Mind managers time to support link workers not fully costed into the model - Some retention difficulties and some link workers not received initial training <p>[interviews, project documentation]</p>	<p>Skill of link workers and training</p> <p>theory 1: Link worker frustration with confusion in the referral process [starting pilot before agreeing the paperwork, constantly managing change]</p> <p>theory 2: Client complex problems [active listening via the 'what matters', being listened to and valued]</p> <p>theory 3: Managing workload and link worker well-being [informal peer and manager support, emotional pressure 'exhaustion', re-dressing work life balance]</p> <p>theory 4: Training, knowledge and skills [identified skills, and gaps in knowledge, need for training needs analysis, mandatory training specifically dignity and respect, mixed views about training received]</p>

What factors influenced engagement with the social prescribing programme?		
Meta-narrative	Thematic synthesis	Reflective diaries
<p>Buy-in of GP practices [inc. experience of stakeholder engagement]</p> <ul style="list-style-type: none"> -Maintaining buy-in of health partners contributes to success of referrals -Effective feedback loops between all partners and maintaining communication promotes a shared partnership approach. In particular, feedback from link workers about patient/clients progress 	<p>Buy-in of GP practices</p> <ul style="list-style-type: none"> -Establishing and maintaining relationships and buy-in with primary care affected referral rates -GPs concerns about sustainability -Good relationships, face to face meetings, provision of feedback helps sustain buy-in -Perceived lack of recognition of third sector skills <p>[interviews, project documentation]</p>	<p>Buy-in of GP practices</p> <p>theory 1: Link worker frustration with confusion in the referral process [Information packs not being provided to clients, difficulties with room availability and bookings, lack of knowledge of the social prescribing model]</p>
<p>Appropriateness of referrals</p> <ul style="list-style-type: none"> -Factors influencing client uptake and adherence to social prescribing (e.g. confusion about the service, accessibility, and patient/client expectations). Need to provide reassurance, information to help alleviate anxieties 	<p>Appropriateness of referrals were commented on in the context of the impact of COVID-19 (see below)</p>	<p>Appropriateness of referrals</p> <p>theory 2: Client complex problems [lack of familiarity with, and confusing referral process]</p>
	<p>Impact of COVID-19</p> <p><u>Clients</u></p> <ul style="list-style-type: none"> -Move to online and telephone support '<i>more convenient</i>' -Advantages and disadvantages to online and telephone support e.g. digital exclusion, poverty and accessibility, flexibility - clients welcome not having to go to the service -Greater flexibility since delivery change, clients can access shorter-term support <p><u>Open referrals</u></p> <ul style="list-style-type: none"> -For some LMs, open referral pathways increased inappropriate referrals <p><u>Types of referrals</u></p> <p>Acceleration of client issues due to COVID-19</p> <p><u>Staff</u></p> <p>Increase in referrals due to open pathways led to link worker workload increasing '<i>massively</i>'</p> <ul style="list-style-type: none"> -Acceleration of client issues due to COVID-19 and '<i>more people in crises</i>' described as '<i>quite demanding</i>' -Telephone and online support more efficient and ability to support more clients <p><u>GP practices</u></p> <ul style="list-style-type: none"> -Open referral pathway led to increased referrals (with exception of one local Mind who experienced drop in referrals) <p>[interviews, project documentation]</p>	

Factors influencing social prescribing participation and sustainment rate

- The skills of the link worker are key to enabling participation and sustainment. Core features include:
 - Their role in supporting clients, and clients feeling listened to and valued
 - Developing and maintaining trusting, reciprocal relationships with partners
- Knowledge of third sector and community provision
- Link worker training, development, and support is important to enable link workers to perform their role effectively. Important considerations are:
 - Link worker well-being and the importance of informal peer and management support (e.g. supervision)
 - A 'link worker' only space/network, to share best practice and knowledge exchange
 - Established route of information sharing between local Minds and link workers
 - Needs training analysis, tailored, co-produced training programmes
 - Manager time to support link workers fully costed into the model
- Securing and maintaining the buy-in of GP practices and health partners contributes to the success of referrals. Aspects include:
 - Effective feedback loops between partners, providing updates about patients progress
 - Good relationships and feedback helps to sustain buy-in
- Relationships with receiving organisation were highly valued and strong reciprocal partnerships were evident. Link workers are central to sustaining these relationships. However, communication/feedback about clients could be improved.
- The COVID-19 pandemic led to the suspension of the trial and a change to the delivery of the model to open referral pathways and the provision of telephone and online support. These changes led to increased referrals (with exception of one local Mind who experienced a drop in referrals) and had advantages and disadvantages:
 - The move to online and telephone support was regarded as positive, enabling more convenience and flexibility to the client
 - The provision of telephone and online support offered link workers more efficiency and increased capacity to support more clients
 - There are some disadvantages to online and telephone support (e.g. digital exclusion, poverty)
 - Increase of referrals from opening of referral pathways led to workload for link workers increasing and an increase in inappropriate referrals for some LMs
 - An acceleration of client issues (COVID-19 related)

Overall

- This question is multi-faceted, and has accordingly a multi-faceted response. There are very many reasons to assert that this social prescribing service has worked effectively in increasing and encouraging participation, and sustaining people throughout the programme. The service was agile in their response to the COVID-19 pandemic, and demonstrated positive new ways of working via online and telephone support.

WHAT IS THE ROLE OF SOCIAL PRESCRIBING ON THE WIDER HEALTH SYSTEM?

Table 7.4 triangulates data from the evidence base collected throughout the study focused on the role of social prescribing on the wider health system.

Table 7.4: Summary of findings – What is the role of social prescribing on the wider health system?

What is the role of social prescribing on the wider health system?		
Meta-narrative	Thematic synthesis	Reflective diaries
The evidence base for the benefits of generic social prescribing ' <i>largely inconclusive</i> ', a need to increase the methodological rigour of studies in relation their design, analysis, and transparency in reporting (which was why the Welsh Government commissioned an RCT for this study).	-General feeling from practices that social prescribing is better situated in community - Sentiment echoed by Mind Cymru programme staff, who added that this should include a broadening of referral pathways beyond just GP referral, inclusive of other health professionals including CMHTs, with open access in the community. -Complex interrelated needs of clients highlights importance of social prescribing for a broader suite of support beyond MH services and treatment [interviews]	Theory 3: Managing workload and link worker well-being [the need for the service, 'reduce impact on GP time']

Table 7.4 indicates that social prescribing is an important provision, particularly given the often complex and interrelated needs of clients. As such, social prescribing offers a broader, holistic support than traditional mental health services. In some circumstances, social prescribing may be more easily accessed in the community. However, where it is successfully integrated within the health system, the service could also benefit from widening the referral pathways beyond GPs to include a broader range of health professionals including community mental health teams and other mental health specialists.

Overall

- It is difficult to be definitive about this question based on the data that is available to the study. It may well be the case that there are positive system effects of social prescribing, but evidencing that is not possible within this study.

RECOMMENDATIONS

As with all studies of this kind, there are important learning points that have emerged. Many of them are positives for Mind Cymru, building on the successes of what has worked well in this project. To ensure the model continues to be as effective as it possibly can be, recommendations are offered below the four key questions as below. The recommendations are made to Mind Cymru and the local Minds, and focus on future projects like this one, thinking about how to optimise the service model:

1. Effectiveness of the social prescribing model

- Priority must be given to ensuring the perspectives of the clients is captured to better understand their experience of the social prescribing model given the limitations of this study.
- Based on the experience of this study, careful thought should be given before Mind Cymru engages in a randomised controlled trial on social prescribing. Notwithstanding the challenges around COVID-19, there are logistical and other methodological issues to be considered.
- Project elements like peer navigators and the use of uplift funding should be co-designed with local Minds in respect of the infrastructure, resource and expectations so as to identify potential gaps and determine how they can best be addressed.

2. Barriers and enablers to implementing the social prescribing service

- Developing and sustaining effective working partnerships is crucial to the success of the service. Key stakeholders (clients, local Minds, link workers and their managers, health service partners, community and third sector partners) should be involved in all aspects of the design, development and continued delivery of the model to sustain buy-in and engagement.
- Should another randomised controlled trial be deemed necessary, a sufficient resource to manage the trial need to be identified. In addition a more robust package of preparation and training needs to be provided to all staff to ensure understanding of the requirements and management of a trial.

3. Factors influencing engagement with the social prescribing programme

- Training, development, and support is important to enable link workers to perform their role effectively, especially given the increased workload of link workers and the acceleration of issues clients are presenting with as a result of the COVID-19 pandemic. Individual link worker training needs should be analysed and co-produced development plans enacted.
- Regular supervision of link workers is needed, and more resource made available to local Minds to ensure that they are able to do this.
- A practice network or a shared, confidential space for link workers to share ideas, experience, best practice, and receive informal peer support needs to be developed and nurtured.

- More needs to be done to ensure effective feedback and communication between the social prescribing service and referring and receiving organisations.

4. Role of social prescribing on the wider health system

- Widening the referral pathway to include a broader range of health professionals including community mental health teams and other mental health specialists should be implemented as this has the potential to increase referral rates to social prescribing programmes.
- Professional registration of link workers should be considered in order to offer greater awareness and recognition of the role amongst all stakeholders.

This study, albeit reprogrammed in the light of COVID-19, has generated an evidence-base that we hope will form the platform for developing other service models reflecting on, and learning lessons from this one. It was clear from the information gathered that a shared common purpose exists between all of those involved in the project: to hold people in need of care and support at the centre of everything that is done.

In describing the evidence we have gathered, reviewed and analysed, we trust that this report will provide a firm foundation upon which the aspiration of developing effective social prescribing service models in partnership across Wales can be achieved.

APPENDICES

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INTERVIEW SCHEDULES

Local Mind link workers and managers

Section A: Background and experience

1. Tell me about your experience delivering/managing the social prescribing service at your local Mind *before* coronavirus.
 - a) Can you give an example of a challenge that you have encountered?
 - b) Can you give an example of a rewarding situation?
 - c) Do you think this role had an impact on your own well-being?
2. Apart from seeing clients/managing this service, what other aspects were there to your role?
3. How did feel about balancing these things with seeing clients?
4. As the service progressed over time, did anything change about the way you were delivering/managing it?
5. Did you feel equipped with the skills and knowledge needed for your role? If so in what way? If not, why not?
6. What feedback did you receive about your role and its impact on the clients, GP practices and organisations you were working with?

Section B: Partnerships and referrals

7. Can you tell me about the relationships you had with the people who referred clients into your service?
8. Did you feel that the clients referred to you/your link workers were appropriate referrals for the service?
9. How did you handle any inappropriate referrals?
10. Can you tell me about the relationship with the different organisations you referred individuals onto?
11. If you made a referral to another service, can you tell me about your experience of doing do?

Section C: Delivery

12. Thinking about the experience of your/your link workers' clients, what worked well and what worked less well about how the service was delivered?
13. What do you see as the factors that influenced the rate of participation in this social prescribing service?
14. Are there any changes you would have made, but were unable to make, around the way the service was delivered?

15. Were you able to involve volunteer peer navigators during the service?
16. Did you apply for any uplift funding, either for another Mind service or on behalf of another organisation?

Section D: Coronavirus

17. We know that during the coronavirus pandemic, the social prescribing service was adapted so that it could respond appropriately and support clients during the outbreak. How did you feel about this change?
18. Are there any aspects of the adapted model that are making it easier to deliver the social prescribing service compared to service delivery before coronavirus?
19. Are there any aspects of the adapted model that are making it harder to deliver the social prescribing service compared to service delivery before coronavirus?

Section E: Overall reflections

20. What are your expectations about the role of link workers in the future?
21. What do you think are the key aspects of a high quality social prescribing service, now you have experience of being a link worker/managing a link worker service?
22. Thinking about how your service worked alongside the health and social care system, mental health services, and the wider voluntary community sector in your area, was there a distinct role (and need) for the social prescribing service?
23. Were there any unintended consequences associated with your involvement in the social prescribing service?
24. What are your views about the role of social prescribing on the wider health system (beyond the area you operate in)
25. Based on your experience, what conclusions do you draw and what recommendations would you make for the planning and commissioning of social prescribing in future?
26. Thank you. Is there anything else that you would like to tell me about your experience of the social prescribing service?

Mind Cymru programme staff

Section A: Background

1. Can you tell me about your role/responsibilities within Mind Cymru?
2. What was your involvement with the social prescribing

Section B: Design and development

3. Can you tell me a bit about why Mind Cymru were interested in delivering a mental health social prescribing service across Wales?

4. Can you describe the process Mind Cymru went through to design and develop their social prescribing model?
5. Were there any particular factors you had to consider when developing this service?
6. Can you tell me a bit about the peer navigator element of the model as it was intended to work?
7. What was your experience of implementing this element?
8. Can you tell me a bit about the uplift funding element of the model as it was intended to work?

Section C: Implementation

9. What was your experience of implementing this element?
10. Thinking about getting the local Minds set up to start delivering the service, can you tell me a bit about the planning and preparation this involved?
11. Can you tell me about your experiences working with the local Minds during the dry run period and during the trial?
12. Do you think there is anything that worked particularly well about the way the service was set up and delivered? What worked less well?
13. What do you see as the factors that influenced the referral rates during the dry run period and trial?
14. As the service progressed during the dry run and trial, were any changes made to the service design or delivery?

Section D: Overall reflections

15. Reflecting on the experience during the project, how effective do you think the service model was?
16. How does this compare to the adapted model that you are delivering in response to the coronavirus pandemic?
17. Reflecting on your experience of the social prescribing service overall, what (if anything) could have been done differently and why?
18. Were there any unintended consequences associated with your involvement in the social prescribing service?
19. Thinking about the three health boards the local Minds operated in, how well do you think the social prescribing service worked alongside the health and social care system and the wider voluntary community sector in those areas?
20. What are your views about the role of social prescribing in the wider health system?
21. Based on your experience of developing and implementing this service, what conclusions do you draw and what recommendations would you make for the planning and commissioning of social prescribing in future?

22. Thank you. Is there anything else that you would like to tell me about your experience of the social prescribing service?

Stakeholders: referring organisations

Section A: Background

1. Can you tell me about your role/responsibilities within your organisation?
2. Can you tell me what your understanding is of [insert local Mind]'s social prescribing service?
3. Besides making referrals into the service, did you have any other role in setting up and supporting [insert local Mind]'s social prescribing service whilst it was linked to your GP practice?

Section B: Referral process/experience

4. Can you tell me what the referral process to [insert local Mind]'s social prescribing service was?
5. Can you tell me about your experience making a referral to the social prescribing service?
6. How did you explain the service to the patient/s you referred to it?
7. Did any patients feed back to you about the service they had received?
8. Do you refer your patients to voluntary community based services? If yes, which ones and why? If not, why not?
9. Do you refer your patients to other sources of mental health support? If yes, which ones and why? If not, why not?
10. How confident did you feel confident about making a referral to [insert local Mind]'s social prescribing service

Section C: Overall reflections

11. Reflecting on your experience of being a referring partner for [insert local Mind]'s social prescribing service, what worked well, and what didn't work as well?
12. Were there any unintended consequences associated with your involvement in the social prescribing service?
13. Were there any changes you would have liked to have seen to [insert local Mind]'s social prescribing service? If so, what are they and why?
14. What are your views about the role of social prescribing on the wider health system?
15. Thank you. Is there anything else that you would like to tell me about your experience of being a referring partner to [insert local Mind]'s social prescribing service?

Stakeholders: receiving organisations

Section A: Background

1. Can you tell me about your role/responsibilities within your organisation?
2. Thinking back to before the coronavirus pandemic, we believe your organisation received a/some referrals from [insert local Mind]'s social prescribing service. You may have also received some 'uplift' funding so that you could accept more referrals from the service.
3. Can you tell me what your understanding is of the [insert local Mind]'s social prescribing service?

Section B: Experience of receiving referrals

4. Can you tell me about your experience of receiving referrals from the social prescribing service?
5. Tell me about your relationship with [insert local Mind] and the Link workers referring into your service?
6. Did the individual/s referred from the social prescribing service meet the eligibility criteria for your own service?
7. What has been the effect on your organisation of receiving uplift funding?
8. What was the outcome/s for the people referred to you?

Section C: Overall reflections

9. Reflecting on your experience of receiving referrals from the [insert local Mind]'s social prescribing service, what worked well, and what didn't work as well?
10. Were there any unintended consequences associated with your involvement in the social prescribing service?
11. Were there any changes you would have liked to have seen to the [insert local Mind]'s social prescribing service? If so, what are they and why?
12. Thinking more broadly, what are your views about the role of social prescribing on the wider health system and voluntary community sector?
13. Thank you. Is there anything else that you would like to tell me about your experience of being an organisation who received referrals from the [insert local Mind]'s social prescribing service?

REFLECTIVE DIARY TEMPLATE

Reflective Diary

Date of diary insert: /...../.....

Participant code:

Surgery code:

Thank you for participating in this part of the evaluation. We would like to capture your reflections on your experience of being a link worker by keeping a weekly diary. We would like you to reflect on the mundane as well as the extraordinary events that happen during your week.

This means that every week [or more often if you would like] we are asking you to complete the following framework either in paper or Word format (Driscoll, 2007). The main question is highlighted to help you with the process of reflecting on what happened to you.

Subsequent questions (trigger questions) underneath the three main questions are there to help you explore the situation or your role, the context of what happened and provide learning for the future. You do not need to answer them all.

At the end of each calendar month please send your completed reflections to your line manager. Please remember that we don't want you to identify anyone [patients, people or yourself] in this activity.

What?: Returning to the situation

- What is your first impression of what happened?
- What exactly occurred? Give some detail...
- What did other people do who were involved in the situation?
- What did you see? What did you do?
- What was your reaction to the situation?
- What do you see as a key message that you want to share?

So what?: Understanding the context

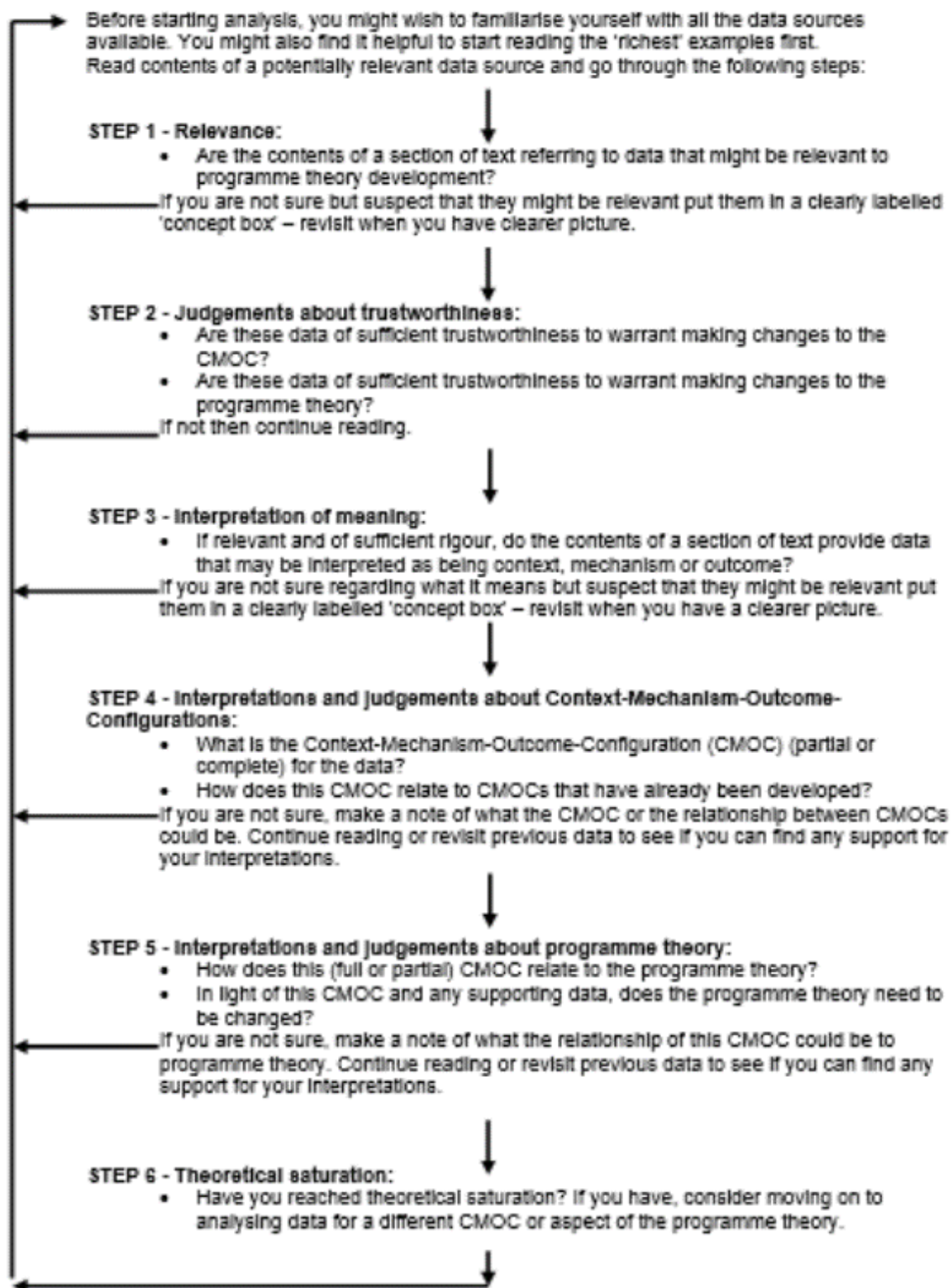
- What were you feeling when you started this new role and process? Or what were you feeling at the time of the event?
- What are you feeling now? Are there any differences and, if so, why?
- What effects do you think your role may have or not have?
- What positive things can you think of about what you did?
- What have you noticed about your behaviour since you started this role?
- What troubles you about the role or the situation, if anything?
- What observations does any person helping you in your role make of the way in which you act?
- What are the differences in experiences in comparison to your colleagues? If any?
- What are the main reasons for feeling differently from your colleagues?

Now what?: Modifying future outcomes

- What impact do you think your role will have on primary care or the individuals referred to you?
- What are the implications for you and others based on what you have described above?
- Are there any changes that need to happen to your role? Or the social prescribing service process to improve outcomes?
- What can you do to help embed the changes needed into practice?
- What should be tackled first?
- What might you do differently if you started this role or service from the beginning?
- What further information would you need to face a similar situation again?
- How will you notice if you behave differently if you found yourself in a similar situation again?
- Are there any further comments you'd like to make about this week's experience?

WONG AND PAPOUTSI (2016) FRAMEWORK

Data analysis processes



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