
EVALUATION OF THE BRITISH RED CROSS SOCIAL PRESCRIBING SERVICE

Final Report

for British Red Cross

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INTRODUCTION

British Red Cross 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 them to get the support they need, when they need it.

This service was offered by social prescribing 'link coordinators' at one of two British Red Cross Teams (referred to as Sites 1-2 in this report) located within two health board areas/localities in Wales, for people aged 18+ experiencing mild/moderate mental health problems and/or emotional wellbeing disorders. General Practitioners and health professionals within GP practices, and the Welsh Ambulance Service (WAST) referred individuals to the service.

The project commenced in January 2019, but due to delays in receiving ethical approval, data collection began in December 2019 and ran until the research was paused in March 2020.

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 coordinators. 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 coordinator 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 two 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. 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.

There are two elements to the re-specified evaluation:

1. **Process Evaluation**
2. **Outcome Evaluation**

This report draws together findings from the Process Evaluation and the Outcome Evaluation, of which there were n=14 key questions identified, to which data from this report contributes. These questions were adjusted to augment the qualitative data collection to better reflect the discussions within stakeholder interviews and the entries of the link coordinator reflective diaries (see methods section below) but remained aligned to the key substantive questions posed (see Appendix for details).

1. WHAT CAN WE LEARN ABOUT THE DELIVERY OF THE SOCIAL PRESCRIBING INTERVENTIONS FROM THE EARLY IMPLEMENTATION OF THE BRITISH RED CROSS SOCIAL PRESCRIBING SERVICE?
 - *How did the project teams plan and prepare for the delivery of the service from the outset?*
 - *How did the wider context affect the project?*

2. WHAT WERE THE EXPERIENCES OF PROVIDING A SOCIAL PRESCRIBING SERVICE AS PART OF A RESEARCH TRIAL?
 - *What impact did the development of the research trial have on project implementation and delivery?*

3. AS THE SERVICE PROGRESSED BEFORE THE RESEARCH TRIAL, DURING THE RESEARCH TRIAL AND INTO THE POST-COVID-19 PHASE, WHAT LESSONS WERE LEARNED AND WHAT CHANGES WERE MADE TO THE SERVICE DESIGN?
 - *What were the factors that influenced referral rates in the service?*
 - *To what extent did the project reach its intended target groups?*
 - *How does the original model compare to the adapted model that was delivered in response to the Covid-19 pandemic?*

4. OVERALL, WHAT WORKED WELL, OR LESS WELL, FOR WHOM AND WHY?
 - *Reflecting on the experience, how effective do you think the service model was?*
 - *Reflecting on the experiences of the social prescribing service overall, what (if anything) could have been done differently and why?*
 - *How well embedded in the social prescribing service alongside the health and social care system and the wider voluntary community sector in the two areas it is working in?*

5. WHAT CONCLUSIONS MIGHT WE DRAW FROM THE IMPLEMENTATION OF THE MODEL?

STRUCTURE OF THE REPORT

The report begins with the methods chapter, which describes the three data sets collected and analysed for this evaluation. This is followed by ‘key findings from the literature’, which

provides a broad context for the evaluation and its findings. Next, is the findings from the three data collection methods; the first is a realist evaluation of link coordinator reflective diaries, the second is service outcome data collected from individuals receiving the intervention, and the third, interviews with stakeholders of the British Red Cross Social Prescribing Service. The final chapter is the conclusion, which offers a summary of the findings against the key questions outlined above.

METHODS

This chapter sets out the methods used for the Process Evaluation and Outcome Evaluation, both of which used a mixed method approach to collect and analyse data to evaluate the British Red Cross social prescribing service.

ETHICS

Ethics permission for this study was secured from the University of South Wales' Faculty of Life Sciences and Education Ethics Committee in October 2020 to collect data and undertake analysis against all of the elements of the methods as described above. Permission to interview NHS stakeholders was sought through the two individual health boards. Each of the health boards provided service evaluation permissions.

PROCESS EVALUATION

Methods used in the Process Evaluation were:

1. Realist evaluation of reflective diaries, completed by link coordinators throughout the project.
2. Interviews with key stakeholders, reflecting on the key learning points from the service development, implementation and delivery.
3. An online multi-agency stakeholder workshop, to consider the key findings of the process evaluation, and reflect on the project to date.

REFLECTIVE DIARIES

The aim of collecting the reflective diaries was to understand the experiences of link coordinators delivering the British Red Cross social prescribing service. Link coordinators from the two sites were asked to complete the reflective diaries as part of their role in the social prescribing service. Reflective diaries were collected from the two sites between April 2019 and December 2020. The two sites provided n=27 diary entries across n=50 pages. Details of the diary entries analysed is provided in Table 1.

Table 1: Diary entries per site

	Total entries	Total pages
Site 1	10	28
Site 2	17	22
Total	27	50

Link coordinators submitted their diaries to someone centrally at British Red Cross where they were anonymised before transferring them to the evaluation team for analysis at University of South Wales. A reflective diary template was provided to all participants to

follow (Appendix). Link coordinators chose either to write the diary on paper or to record their spoken word. These voice recordings were shared through an encrypted email using a code, then transcribed verbatim prior to analysis.

Reflective diaries were analysed using a realist evaluation approach, Wong and Papoutsis (2016) six steps (Appendix). Realist evaluation was used because the role of the link coordinator in social prescribing is viewed as a complex role working at the interface of health (often primary 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 site was analysed separately initially and then triangulated to provide the results.

STAKEHOLDER INTERVIEWS

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

- British Red Cross managers who were involved with the design, development, and implementation of the service;
- British Red Cross managers and link coordinators, who were involved in the design of the social prescribing service, then managing and delivering the service in one of the two sites;
- Referrers into the social prescribing service, who made referrals into the project; and
- Receiving organisations to whom link coordinators from the social prescribing service made referrals.

Interviews were undertaken during January 2021. In total n=11 interviews were completed:

Table 2: Total number of interviews – Process Evaluation

Locality	Number of interviews
Site 1	7
Site 2	4
Total	11

Table 3: Interviews by role

Role	Number of interviews
BRC Regional manager	2
BRC Programme manager	2
BRC Link coordinator	4
Referring organisations	2
Receiving organisations	1
Total	11

MULTI-STAKEHOLDER WORKSHOP

An online multi-agency stakeholder workshop, facilitated by members of the study team (and a PhD student), was held in April 2021. The aim was for stakeholders to consider the key findings from the Process Evaluation, and reflect on the project to date by asking ‘What does the process evaluation tell us we should do the same or do differently when working together?’ The workshop was structured based on the main themes/findings of the Process Evaluation:

- Managing and delivering a research trial
- The impact of Covid-19
- Role, skills and experience of Link coordinators
- Partnerships and Engagement

Attendees included representatives from the British Red Cross service, external partners, and other stakeholders (e.g. Wales Council for Voluntary Action, and Health Education and Improvement Wales). Discussions were captured using the online platform MURAL¹ and were an important part of the validation of findings and informed the Outcome Evaluation phase. A visual representation of the workshop is provided in the Appendices.

OUTCOME EVALUATION

Methods used in the Outcome Evaluation were:

1. Outcome service data collected from clients receiving the intervention.
2. Interviews with key stakeholders, reflecting on the outcomes and difference made for clients of the social prescribing service.

OUTCOME SERVICE DATA COLLECTION

British Red Cross link coordinators collected demographic information and outcome data using three measurements tools from clients accessing and receiving service at two time points: at baseline and at the end of the service.

The three outcome measurement tools used were:

1. **British Red Cross Wheel of Change:** The Wheel of Change consists of 7 questions which scores service users between 1-10 for each question. A score of 10 indicates a willingness to make changes in their life, whereas 1 indicates a state of being ‘stuck’, unable to make change.
2. **EQ-5D:**² this is a standardised measure of health-related quality of life consisting of 1 question for each of the five dimensions, Mobility, Self-care, Usual activities, Pain/discomfort, Anxiety/depression, using a scale of 1-5, where 1 indicates a good

¹ <https://www.mural.co/>

² <https://euroqol.org/support/terminology/>

sense of wellbeing. It also contains a health scale measurement and a question relating to prescribed medication.

3. **Warwick Edinburgh Mental Well-being Scale:**³ (WEMWBS) is an established mental wellbeing measurement tool and uses a 14-item positively worded scale (Tennant et al, 2007). Total scores on WEMWBS are derived from summing responses to the 14 items, which are rated using 5-point Likert scales. Scores range from 14 to 70, with higher scores indicating greater mental wellbeing.

Analysis was undertaken of the data collected by the British Red Cross Social Prescribing Service, and each site was considered individually. The site 1 dataset consisted of 173 individuals who had been referred to the service during the period October 2018 to October 2021. The site 2 data consisted of 141 individuals who had been referred to the service during the period December 2018 to August 2021.

STAKEHOLDER INTERVIEWS

Telephone and online interviews were undertaken with stakeholders of the social prescribing service with the aim of understanding the outcomes achieved and what difference (if any) the support had for clients accessing the service. Stakeholders invited to take part included:

- Beneficiaries
- Link coordinators
- Referrers into the social prescribing service; and
- Receiving organisations to whom link coordinators made referrals

Interviews were completed during October 2021. In total n=15 interviews were completed (see below).

Table 4: Total number of interviews - Outcome Evaluation

Locality	Number of interviews
Site 1	11
Site 2	4
Total	15

Table 5: Interviews by stakeholder type

Stakeholder type	Number of interviews
Beneficiary	8
Link coordinator	3
Referring/Receiving organisations	4
Total	15

³ <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/>

All qualitative data was transcribed verbatim and anonymised, and transcripts analysed using thematic analysis (Braun and Clarke, 2006).

LIMITATIONS

Like any such study there are inevitably limitations – there are two of note. Firstly, whilst data was returned from a good number of participants, the number of complete datasets (across all three instruments and two points in time) did not allow for any ‘individual’ level analysis. What we have provided instead are analyses of the ‘population of participants at the different timepoints in the different sites. Secondly, whilst there was a spread of interviewees across the process and outcome evaluation periods, there were a relatively small number of beneficiaries (n=8) that were interviewed. Similarly, there was a disproportion of interviews from Site 1 as opposed to Site 2.

Both of these factors need to be considered when reading the chapters that follow.

FINDINGS FROM THE LITERATURE

Using six realist and systematic reviews, this section presents key findings from the literature. The purpose is to provide a context for the evaluation, 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.

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).

This section 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 in preparation*).
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, were included. Grey literature (e.g. reports) were excluded.

This section seeks to set the wider context for this evaluation by considering the wider evidence-base on social prescribing together with influencing factors on social prescribing models, for example:

- Reputation of the provider organisation;
- Skill of link coordinators and training;
- Buy-in of GP practices and experience of stakeholder engagement;
- Referral pathways and relationships with referred-to organisations; and
- Appropriateness of referrals

As the factors above indicate, the focus is 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.

COMMISSIONING OF SOCIAL PRESCRIBING MODELS AND THE EVIDENCE-BASE THAT SUPPORTS THEM

Three important aspects were identified: quality of the evidence, factors effecting quality, and challenges to evaluation.

Quality of the evidence

Social prescribing is widely advocated and implemented (Bickerdike et al (2017), yet 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).

Factors affecting quality

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 in preparation; 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 in preparation) 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 in preparation).

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.

Challenges to evaluation

A '*complex intervention*' (Tierney et al 2020; Roberts et al in preparation), social prescribing includes a range of components such as educating and empowering individuals, multiple stakeholder involvement (patients/clients, health, third sector, link coordinators) 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 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 outcome evaluations in isolation can be at the expense of addressing other important questions; effect sizes do 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 et al (in preparation) 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 in preparation; 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 in preparation; 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 in preparation), which is problematic given the complexity of social prescribing interventions.

ENABLERS AND BARRIERS IN SOCIAL PRESCRIBING

Regarding the enablers and barriers to social prescribing, key features identified include: the role, skills and experience of link coordinators and their training, the buy-in of GP practices and experiences of stakeholder engagement [incl. relationships with referred-to organisations], and barriers to client uptake and adherence.

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

Table 6: Facilitators and barriers (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, e.g. requires a higher level of flexibility than required for paid staff. Volunteer turnover is generally higher than paid staff turnover
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
Navigator ready general practices	General practice staff disengagement
A general practice culture that supports the biopsychosocial model of health	Patient disengagement

Facilitators	Barriers
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	

Role, skills and experience of link coordinators and training

Working directly with clients, link coordinators 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 developed with link coordinators; the provision of personalised appointments that are not time limited (Wildman et al 2019; Woodall et al 2018); their person-centred approach and feeling listened to and valued (Pescheny et al 2018b).

For 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 in preparation). For these groups, enabling mechanisms associated to the role and skills of the link coordinators 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)

Despite the important and valued feature of the link coordinators 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 (in preparation) 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 coordinators varies, a core requirement of the person specification was knowledge of local community and third sector services. Nonetheless, with a variety of skills set, training and knowledge, it is difficult to ascertain what is required to effectively fulfil the link coordinator role (Bickerdike et al 2017).

For link coordinators 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 coordinator feels confident and equipped to perform their role, whilst supervision provides the space to explore and discuss difficulties or anxieties. If link coordinators’ 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 coordinators (Tierney et al 2020).

Buy-in of GP practices and experience of stakeholder engagement [incl. relationships with referred-to organisations]

The buy-in and engagement of health (GPs, health professionals, and practice staff) is a core facilitator of the implementation and delivery of social prescribing programmes (Pescheny et al 2018a). Factors that can influence buy-in and engagement 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). Approaches that may encourage and maintain the engagement of health (p.10):

- Regular education events and training sessions;
- Encouraging link coordinator 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 coordinators, 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 all stakeholders (GPs, third sector, patients/clients and link coordinators) and the development of reciprocal partnerships (Pescheny et al 2018a; Birkdale et al 2017). This includes the provision of feedback from link coordinators about patient/client progress and outcomes, which encourages support for social prescribing (Bickerdike et al, 2017) and promotes shared delivery and partnership working (Pescheny et al 2018a).

However, difficulties persist in establishing and maintaining a robust and consistent means of feedback between link coordinators and referrers (Bickerdike et al 2017, Whitelaw et al 2017). Roberts et al (in preparation) 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 coordinators 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]

Where reported, a client's attendance at the first appointment with their link coordinator ranged from 50% to 79% and that individual's attendance at activities they were referred on to by their link coordinator varied from 58% to 100% (Bickerdike et al 2017). Through accessing, developing knowledgeable activities and assisting transitions between services, link coordinators 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 coordinators, and the social prescribing activity) in order to meet client need and to contribute to the success of the referral.

Factors that can 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 coordinator
- 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 (Roberts et al, in preparation) 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 fear of stigma of psychosocial problems, expectations and the short-term nature of some social prescribing programmes (Pescheny et al 2018b).

Summary

When thinking about the development, implementation and delivery of future models of social prescribing programmes, key considerations are:

- **Role, skills and experience of link coordinators**

Link coordinators 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 coordinators 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 coordinators 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 coordinators. With the exception of link coordinators 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 coordinators in their role and provide the space to explore and discuss difficulties or anxieties. Overstretching link coordinators 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 coordinators.

Given the lack of person specification and skills required, link coordinators 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 coordinator role for health, stakeholders, patients/clients, social prescription 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

Strong, effective relationships and partnerships (with and between referrers, patients/clients, link coordinators, 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 coordinators 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**

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 coordinators, health, third sector and community services) and the programmes available. Consultations and the co-production of information with stakeholders, including patients/clients, (e.g. preferred formats, dissemination) may raise awareness of social prescribing and help alleviate anxieties.

REFLECTIVE DIARIES

Using the reporting standards for realist evaluation (Wong et al, 2016), this chapter presents findings from the reflective diaries that were completed by link coordinators. A realist evaluation approach was taken to this aspect of the study, which aimed to understand the experiences of link coordinators delivering the British Red Cross social prescribing service. In order to preserve anonymity, the diary notes of link coordinators are provided by number (LC1, LC, LC3, LC4, LC5), and not by their geographical site. The diary entries that were analysed captured a range of experiences across the two sites from April 2019 to December 2020.

The research question asked: *What were the experiences of link coordinators, delivering the British Red Cross social prescribing service, as 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 coordinator supported learning environment’*
2. *‘Client complex problems’*
3. *‘Link coordinator perspectives about the role’*
4. *‘Ability to make a difference’*

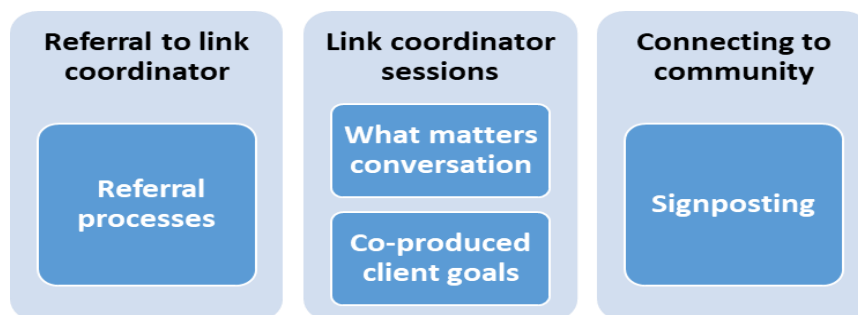
Each of the four mid-range theories are discussed in the following section and are accompanied by which of the evaluation questions (Q1-Q5) the data contributes to addressing.

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 coordinators often work in primary care and the community. Together with the client, link coordinators have a ‘what matters’ conversation, develop personal goals and signpost them to community groups (Figure 1).

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

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 1: Presenting the initial overview of the social prescribing programme theory (blue) with later theory development about the link coordinator experiences during the British Red Cross pilot



THEORY ONE: LINK COORDINATOR SUPPORTED LEARNING ENVIRONMENT
(Addressing Q1, Q2, Q4, Q5)

This theory describes what we have learned about the link coordinators need for a supportive learning environment and their contribution to other learning environments. Table 7 below shows the Context-Mechanism-Outcome Configuration (CMOC) and if/then statements, which underpin the explanations for Theory One 'Link coordinator supported learning environment'.

One link coordinator described the past year until August 2019, as '*an interesting learning curve, it's a pilot, it's all been about learning and we have learnt a lot*' (LC4). A link coordinator had '*started with the service.....following intensive training*' (LC2).

Link coordinators identified their own learning needs, such as further knowledge of local housing associations and local housing support, keeping up to date with Department of Work and Pensions (DWP) developments, employment law (LC3), and understanding specific health conditions (LC1).

As time goes on and I meet and support more individuals with specific conditions, it is becoming more evident that I need training to understand these conditions better so that I can effectively support the individuals referred into the service (LC1)

One link coordinator read and reflected on a broad range of national social prescribing reports including outcome measures, community development, and partnership working (LC3). Another reported undertaking a level three mental health qualification,

acknowledging that *'it's [the role] going to be a continuous learning process and I'm all for that because I love learning'* (LC1).

Table 7: CMO configurations and if/then statements for theory one: Link coordinator supported learning environment

Context (Resource)-Mechanism (Behaviour)- Outcome		
Theory One: Link coordinator supported learning environment		
Mixed emotions, excited, anxious and unsure of the role and the processes involved at the start of the new role (LC3)	Friendly staff supported new member of staff and induction given around client files and how they are structured and processes (LC3)	New member of staff enjoyed the first day because of gaining a good understanding of processes and procedures (LC3)
Regularly keep reflective diary (LC3, LC1)	Reflexivity reveals training needs (LC3, LC1, LC4)	Recommendation to address the identified gaps in knowledge to manage complex cases (LC3, LC1) and to read more about the topic areas (LC3)
<p>'If/then' statements</p> <p><i>If new staff are anxious and unsure of the role and the processes involved at the start of a new social prescribing role then friendly and supportive staff providing an induction around client files, their structure and processes can lead to a new member of staff feeling that they have enjoyed the first day (LC3)</i></p> <p><i>If the link coordinator 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 complex cases (LC3, LC1)</i></p>		

There was also reflection on Good Clinical Practice (GCP) research training in preparation for the research trial expressed as:

- *'Just scared me stupid'* (LC1) and;
- *'Waiting a month for my trial passport to begin supporting people on the service and trial'* (LW2)

The realisation that the same rules applied for this trial as it does with medical drug trials, created some anxiety as to the role ahead for example managing site files.

Highlighting the value of opportunities to meet and share knowledge with others, another diary entry described a meeting with medical students where they discussed the varying perspectives of social prescribing including the differences between nations in the UK, the link coordinator role as a developing profession, the use of social prescribing by different professional, and how it is developing (LC5).

THEORY TWO: CLIENT COMPLEX PROBLEMS

(Addressing Q3, Q4, Q5)

This theory gives some explanation about the client complex problems, their needs and the interventions used. Their presenting problems were broad and often required several sessions (n=12). They included a mixture of ‘*complex medical needs as well as mental health issues*’ (LC1). Examples of medical needs included cataract operations, facial paralysis, falls, autism and loss of limb movement.

At the present time all the people that I’m supporting had complex medical needs as well as mental health issues. At the moment it’s their physical, they are all pretty unwell. I think it’s worth noting that when somebody has a range of conditions including mental health conditions, I don’t think it’s ever going to be a steady improvement where they just improve and improve and improve. What I’ve seen with my service users is that they have a couple of good weeks and then their medical condition will flare up and that will cause them maybe to go backwards because they are not so mobile and in more pain. [So its] not straightforward when somebody has a range of issues (LC1)

Table 8 below is the Context-Mechanism-Outcome Configuration (CMOC) and if/then statements, which underpin the explanations for Theory Two ‘Client complex problems’.

Table 8: CMO configurations and if/then statements for theory two: Client complex problems

Context (Resource)-Mechanism (Behaviour)- Outcome		
Theory Two: Client complex problems		
Client referred with complex problems and negative behavioural responses (LC4)	Engagement with link coordinator (LC4)	Client agreement to a social prescription; and changes to positive behavioural responses to life challenges (LC4)
Client is amenable to conversing and listening to knowledgeable, trustworthy and skilled link coordinator (LC3, LC4)	Client confiding in the link coordinator about personal and private information (LC3)	Link coordinator helping/supporting client with difficult situations (LC3, LC4)
‘If/then’ statements		
<p><i>A client referred with complex problems and negative behavioural responses, triggers the engagement with the link coordinator, which results in an agreement to a social prescription and client changes to positive behavioural responses to new life challenges (LC4)</i></p>		
<p><i>A complex client is amenable to conversing and listening to a knowledgeable and skilled link coordinator leading to the client confiding in the link coordinator about personal and private information, which results in the link coordinator supporting the client with difficult situations (LC3, LC4)</i></p>		

Referrals to the link coordinators included life style issues, sacked from employment, arranging a Lifeline installation, anxiety and depression, low confidence, loneliness, stress, paranoia, suicidal ideation, housing tenancy issues, recovery after being sectioned (including lack of confidence, self-worth, feeling hopeless, feeling guilty for being ill), alcohol abuse, Post Traumatic Stress Disorder, benefits applications, vulnerability due to physical condition, trauma, broken relationships, frequent calls to WAST due to frequent falls, bereavement, abusive and violent behaviours, history of 'difficult childhoods including bullying as well as various forms of abuse' (LW1), and bipolar disease.

In 2019, link coordinators reflected that within the first few months that they were surprised at the low levels of referrals and there was still some ambiguity as to the level of complex client the link coordinators should receive (LC5, LC1).

I still find it very, very surprising that the surgeries don't have more people to pass over to me or readily pass over to me. I find that astonishing, I know that there is criteria but I still find it very surprising that the number of referrals from GPs is so low (LC1)

Up to now is the level of clients which are suitable or what we deem as suitable, that is a question to think about in terms of what is the criteria for who we work with; what level complexities do they have? What are our skills levels? Do we broaden who we deal with or the issues we deal with? If so what is the kick on to us in terms of what training we need, or development we need? Do we stay low level light touch sort of work or more complex? That's some of the areas I think that are food for thought going forward (LC5)

Pre Covid-19, a client referred with complex problems such as a combination of physical ill health, bereavement and negative behavioural responses to daily life challenges such as feeling useless, the engagement with the link coordinator and agreement to a social prescription resulted in client change with positive behavioural responses to new life challenges (LC3). Link coordinators used humanistic approaches together with positive reinforcement, cognitive behavioural booklets with self-directed tasks, and understood the importance of communication with the referrer and the multidisciplinary team providing up to date feedback (LC3).

THEORY THREE: LINK COORDINATOR PERSPECTIVES ABOUT THE ROLE (Addressing Q2, Q3, Q4, Q5)

This theory describes the mixed emotions experienced by the link coordinators when managing their workload and their own well-being. Table 9 below illustrates the Context-Mechanism-Outcome Configuration (CMOC) and if/then statements, which underpin the explanations for Theory Three 'Link coordinator perspectives about the role'.

The link coordinators experienced both positive and negative emotions and experiences including:

- Finding it difficult to take time off because of their felt commitment to the clients (LC4) and working late to complete urgent safeguarding paperwork (LC1)
- Frustrations due to the research trial, particularly balancing the data collection with service delivery (LC4, LC1)
- Frustrated by number of referrals (LC1), sad and uncertain (LC1), ‘*sceptical about the future*’ because of the number of referrals and the type of referral pathways (LC1, LC4, LC5) and level of client complexity (LC1, LC5)
- Excitement and anxiety about starting a new role, anxiety at meeting new colleagues (LC3)
- Happiness and satisfaction at resolving a client’s problem (LC3)
- Helplessness, anger, and feeling a failure and frustration when unable to resolve an issue for a client (LC1) due to not being able to engage properly over the phone with clients due to their ‘*anxiety and medical conditions*’ (LC2)
- Reflecting that link coordinators were low paid for the multiple roles they undertook (LC5)

Table 9: CMO configurations and if/then statements for theory three: Link coordinator perspectives about the role

Context (Resource)-Mechanism (Behaviour)- Outcome		
Theory Three: Link coordinator perspectives about the role		
Link coordinator mixed emotions about the developing role (LC1P)	Questioning their individual value (LC1, LC4)	Looking for other jobs and leaving the organisation (LC1)
Uncertainty during COVID-19 (LC2, LC1)	Feelings of frustration and failure (LC2)	Difficult to be positive with clients (LC2)
	Resourceful and resilient (LC2, LC1)	Positive feelings of hope because later seeing clients adapt and change to meet the continuing challenges (LC2, LC1)
Balancing home life with work life during COVID-19 (LC2, LC1)	Flexible working to meet needs (LC2, LC1)	Tiredness, ‘ <i>torn responsibilities</i> ’ and ‘ <i>feeling of being unproductive</i> ’ leading to ability to adapt and cope with change (LC2)
‘if/then’ statements		
<p><i>If a link coordinator continues to have mixed emotions about the developing role then they question their individual value which results in them looking for other jobs and leaving the organisation (LC1)</i></p> <p><i>In a climate of uncertainty such as COVID-19 this initially triggered feelings of frustration and failure which resulted in difficulties to be positive with clients (LC2). This later changed as Link Coordinators felt resourceful and resilient resulting in positive feelings of hope as they saw clients adapt and change to meeting the continuing challenges (LC2).</i></p> <p><i>When trying to balance home-life with work-life this triggers flexible working to meet client and family needs. This results in tiredness, ‘<i>torn responsibilities</i>’ and ‘<i>feelings of being unproductive</i>’ leading to ability to adapt and cope with change (LC2)</i></p>		

All of these feelings were compounded during the Covid-19 pandemic, which led a link coordinator to express uncertainty about the future. At first this initially triggered feelings of frustration and failure which resulted in difficulties to be positive with clients (LC2). This later changed as a link coordinator reported feeling resourceful and resilient resulting in positive feelings of hope as they saw clients adapt and change to meeting the continuing challenges (LC2).

I have seen positives in the way myself, others and our services users have adapted and coped so far with the physical and emotional roller-coaster of the pandemic lockdown (LC2)

It does take it out of you when you are supporting people, not physically but emotionally and mentally especially when you are having difficult conversations (LC1)

I am also very aware of my own mental well-being, even though the number of people that I am supporting is quite small, their needs are significant and it is very draining both mentally and emotionally particularly as I want to do the very best for people that I am supporting (LC1)

We work for a charity, we are low paid £20K but I feel at the moment I'm doing a lot of the roles not just my own. So it leads me to think actually is it time to look outside of the Red Cross and here's my twenty/thirty years' experience in the public sector and dealing with people plus my qualifications elsewhere. That's what I'm thinking at the moment (LC5)

I like to be busy, I like to feel that I'm doing something worthwhile. At times I've really questioned whether or not I've not made a mistake coming into this role, but whether or not I could be doing something that would utilise my experience and skills a bit better. Because certainly there have been times in this role, particularly lately, when I've really questioned whether or not I've made the right decision and whether I should actually look for another job and I have looked for other jobs, that's how down I felt on occasions (LC1)

Covid-19 led to some changes in work-life balance with working at home expressed as 'very difficult at times, both emotionally and managing workload', although there was support from managers, not being around colleagues for support had an effect (LC2). Whilst trying to be flexible to meet client and family needs this initially resulted in tiredness, 'torn responsibilities' and feeling of being unproductive. However, this changed later in 2020 to an acknowledgement in an ability to adapt and cope with the changes needed (LC2).

THEORY FOUR: ABLE TO MAKE A DIFFERENCE

(Addressing Q1, Q3, Q4, Q5)

This theory describes what we have learned about the link coordinator needs and their ability to make a difference. This is illustrated by case studies within the diaries, which are noted here. They demonstrate the difference in contextual operational environments for the link coordinators pre and post Covid-19, which challenge the link coordinators ability to make a difference for the client. The shift from face to face provision which facilitated relationship building to later using telephone provision only. The Covid-19 pandemic increasingly limited the link coordinator’s ability to refer and include community assets in a social prescription. The form of communication may also not have been suitable for complex referrals with challenging communication issues.

Table 10 below is the Context-Mechanism-Outcome Configuration (CMOC) and if/then statements, which underpin the explanations developed for Theory Four ‘Able to make a difference’.

Table 10: CMO configurations and if/then statements for theory four: Able to make a difference

Context (Resource)-Mechanism (Behaviour)- Outcome		
Theory Four: Able to make a difference		
An attempt to maintain fairness in service provision (LC3)	Effective planning and timetabling (LC3)	Ability to support a successful outcome and result in a positive experience for link coordinator and client (LC3)
The link coordinator identifies the client as at increasing risk (LC1)	Referrals to statutory organisations e.g. social services and police (LC1)	Link coordinator frustration and concern at not getting a response and client continues to deteriorate (LC1)
Pandemic with lack of supportive community interventions (LC1)	LC going the extra mile to provide support (LC1)	Expressed positive outcomes for clients (LC1)
‘If/then’ statements		
<i>In an attempt to maintain fairness in service provision this triggered effective planning and timetabling (setting start and finish dates to maintain a strict amount of sessions) and will lead to ability to support a successful outcome and result in a positive experience for link coordinator and client (LC3)</i>		
<i>If the link coordinator identifies that a complex client is increasingly vulnerable and at risk, this triggers repeated referrals to statutory organisations for assessment. A lack of response leads to increasing frustration and concern and client continuing to deteriorate (LC1)</i>		
<i>Supporting complex clients in a pandemic where there is a lack of supportive community interventions triggers the link coordinator and statutory services ‘going the extra mile’ to provide support this results in positive outcomes for client (LC1)</i>		

Link coordinators were very aware of the limitations of the service provision such as not being able to accompany clients on visits (LC3, LC2). The case studies also demonstrate the

increase in client complexity from signposting to community assets to providing a higher level of support for people with mental health problems and the link coordinators going the extra mile to ensure a positive outcome for the client. Later in 2020, the diaries report some resourcefulness as they and statutory services adapt and change to meet client needs (LC1).

In order to make a difference, the link coordinators and their managers spent time meeting primary care staff (GPs etc.) and other professionals (often multi-agency meetings) within the Health Boards (e.g. Mental Health Crisis Team) to agree referral pathways and encourage the referral processes once agreed (LC5, LC1). Even so, there were still some concerns as to whether they would get *'the right volume of referrals of appropriate clients'* (LC5). Described as *'frustrating time in terms of referrals'* by one link coordinator with small numbers of referral noted in 2019 (LC1). This later altered to operating a waiting list in December 2020, having widened the referral pathway and engaged with the primary mental health team. The impact of which was to increase link coordinator caseloads and employ a volunteer to provide telephone support (LC1).

Myself and my colleague had to work hard to get referrers in place when in reality we were employed on the premise that surgeries, WAST etc. were ready to go with lots of referrals. That was not evident and we had to work hard to build those up and build the relationships up with the referrers (LC5)

The link coordinators understood the importance of working together with other people developing accessible networks such as housing associations, Citizen's Advice, MIND (LC3), hospital staff. One link coordinator found they were having difficulty getting statutory services to listen to their requests for assessment (LC1). The client was complex and following some investigation the link coordinator identified that they were increasingly vulnerable and at risk of falls, and later on had expressed suicidal thoughts. This situation triggered repeated referrals to social services and the police. However, this led to increasing frustration and concern as the link coordinator was not able to get a response for the client, which led to increasing hospital admissions.

Link coordinators also understood the importance of fairness in maintaining the same provision to all clients and were conscious of spending too much time with specific clients and creating a dependency (LC3, LC1). Effective planning and timetabling was essential to maintain a strict amount of weeks or sessions in order to support a successful outcome and result in positive experiences for link coordinators and clients (LC3).

SUMMARY

What were the experiences of link coordinators, delivering the British Red Cross social prescribing service, as expressed within the reflective diaries?

In this section, we discuss the relationship between the context and the mechanisms identified in Tables 5-8. In realist evaluation, we surmise that altering the context has an effect on the mechanisms and the outcomes. For example, in theory one, **'Link**

coordinator supportive learning environment', link coordinators individually created a learning environment for themselves through reading articles and reports, reflecting on their gaps in knowledge, accessing learning themselves to meet their learning needs. All in preparation to develop the knowledge and skills to manage their caseloads and to contribute to others' learning. They experienced '*excellent*' training in their induction. Ensuring that a supportive learning environment right from the beginning allays anxiety and provides a positive role experience.

In theory two, '**Client complex problems**' were seen to be dependent on the client's individual agency (based on their sense of self) as to whether they conversed (or listened) with the skilled link coordinator. Agency is a complex process of interpretation or negotiation of how individuals have developed and lived their lives (Agich, 2003). The context of a trusting and knowledgeable link coordinator is key to triggering the client to confide personal /private information in order to develop goals and co-produce solutions.

In theory three, '**Link coordinator perspectives about the role**' there was a climate of uncertainty in this case due to Covid-19. It placed great demands on the workforce as they flexed to meet client, service and their families' needs. This at first triggered feelings of frustration and failure, which resulted in difficulties to be positive with clients. Later in 2020, they reported experiences of being hopeful, resourceful and resilient, bouncing back from the challenges of 2019 and early 2020. The context of uncertainty and how to manage it, is key to altering the link coordinator experience.

In theory four, '**Able to make a difference**' link coordinators reported at the beginning of the trial/service (2019), that making a difference to clients was a really important aspect of the role. They identified that there was a gap between the numbers of referrals they were expecting and the number they received. This led to them spending time chasing GP referrals, building relationships and other referral sources, and at times experiencing difficulties with being heard when referring to statutory services. All of these early experiences triggered feelings of frustration, which later in 2020 changed as the roles matured, and link coordinators adapted to the challenges and developed their networks. This theory raised some reflection about the limitations of the role and the boundaries between statutory mental health provision and the role of the link coordinator.

SOCIAL PRESCRIBING OUTCOMES SERVICE DATA

This section presents findings from the outcomes service data collected from individuals accessing and receiving the social prescribing service at one of two British Red Cross Teams (Sites 1-2). Measurement tools used to collect data at two time points, baseline and end of service were:

1. British Red Cross Wheel of Change
2. EQ-5D-5L
3. Warwick Edinburgh Mental Well-being Scale (WEMWBS) – 14-item

SITE 1

WHO DID THE SERVICE WORK WITH?

(Addressing Q4)

The data consisted of 173 individuals who had been referred to the service during the period October 2018 – October 2021. Of the 173 referrals received, 9 individuals declined the referral and 63 were not supported. Of the 63 not supported, 39 noted reasons as to why the individual was not supported of which the most frequent reason was “unable to make contact”.

Graph 1 below compares the age of individual as a percentage of all referrals against those who went onto receive support. The age band 46-55 years was the highest across both groups. The percentage of 18-25 year olds who went on to receive support was lower than those referred as was the 76+ years age group. The 26-35 year group decreased marginally in those who went on to receive support. The percentage in age bands 36-45, 46-55, 56-65 and 66-75 years was higher in those who went onto receive support than those at referral stage.

Graph 1: Number of all referrals by age (n=173)



The average age of all referrals was 48 years old and the average age of those who went onto receive support was 49 years old. The youngest person referred to the service was 18 years old and the oldest was 88. The youngest person who went on to receive support was 19 years old and the oldest was 83.

Table 11 shows the numbers and percentage of individuals referred to the service who spoke Welsh as a first language or were Welsh speakers. Of the 46% of individuals where this information was known, 1% had Welsh as their first language and 2% were Welsh speakers.

Table 11: Welsh Language

	Welsh is first language		Welsh Speaker	
	No.	%	No.	%
Yes	1	1%	4	2%
No	78	45%	74	43%
Unknown	94	54%	95	55%
Total	173	100%	173	100%

Individuals were asked at referral if they felt lonely or isolated and 45% answered yes which is shown in Table 12 below.

Table 12: Do you feel lonely or isolated?

	Identifies with feeling lonely/isolated	
	No.	%
Yes	78	45%
No	18	10%
Unknown	77	45%
Total	173	100%

FOR HOW LONG DID THE SERVICE WORK WITH PEOPLE? (Addressing Q4)

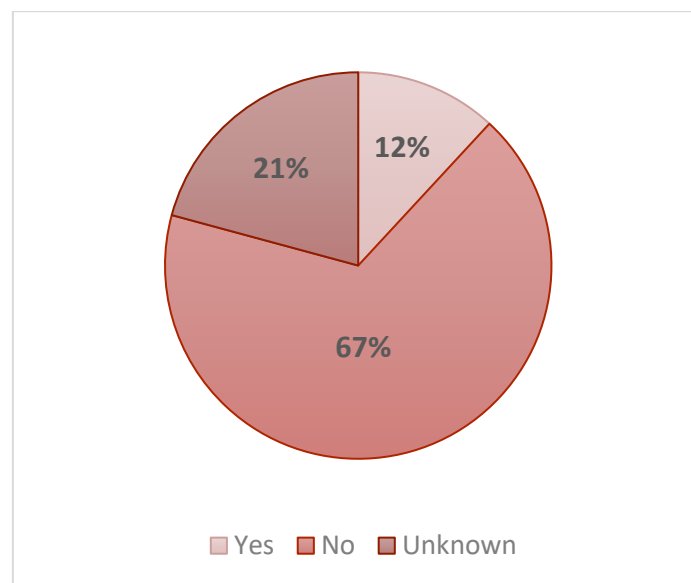
The data in this section considers the supported service users only on a whole population basis unless otherwise stated. This is due to limitations in respect of the number of individuals for whom a complete dataset at multiple time points existed. Accordingly, the number of service users with data for each question varies and is noted at the relevant points.

In terms of the length of support, the mean number of weeks beneficiaries were supported for was 13. The shortest time support was provided for was 4 weeks and the longest 34 weeks. The modal length of time that support was offered for was 12 weeks, with 14% of service users receiving support for this duration. There were 69% of service users who completed their programme of support. There were 10% of service users who were frequent attenders.

WHAT DIFFERENCE DID THE SERVICE MAKE FOR PEOPLE? (Addressing Q4)

There were a number of outcome measures and other metrics that were gathered in order to describe the change in circumstances during the lifetime of people's support from the service. Graph 2 shows the number of service users which had reduced their use of prescribed medication by time their support ended. The graph shows 12% answered yes, 67% answered no, and 21% were unknown (n=101.)

Graph 2: By end of support had the service user reduced their use of prescribed medication?



Data relating to the well-being of service users was measured at the start of their support and at the end. Three tools were used, the BRC Wheel of Change, the EQ-5D and the Warwick Edinburgh Mental Well-being Scale (WEMWBS). The whole population scores (unless otherwise stated) for the service users for each of the measurement tools are shown below.

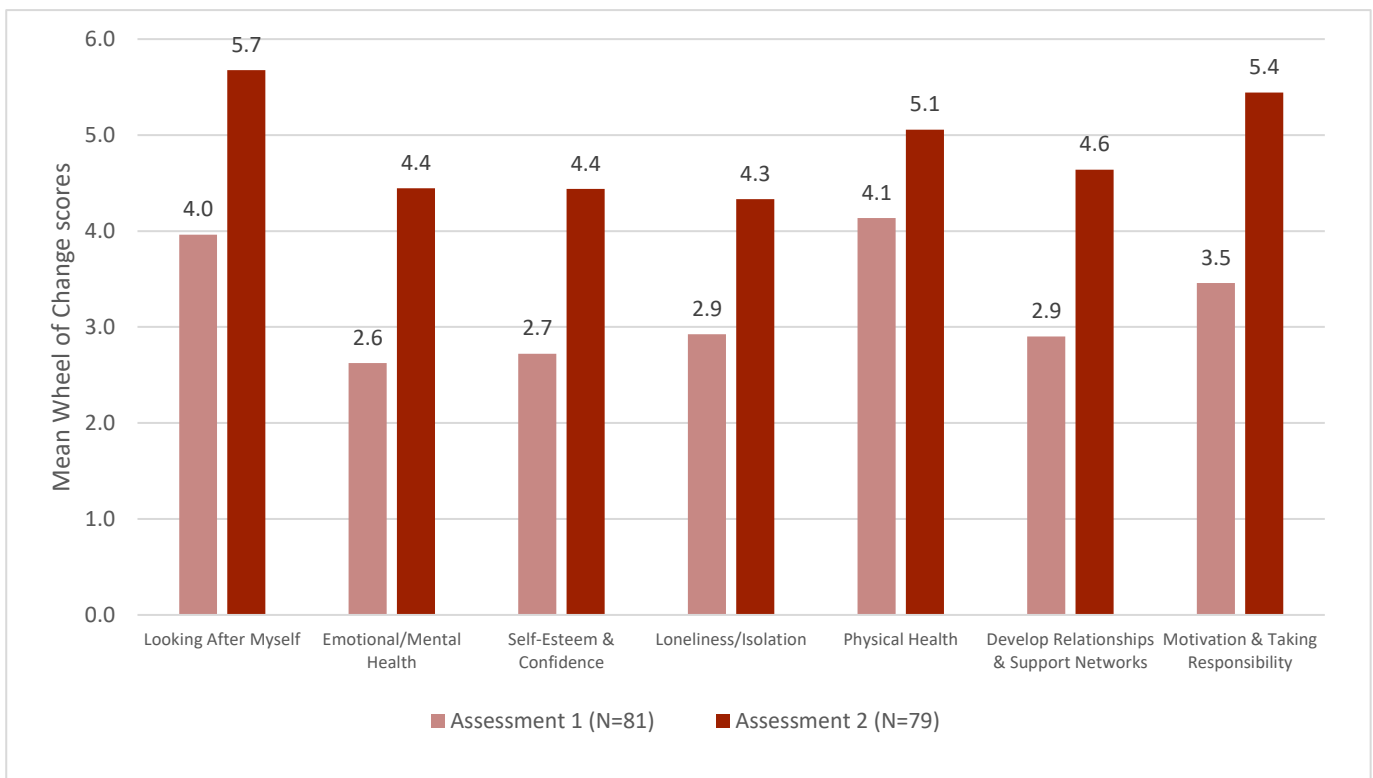
BRC Wheel of Change

The Wheel of Change well-being measurement tool consists of seven questions which scores a service user between 0-10 for each question. The score of 10 indicates a willingness

to make changes in their life, whereas 0 indicates a state of being ‘stuck’, unable to make change. Moving people from low to high scores was the aim of the service.

Graph 3 shows the mean score for each of the seven questions at both first and second assessment. On the basis of the population as a whole, all question scores increased from assessment 1 to assessment 2. The minimum mean values increased from 2.6 at Assessment 1 to 4.4 at Assessment 2, with the maximum mean scores also showing a similar improvement, from 4.0 at Assessment 1 to 5.7 at Assessment 2.

Graph 3: Wheel of Change – mean scores across time⁴



EQ-5D-5L

The second tool used to measure impact on service users was the EQ-5D-5L. This validated tool consists of two components: the EQ-5D descriptive system and the EQ visual analogue scale (EQ VAS).

The descriptive system comprises five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has five levels: 1. no problems, 2. slight problems, 3. moderate problems, 4. severe problems and 5. extreme problems. Each person is asked to indicate their health state by ticking the box next to the most appropriate statement in each of the five dimensions. This decision results in a 1-digit number that expresses the level selected for that dimension. The digits for the five dimensions can be

⁴ We have not undertaken any statistical analyses of these data give that the Wheel of Change is not a validated tool and as such has no guidance on how such analyses could be undertaken.

combined into a 5-digit number that describes the patient’s health state, e.g., 13451, 52234. Population norms for a range of countries are then applied to these indices on a scale from 0-1, where 1 equates to the best health state that can be imagined i.e., an index score of 11111.

The EQ VAS records the person’s self-rated health on a vertical visual analogue scale, where the endpoints are labelled ‘the best health you can imagine’ and ‘the worst health you can imagine’. The VAS can be used as a quantitative measure of health outcome that reflects the person’s own judgement.

Below we will present data from the two timepoints (Assessment 1 and Assessment 2, at which 60 responses were analysed) from both the EQ-5D-5L index values and EQ VAS. These comparisons will allow us to provide an indication of the statistical significance of any differences across time within Site 1.

EQ-5D descriptive system

Across all five dimensions, the proportions of people selecting index level 1 (no problems with their health-related quality of life) improved, with the largest increase (+9%) in the self-care domain. Similarly, there was a decrease in the proportions of people who were selecting level 5 (extreme problems) with a notable decrease of 17% in the anxiety and depression domain. These data begin to demonstrate the kinds of impact that the service was designed to deliver. Detail on the proportions of response by level and domain is provided in Table 13.

Table 13: EQ-5D-5L – Proportions (%) of responses by domain and level across time⁵

Dimension	Mobility		Self-care		Usual Activities		Pain/ Discomfort		Anxiety/ Depression	
	A1	A2	A1	A2	A1	A2	A1	A2	A1	A2
Level 1	45%	49%	38%	47%	17%	25%	29%	34%	1%	2%
Level 2	20%	14%	32%	29%	23%	29%	19%	19%	1%	36%
Level 3	19%	24%	14%	15%	33%	32%	29%	31%	42%	37%
Level 4	13%	12%	16%	8%	19%	8%	13%	10%	30%	17%
Level 5	3%	2%	0%	0%	7%	5%	10%	7%	25%	8%

In terms of the difference made over time, we considered the population index scores, based on the profile of the responses given, at both Assessment 1 and Assessment 2. Table 14 provides an account of this.

⁵ Assessment 1 = A1, and Assessment 2 = A2

Table 14: EQ-5D-5L – index scores and change across time

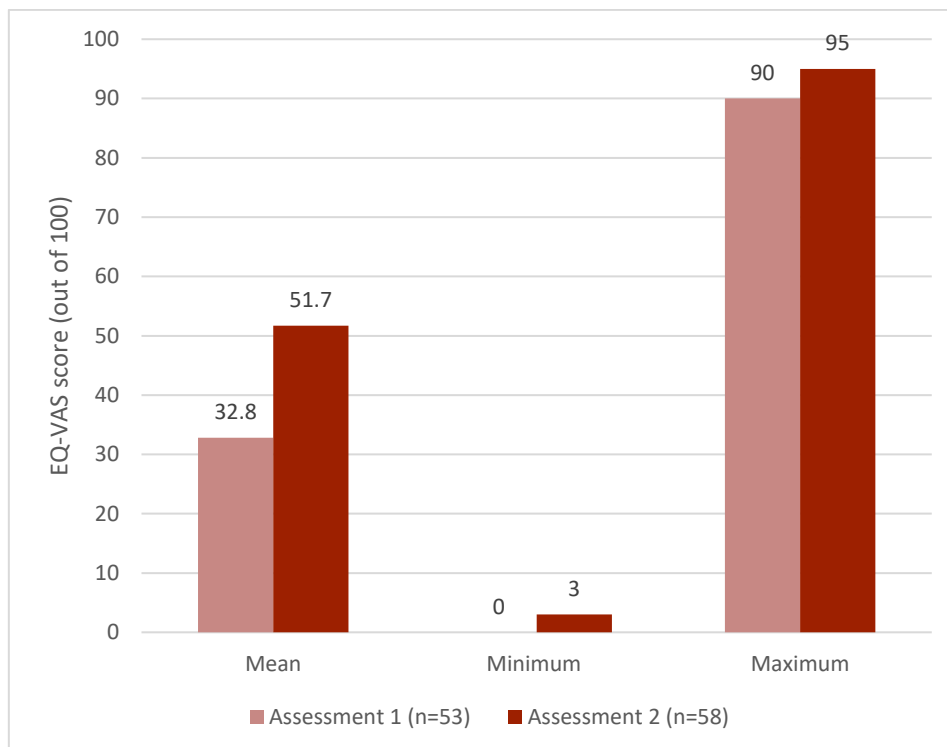
Assessment	N	Min	Max	StdDev	Mean Index score
Assessment 1	60	0.246	1	0.308	0.511
Assessment 2	60	0.214	1	0.276	0.622

The change in index score is the key reference point. Further to the paired t-test that was undertaken, the results above indicate that the data provides very strong evidence ($p < 0.0001$) of a statistically significant difference between the scores gathered at Assessment 1 and 2.⁶ In short, within Site 1, the participants reported higher health-related quality of life scores after having been supported by the programme.

EQ-VAS

Further, the EQ-VAS data was collected. 5D health scale question asks services users using a scale of 1-100 where 100 is the most positive and 1 is the least to assess how they feel today. Graph 4 shows the mean, minimum and maximum scores for the VAS at both Assessment 1 and Assessment 2.

Graph 4: EQ-VAS – mean, minimum and maximum scores across time



⁶ A paired t-test was undertaken – associated values were: $t = -6.2533$, $df = 59$, $p\text{-value} = 4.893e-08$

Positive change is seen across all three measures, with the mean, maximum and minimum all increasing between Assessment 1 and Assessment 2.

In terms of the significance of those differences, Table 15 provides an account of the change over time.

Table 15: EQ-VAS – scores and change across time

Assessment	N	Min	Max	StdDev	Mean VAS score
Assessment 1	53	0	90	16.990	32.785
Assessment 2	58	3	95	19.667	51.693

The nearly 20-point positive increase in VAS change is striking and further to the paired t-test that was undertaken, the results above indicate that the data provides very strong evidence ($p < 0.0001$) of a statistically significant difference between the scores gathered at Assessment 1 and 2.⁷ Within Site 1, the participants reported higher health-related VAS scores after having been supported by the programme.

Warwick Edinburgh Mental Well-being Scale (WEMWBS)

The Warwick Edinburgh Mental Well-being Scale (WEMWBS) asks 14 questions to measure an individual’s well-being using a scale 1-5 where 5 indicates the best indicator for well-being. The maximum score that can be recorded is 70, and the minimum is 14.

In terms of frequency distribution, the proportions of people selecting the lower scores as opposed to the higher score has changed markedly between Assessment 1 and Assessment 2 – see Table 16. The profile of response at Assessment 1 shows a population whose responses indicated a range of issues associated in particular with a lack of self-esteem and self-confidence, with more than a quarter of all respondents indicating they were at the lowest level (Level 1) for more than half of the statements (8 out of 14), and 70% of responses at either Level 1 or 2.

In contrast, the frequency distribution at Assessment 2 presents a different picture. We now see nearly 30% of all responses at the highest two levels (Level 4 and 5) with a substantial reduction in respondents selecting Level 1 (6% instead of 27%). Being optimistic about the future and taking an interest in new things are two of the statements for which there has been the biggest shift, which could be associated with the kind of social prescribing support that has been received by the beneficiaries at Site 1.⁸

⁷ A paired t-test was undertaken – associated values were: $t = -9.1809$, $df = 50$, $p\text{-value} = 2.63e-12$.

⁸ We would have liked to have been able to compare the data from this evaluation with national data trends and provide a benchmark. Given the paucity of data collection and issues over the quality of national datasets during the pandemic it is not feasible to be able to make sure comparisons with Welsh population surveys.

Table 16: WEMWBS – Proportions (%) of responses by domain and level across time⁹

Statement	Level 1		Level 2		Level 3		Level 4		Level 5	
	A1	A2	A1	A2	A1	A2	A1	A2	A1	A2
I've been feeling optimistic about the future	26%	9%	45%	11%	26%	40%	2%	36%	1%	4%
I've been feeling useful	29%	6%	41%	24%	27%	53%	2%	13%	0%	4%
I've been feeling relaxed	28%	4%	45%	23%	23%	47%	4%	24%	0%	1%
I've been feeling interested in other people	16%	3%	37%	10%	37%	49%	7%	31%	3%	7%
I've been feeling relaxed	37%	10%	44%	34%	16%	36%	1%	17%	1%	3%
I've been dealing with problems well	30%	10%	39%	14%	23%	46%	5%	26%	2%	4%
I've been thinking clearly	18%	3%	48%	19%	29%	51%	4%	24%	1%	3%
I've been feeling good about myself	47%	10%	43%	20%	9%	53%	1%	14%	0%	3%
I've been feeling close to other people	23%	9%	45%	20%	23%	46%	4%	19%	5%	7%
I've been feeling confident	40%	8%	50%	27%	9%	46%	1%	15%	0%	3%
I've been able to make up my own mind about things	10%	0%	39%	10%	35%	43%	9%	31%	7%	16%
I've been feeling loved	24%	5%	35%	19%	32%	53%	4%	17%	4%	7%
I've been interested in new things	24%	5%	46%	20%	25%	36%	6%	36%	0%	3%
I've been feeling cheerful	28%	7%	47%	20%	24%	49%	0%	19%	1%	5%
MEAN PROPORTION	27%	6%	43%	19%	24%	46%	4%	23%	2%	5%

At Assessment 1, the average individual score (taking account of all 14 WEMWBS questions) based on service users with a full set of scores, was 29 out of a possible 70 (n=68), with a minimum of 14 and maximum of 58. The average individual score at Assessment 2 increased to 42 out of 70 (n=59), with a minimum of 16 and maximum of 68 – see Graph 5.

Positive change is seen across all three measures, with the mean, maximum and minimum all increasing between Assessment 1 and Assessment 2. In terms of the significance of those differences, Table 17 provides an account of the change over time.

⁹ Assessment 1 = A1, and Assessment 2 = A2

Graph 5: WEMWBS – mean, minimum and maximum scores across time

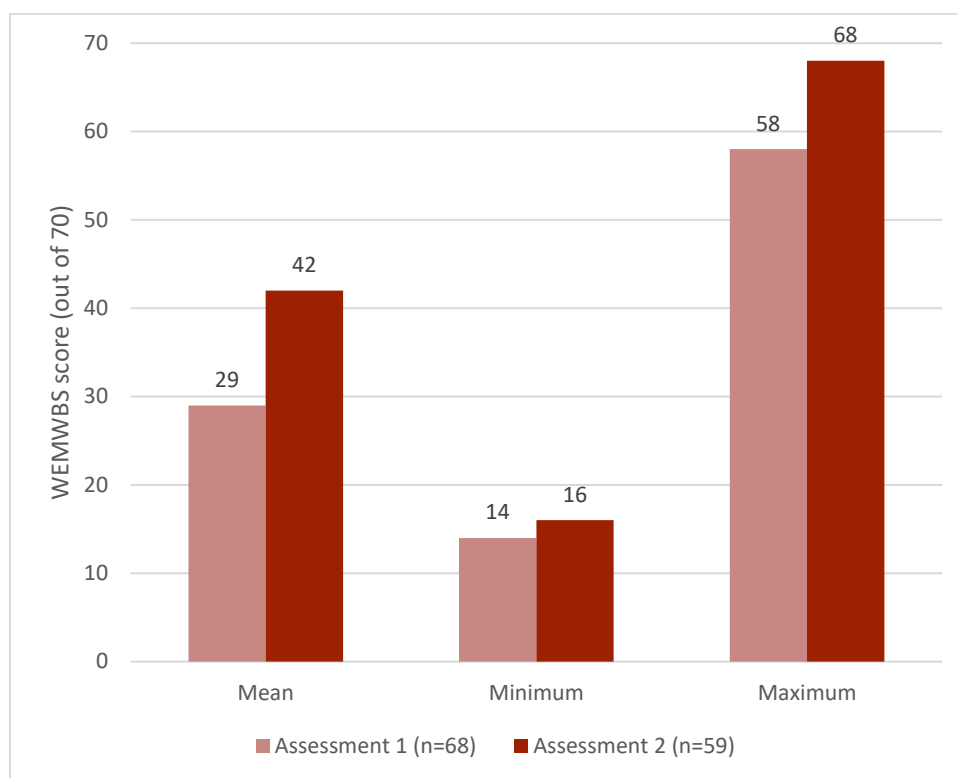


Table 17: WEMWBS – scores and change across time

Assessment	N	Min	Max	StdDev	Mean WEMWBS score
Assessment 1	59	14	58	7.916	29.763
Assessment 2	59	16	68	9.603	42.136

The positive increase in WEMWBS score is marked and further to the paired t-test that was undertaken, the results above indicate that the data provides very strong evidence ($p < 0.0001$) of a statistically significant difference between the scores gathered at Assessment 1 and 2.¹⁰ Within Site 1, the participants reported higher WEMWBS scores after having been supported by the programme.

In context, this means that the population of Site 1 is broadly in line with the bottom 15% of the UK population.¹¹ They note that WEMWBS has a mean score of 51.0 in general population samples in the UK with a standard deviation of 7.¹² This means that 15% of the population can be expected to have a score of less than 42, and equally 15% of the

¹⁰ A paired t-test was undertaken – associated values were: $t = -11.287$, $df = 58$, $p\text{-value} = 2.887e-16$

¹¹ See <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/>

¹² Tennant R, Hiller L, Fishwick R, Platt P, Joseph S, Weich S, Parkinson J, Secker J, Stewart-Brown S. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcome* 2007;5(63)

population can be expected to have a score greater than 60. It should be noted however that the additional and unique impact of the pandemic is not taken into account in these figures.

SITE 2

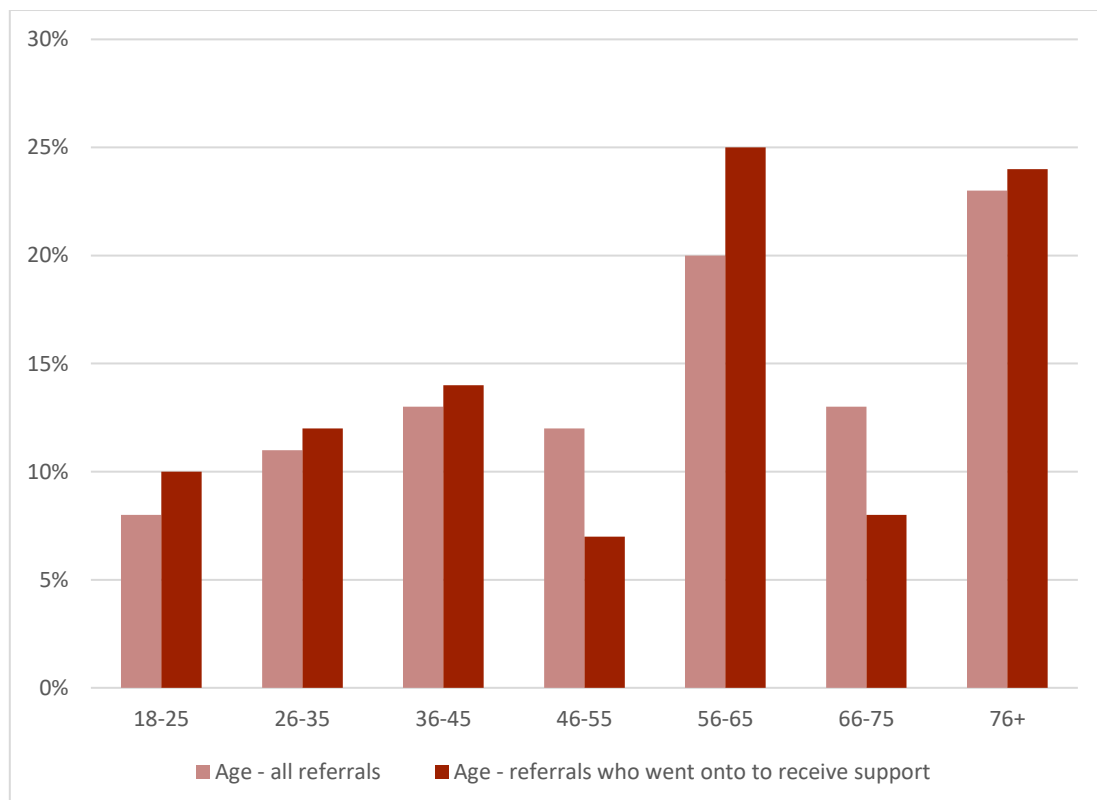
WHO DID THE SERVICE WORK WITH?

(Addressing Q4)

The data consisted of 142 individuals who had been referred to the service during the period December 2018 to August 2021. Of the 142 referrals received, 12 individuals declined the referral and 23 were not supported. There were no reasons given as to why the referrals were not supported.

Graph 6 below compares the age of individuals of all referrals as a percentage against those who went onto receive support. The age band 56–65-year-olds was the highest across both groups. The 26-35 years age band was broadly the same across both groups. The 46-55 and 66-75 age groups numbers who went on to receive support were lower than those at referral. The numbers in the 18-25, 36-45, 56-65 and 76+ age groups were higher in those who went to use the service than at referral. Across both groups the average age was 55 years old, the youngest person was 19 years old and the oldest 94 years old.

Graph 6: Number of all referrals by age (n=142)



No individuals were recorded as being Welsh speakers or Welsh as a first language from the 56% and 57% respectively of individuals who responded to this question. Individuals were also asked at referral if they felt lonely or isolated and 44% answered yes. This is shown in Table 18.

Table 18: Do you feel lonely or isolated?

	Identifies with feeling lonely/isolated	
	No.	%
Yes	62	44%
No	56	39%
Unknown	24	17%
Total	142	100%

FOR HOW LONG DID THE SERVICE WORK WITH PEOPLE? (Addressing Q4)

The data in this section considers the service users who were supported by the project on a whole population basis unless otherwise stated. The number of service users with data for each question varies and is noted at the relevant points.

In terms of their length of support, the mean number of weeks that beneficiaries were supported within the project was 12, which was also the modal value with 21% of service users receiving support for this duration. The shortest time support was provided for was one week and the longest 40 weeks. 59% of service users completed their programme of support, and 36% of service users were frequent attenders.

WHAT DIFFERENCE DID THE SERVICE MAKE FOR PEOPLE? (Addressing Q4)

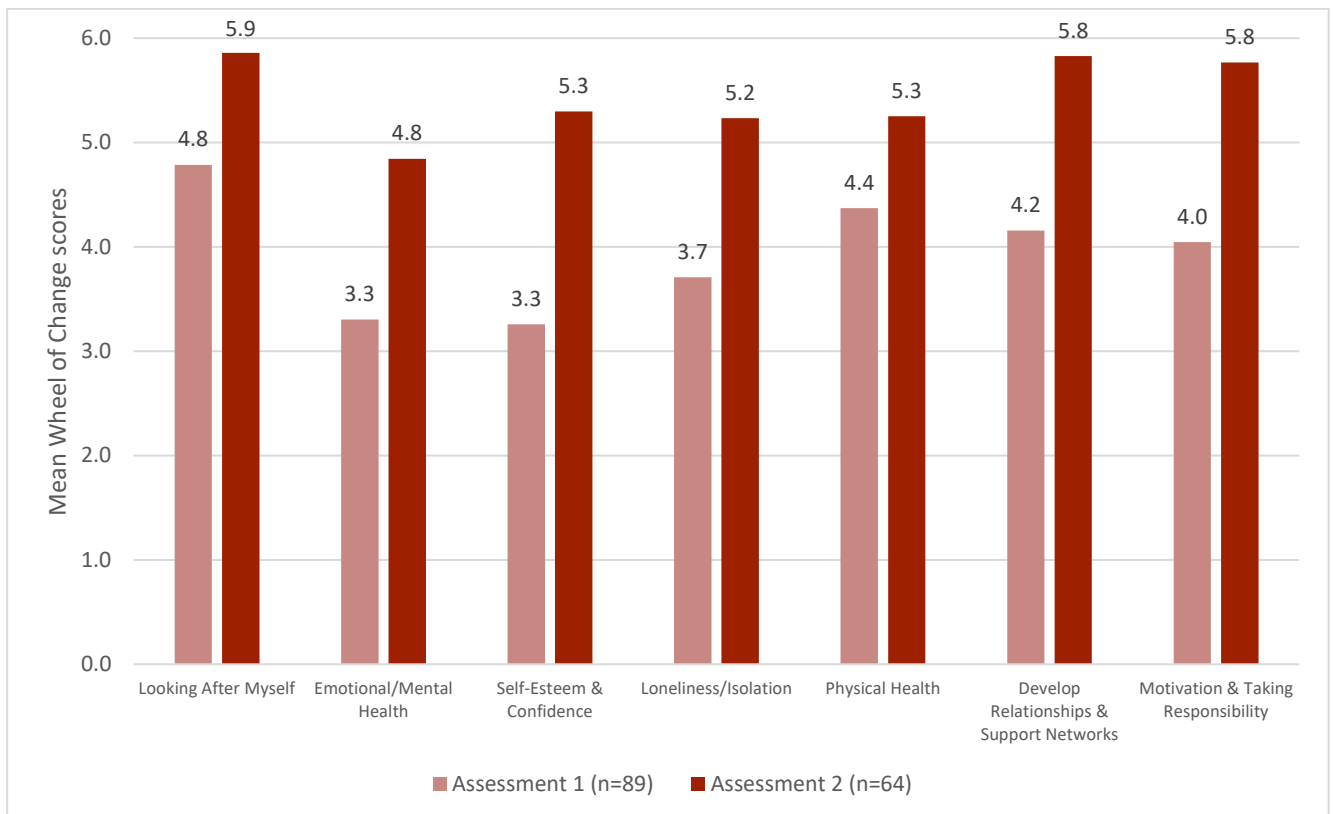
The service users' well-being was measured at the start of their support (Assessment 1) and at the end (Assessment 2) using the same three tools as used by Site 1 - the BRC Wheel of Change, the EQ5D and the Warwick Edinburgh Mental Well-being Scale (WEMWBS). The whole population scores (unless otherwise stated) for the service users for each of the measurement tools are shown below.

BRC Wheel of Change

The Wheel of Change well-being measurement tool consists of seven questions which scores a service user between 0-10 for each question. The score of 10 indicates a willingness to make changes in their life, whereas 0 indicates a state of being 'stuck', unable to make change. Moving people from low to high scores was the aim of the service.

Graph 7 shows the mean score for each of the seven questions at both first and second assessment. On the basis of the population as a whole, all question scores increased from Assessment 1 to Assessment 2. At assessment 1, the mean scores ranged from 3.3 to 4.8 increasing to a range of 4.8 to 5.9 at Assessment 2. The biggest change related to 'Motivation and Taking Responsibility, with an increase of 1.5 on average from Assessment 1 to Assessment 2.

Graph 7: Wheel of Change – mean scores across time¹³



EQ-5D-5L

The EQ-5D-5L was also used to measure service users' well-being in Site 2 (for an explanation of EQ-5D-5L see the corresponding section for Site 1 above).

Below we present data from the two timepoints (Assessment 1 and Assessment 2) for both the EQ-5D-5L index values and EQ VAS. These comparisons will allow us to provide an indication of the statistical significance of any differences across time within Site 2.

EQ-5D descriptive system

Across all five dimensions, the proportions of people selecting index level 1 (no problems with their health related quality of life) improved, with a +16% increase in the usual activities dimension. Similarly, there was a decrease in the proportions of people who were

¹³ We have not undertaken any statistical analyses of these data give that the Wheel of Change is not a validated tool and as such has no guidance on how such analyses could be undertaken.

selecting level 5 (extreme problems) with a notable decrease of 24% in the anxiety and depression domain with no-one selecting this level for that dimension at Assessment 2. These data clearly indicate the positive impact that the service was intending to provide for beneficiaries. Detail on the proportions of response by level and domain is provided in Table 19.

Table 19: EQ-5D-5L – Proportions (%) of responses by domain and level across time¹⁴

Dimension	Mobility		Self-care		Usual Activities		Pain/ Discomfort		Anxiety/ Depression	
	A1	A2	A1	A2	A1	A2	A1	A2	A1	A2
Level 1	51%	54%	51%	66%	13%	29%	18%	29%	0%	7%
Level 2	16%	24%	16%	17%	38%	51%	35%	51%	13%	63%
Level 3	13%	5%	21%	5%	35%	10%	26%	10%	41%	17%
Level 4	11%	10%	8%	5%	11%	7%	16%	10%	22%	12%
Level 5	10%	7%	5%	7%	3%	2%	5%	0%	24%	0%

In terms of the difference made over time, we considered the population index scores, based on the profile of the responses given, at both Assessment 1 and Assessment 2. Table 20 provides an account of this.

Table 20: EQ-5D-5L – index scores and change across time

Assessment	N	Min	Max	StdDev	Mean Index score
Assessment 1	40	0.2	0.922	0.320	0.569
Assessment 2	40	0.2	1	0.274	0.695

The change in index score is the key reference point. Further to the paired t-test that was undertaken, the results above indicate that the data provides strong evidence ($p=0.004$) of a statistically significant difference between the scores gathered at Assessment 1 and 2.¹⁵ This means that within Site 2, participants reported higher health-related quality of life scores after having been supported by the programme.

EQ-VAS

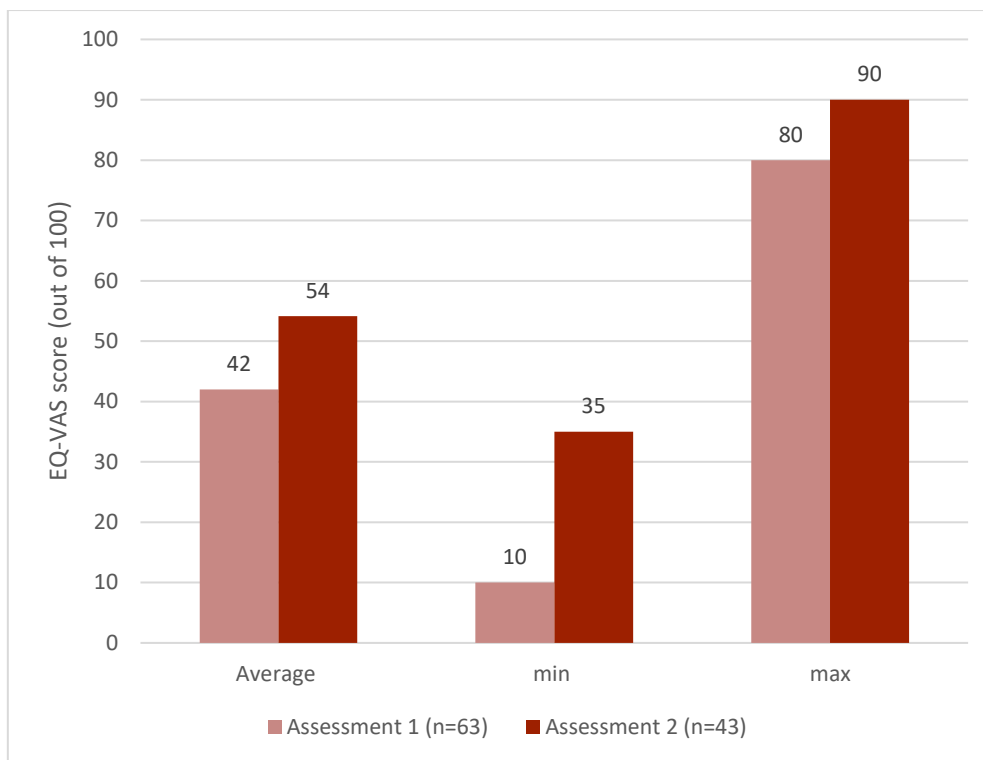
Further, the EQ-VAS data was collected. 5D health scale question asks services users using a scale of 1-100 where 100 is the most positive and 1 is the least to assess how they feel

¹⁴ Assessment 1 = A1, and Assessment 2 = A2

¹⁵ A paired t-test was undertaken – associated vales were: $t = -3.0968$, $df = 39$, $p\text{-value} = 0.003616$

today. Graph 8 shows the mean, minimum and maximum scores for the VAS at both Assessment 1 and Assessment 2.

Graph 8: EQ-VAS – mean, minimum and maximum scores across time



Positive change is seen across all three measures, with the mean, maximum and minimum all increasing between Assessment 1 and Assessment 2. In terms of the significance of those differences, Table 21 provides an account of the change over time.

Table 21: EQ-VAS – scores and change across time

Assessment	N	Min	Max	StdDev	Mean VAS score
Assessment 1	40	10	80	13.819	42.25
Assessment 2	40	35	90	9.594	54.44

The increase in the mean VAS score is important and further to the paired t-test that was undertaken, the results above indicate that the data provides very strong evidence ($p < 0.0001$) of a statistically significant difference between the scores gathered at Assessment 1 and 2.^{16,17}

¹⁶ A paired t-test was undertaken – associated values were: $t = -6.097$, $df = 39$, $p\text{-value} = 3.798e-07$

¹⁷ We would have liked to have been able to compare the data from this evaluation with national data trends and provide a benchmark. Given the paucity of data collection and issues over the quality of national datasets during the pandemic it is not feasible to be able to make sure comparisons with Welsh population surveys.

Warwick Edinburgh Mental Well-being Scale (WEMWBS)

The Warwick Edinburgh Mental Well-being Scale (WEMWBS) asks 14 questions to measure an individual's well-being using a scale 1-5 where 5 indicates the best indicator for well-being. The maximum score that can be recorded is 70, and the minimum is 14.

In terms of frequency distribution, the proportions of people selecting the lower scores as opposed to the higher score has changed markedly between Assessment 1 and Assessment 2 – see Table 22.

Table 22: WEMWBS – Proportions (%) of responses by domain and level across time¹⁸

Statement	Level 1		Level 2		Level 3		Level 4		Level 5	
	A1	A2	A1	A2	A1	A2	A1	A2	A1	A2
I've been feeling optimistic about the future	17%	3%	37%	23%	37%	38%	6%	26%	4%	10%
I've been feeling useful	23%	3%	30%	14%	41%	40%	6%	31%	1%	12%
I've been feeling relaxed	23%	3%	33%	13%	37%	41%	7%	30%	0%	13%
I've been feeling interested in other people	25%	5%	32%	8%	35%	35%	5%	45%	3%	8%
I've been feeling relaxed	22%	8%	40%	23%	33%	45%	3%	25%	2%	0%
I've been dealing with problems well	28%	7%	33%	10%	35%	46%	2%	25%	1%	13%
I've been thinking clearly	24%	3%	26%	11%	38%	38%	9%	31%	4%	16%
I've been feeling good about myself	24%	10%	38%	18%	37%	43%	2%	30%	0%	0%
I've been feeling close to other people	18%	3%	33%	13%	29%	34%	10%	28%	10%	21%
I've been feeling confident	27%	10%	41%	18%	30%	40%	2%	33%	0%	0%
I've been able to make up my own mind about things	13%	0%	20%	7%	39%	33%	21%	33%	7%	28%
I've been feeling loved	16%	3%	27%	5%	35%	43%	18%	48%	3%	4%
I've been interested in new things	13%	0%	35%	20%	41%	45%	6%	35%	5%	0%
I've been feeling cheerful	16%	5%	42%	13%	37%	50%	3%	33%	2%	0%
MEAN PROPORTION	21%	5%	33%	14%	36%	41%	7%	32%	3%	9%

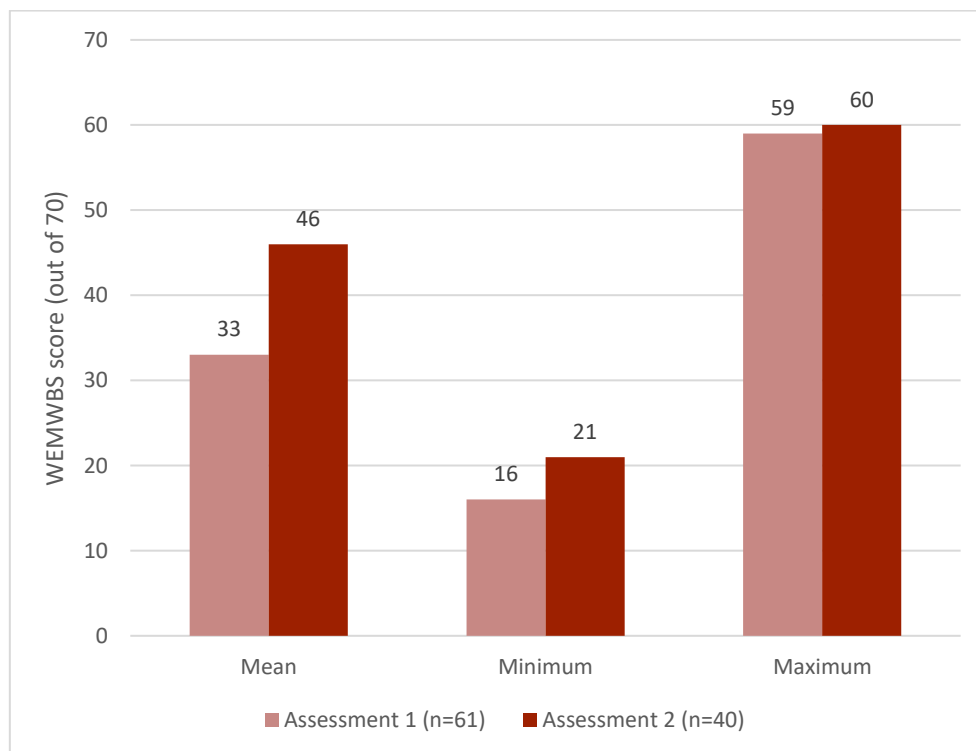
¹⁸ Assessment 1 = A1, and Assessment 2 = A2

The profile of response at Assessment 1 shows a population whose responses indicated a range of issues associated, in particular, with dealing effectively with problems and a lack of self-confidence. Overall, more than a fifth of all respondents indicated they were at the lowest level (Level 1) for more than half of the statements (8 out of 14), and more than half of responses at either Level 1 or 2.

In contrast, the frequency distribution at Assessment 2 presents a very different profile. We now see 10% of all responses at the highest two levels (Level 4 and 5) with a substantial reduction in respondents selecting Level 1 (5% instead of 21%). Feeling close to other people, and being able to make your mind up about things are the two statements which have the largest proportion of responses at Level 5 (21% and 28% respectively), which could well be associated with the kind of social prescribing support that has been received by the beneficiaries at Site 2.

At Assessment 1, the average individual score (taking account of all 14 WEMWBS questions) based on service users with a full set of scores, was 33 out of a possible 70 (n=61), with a minimum of 16 and maximum of 59. The average individual score at Assessment 2 increased to 46 out of 70 (n=40), with a minimum of 21 and maximum of 60 – see Graph 9.

Graph 9: WEMWBS – mean, minimum and maximum scores across time



Positive change is seen across all three measures, with the mean, maximum and minimum all increasing between Assessment 1 and Assessment 2. In terms of the significance of those differences, Table 23 provides an account of the change over time.

Table 23: WEMWBS – scores and change across time

Assessment	N	Min	Max	StdDev	Mean WEMWBS score
Assessment 1	39	16	59	8.706	34.205
Assessment 2	39	21	60	7.829	45.974

The positive increase in WEMWBS score is marked and further to the paired t-test that was undertaken, the results above indicate that the data provides very strong evidence ($p < 0.0001$) of a statistically significant difference between the scores gathered at Assessment 1 and 2.¹⁹ Within Site 2 therefore, the participants reported higher WEMWBS scores after having been supported by the programme.

In context, this means that the population of Site 2 is broadly in line with the middle 70% of the UK population.²⁰ They note that WEMWBS has a mean score of 51.0 in general population samples in the UK with a standard deviation of 7. This means that 15% of the population can be expected to have a score of less than 42, and equally 15% of the population can be expected to have a score greater than 60. This places Site 2 in line with the general population (albeit at the bottom end of that range), but it should be noted that the additional and unique impact of the pandemic (which is likely to have had a downward impact) is not taken into account in these figures.

¹⁹ A paired t-test was undertaken – associated vales were: $t = -8.4296$, $df = 38$, $p\text{-value} = 3.141e-10$

²⁰ See <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/>

INTERVIEWS

This section of the report presents findings from interviews with stakeholders of the British Red Cross social prescribing service. Findings are presented using four overarching themes and are aligned to the evaluation questions in the Conclusion chapter.

1. Planning and implementing the British Red Cross social prescribing model
 - Inception and development
 - Adapting the service delivery model [pre-Covid-19]
2. Implementing and delivering the British Red Cross social prescribing service
 - The research trial
 - Relationships with partners
 - The impact of Covid-19
3. Social Prescribing and the role of the link coordinator
 - Link coordinator role and skills
 - Training, development and support
4. The role of social prescribing and the British Red Cross model
 - Benefits of the social prescribing service [clients and partners]
 - Embedding social prescribing [Inc. challenges]

Each of the four overarching theme headings are discussed in the following section. 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.

PLANNING AND IMPLEMENTING THE BRITISH RED CROSS SOCIAL PRESCRIBING MODEL

(Addressing Q1, Q3, Q4, Q5)

- *Inception and development*

The inception and development of the British Red Cross social prescribing service was informed by several elements; an identified need to provide support for individuals experiencing low to moderate mental health issues, gaps in service provision to meet that need, and to develop social prescribing in Wales.

It [the service] was funded from Welsh Government and the reason we started to look into it was that there was such a need for that low level mental health support in our other services where we do home from hospital regulated services. We could see an

increase in dealing with people with low level mental health issues, and we thought it was an area really that we should be looking into to be able to support people in [area] with more focus on mental health rather than our general sort of support that we do with our other services (Programme manager)

We were interested in it [social prescribing] because we had a little bit of experience in mental health with regards to our existing services and we really wanted to do something specific with regards to mental health rather than having some service users that had mental health issues within our services that were being delivered. So that's really why we became involved, and we were also doing social prescribing in the UK, so we thought it would be good to get involved in that in Wales, and there was a gap in services in [area] and in [area] in terms of something that was tailored for low to moderate people's mental health (Regional manager)

A review of existing data sources helped to inform decision-making for each of the two locations that the service would be delivered from:

The service had to be provided in a rural area, and in the South Wales valleys. We looked at [area], as a rural area and we also looked at the valleys and settled on [area]. We settled on [area] based on the data from a number of sources. You know, the Welsh Index of the Deprivation, our own service data, data from other services and other data from our previous services on knowing where the needs were, data from NHS Wales, data from Welsh Government and from the Welsh Audit Office etc. (Regional manager)

At an operational level, planning and development decisions were jointly agreed amongst projects leads: *It was really a joint decision with the other ILOM's [Independent Living Operations Managers] and the business development manager and how the design of that project would be and how it would work (Regional manager)*

In addition, a project steering group, to discuss the project and its progress, was established from the outset. However, securing the attendance of external partners (organisations making and receiving referrals from the service) was described as 'a challenge'. Time pressures of external partners were cited as possible reasons for non-engagement:

Trying to get people that are referring and our referring partners to come to our steering group meetings has been a challenge and I appreciate everyone has been really busy (Regional manager)

In terms of other types of engagement [with GPs], attending regular stakeholder meetings with us, we were going to have regular stakeholder meetings where we would discuss the project and the progress it was making [...]. None of those partners ever attended any of those. Not only that, it was really difficult to get them to engage,

even on a one to one basis. You know, getting them to respond to emails to pick up answer, the phone calls (Regional manager)

Tasks associated to the planning and implementation of the British Red Cross social prescribing service included: *the recruitment of the link coordinators, discussions with the likes of yourselves [WIHSC] with regards to the trial, with regards to the referral pathways, and speaking to stakeholders (Regional manager).*

Referring to the recruitment of link coordinators, ensuring clarity and guidance about the aim of the service and duties of the role was an important element:

Once I recruited staff, that the staff understood what the service is about, what the aims were, what data we are going to collect, how we are going to provide the service, what we're going to report on and to make sure that we have all the all the information necessary for reporting (Regional manager)

- *Adapting the service delivery model [pre-Covid-19]*

Within its original design the British Red Cross social prescribing service had been intended to support 'frequent attenders' to GP practices and the Welsh Ambulance Trust (WAST). However, once implemented, issues '*quickly became apparent*' from solely focussing on frequent attenders, prompting an expansion to include non-frequent attenders:

Firstly, there aren't that many patients who are frequent attenders for us to be able to reach the numbers we committed to supporting. And secondly, it also became apparent that there are lots of other people who are not frequent attenders but who have a genuine need and some of the surgeries that have best engaged with us. [...] So we adjusted the service slightly as soon as we had the agreement from the Welsh Government to expand the service user base to include non-frequent attenders (Regional manager)

As time progressed, several challenges were encountered, which led to a change in how the British Red Cross social prescribing service worked with WAST. Issues included incorrect referral information and referrals that did not fit the criteria for the service:

It very quickly became apparent that although they [WAST] had said they had lots of suitable people, the people they were actually referring over to us were the people that were appearing in the top five of their matrix that they'd pulled off every month, which were the most complex people that you can imagine and had been going around the system for years and years. Not only did these people have significant physical health needs, they also had significant mental health needs. It was way above anything that the project was designed to support (Link coordinator)

...there was lots and lots of different issues that were coming out, but eventually we thought this isn't going to work properly because it wasn't as smooth as what we wanted was referrals from them. We would only work with WAST then and we would help support the ambulance service to be able to do follow on support from people they were dealing (Programme manager)

'Governance issues' (present during the research trial) were further challenges raised: they [WAST] had a governance issues where did the responsibility lie with that service user once they had been referred to us, where did the clinical responsibility lie? We are providing that support element out in the community but, you know, who else was going to pick up that clinical governance responsibility and they weren't able to do that (Regional manager)

In response, one of the sites adapted their service to receive referrals from the Mental Health Crises Team (MHCT). Developing a positive, trusting relationship provided assurance to the MHCT that the service was *'a safe pair of hands to leave these people refer onto us.'* The new referral pathway: *established very, very quickly actually, and they were really helpful in getting us set up and started to refer to us (Programme manager)*

Discussions with the Welsh Government about proposals to adapt the service delivery model, such as the expansion to include non-frequent attenders were valued:

The Welsh Government have been very willing to listen and very responsive so when we told them frequent attenders is perhaps, now that we've started the project, we've learned that perhaps frequent attendance is too narrow an area and that we need to expand it. They were willing to listen and they agreed for us to expand, so we expanded (Regional manager)

IMPLEMENTING AND DELIVERING THE BRITISH RED CROSS SOCIAL PRESCRIBING SERVICE

(Addressing Q1, Q2, Q3, Q4, Q5)

– The research trial

Participants reflected on the challenges of implementing the British Red Cross social prescribing service in tandem with establishing a research trial. A lack of preparedness associated to not fully understanding the processes required was referred to: *There are severe restrictions and limitations on what you can and what you can't do [in a trial], which we were totally unprepared for, which we weren't aware of at the start (Regional manager)*

A key requirement of the research trial meant securing relevant ethics permissions from both USW committees and the NHS Research Ethics Service. Time was spent undertaking actions linked to this process such as: *amendments made not necessarily to the service model, but to paperwork or to the data we were going to collect. The way we were going to*

collect the data to the training of the staff to how the staff had to be approved had meant that out of the three years of the pilot, we lost more than one, slightly over a year and a half on getting all of this sorted out (Regional manager)

Procedures required by the trial were described as ‘daunting’, for example, understanding the requirements, completing training, securing research passports, and data collection and recording: *the amount of paperwork and record keeping was unbelievable (Programme manager)*

There are so many of those procedures to follow and its discomfort rather than discontent. [...] ... people were just out of their comfort zone and then that that always makes people a little bit nervous (Programme manager)

The provision of external research training and support from British Red Cross was an important aspect to enable staff to understand and undertake the duties of the trial: *I had all the training that was needed and I felt ready to go as soon as we had the envelopes and the PIN numbers (Link coordinator)*

The staff, myself, we have to do more training, but fair play to [name] University and everybody else and the people in Red Cross, they were brilliant and it was quite smooth (Programme manager)

I felt I couldn't wait to get my teeth into that side of it. I found it really interesting to have to go through [the process] and get an honorary research, passport and be a principal investigator. I thought it was fantastic. I was taking a lot from the whole process so I was a bit disappointed when it came to an end (Programme manager)

The conditions imposed by the research trial on the delivery of the service had raised concerns amongst staff. In particular, being unable to provide the service to clients unless they agreed to the trial, coupled with its waitlist design felt at odds with the ethos of the British Red Cross: *We don't like to see people suffer or struggle in anyway, and so if they came out as a waitlist, that was kind of went against the grain (Link coordinator)*

I think the biggest thing for us was the fact that we couldn't support them [clients] if they didn't agree to go in on the trial because you had to have their permission and they had to have agreed to go on the trial and everything else [...]. That sort of went against everything that we understand that Red Cross would normally do. We support people in a crisis we don't actually say ‘well, because you won't do this you can't have that’ (Programme manager)

...our stumbling block was having this kind of wait period and initially we'd get a referral and we'd want to act straight away rather than having to wait, so for us that was a bit of a 'ooh' and something new for us (Regional manager)

The trial 'didn't fully take off', yet early indications suggested the four-week wait period was not considered too much of an issue by clients. Yet without the trial continuing, it was not possible to be certain about this:

...although we were starting to see referrals coming through, we were starting to see that service users were understanding that they'd have to wait four weeks and all those concerns we had initially about that four weeks, we weren't seeing when we started to take referrals on and then obviously the trial didn't continue. So who's to say it may have worked really well who knows (Regional manager)

Furthermore, for clients on a waitlist intervention: *We did manage to offer some low-level support through our other services if that was required (Programme manager).*

Finally, a regional manager reflected: *I think for us internally that was a big lesson not to be afraid to try something like that because it's not as bad as we thought (Regional manager).*

The Covid-19 pandemic led to the closure of the research trial and the removal of the trial conditions, including the widening of referral pathways, which had been seen as affecting the numbers of referrals received: *[closing the trial] allowed us also to widen the pool of people that we can support. (Regional manager).*

Other benefits of the trial ending referred to less time spent on administration: *We used to spend a hell of a lot of time on database work, so since the revamping of the study of the project where we've got a merged database now, so instead of filling in three databases, I just fill in one database (Link coordinator).*

– *Relationships with partners*

Referrers to the British Red Cross social prescribing service [primary care/GPs]

The challenge of securing on-going engagement and referral partnerships, particularly with GP practices was a consistent feature throughout the interviews with British Red Cross staff. Despite early preparatory work such as letters sent to surgeries, attempting to arrange meetings, and attending their multi-disciplinary team meetings, these challenges ensued and were attributed as affecting the numbers of referrals received by the service:

There had been a letter sent out in a couple of meetings, arrangement things, but there was very little in terms of engagement. There was one surgery who was referring and that was it. [...]. ...despite the massive amount of banging my head against various

walls, that never improved a huge amount. I think that's because we didn't get it right at the start (Programme manager)

The staff, like [name], was going to their multi-disciplinary team meetings and they were explaining, you know, what we do, what we can do, but the engagement from the GP's was very, very limited (Programme manager)

We spoke with certain number of GP surgeries who agreed to be part of the project and in the sense that they would refer the people to us identify people who could benefit from this support. [...]. I think we had four or five initially to start with and out of those four or five, I think there were two that never really engaged to any degree whatsoever. Afterwards, a further two engaged very, very modestly and it is only really one that continued to do that throughout continued to provide referrals throughout (Regional manager)

Factors thought to impede buy-in and engagement from GPs included:

- Time and capacity of GPs: *they're very busy and contact with them is extremely difficult (Programme manager)*
- Duties/tasks associated with the research trial: *there was this stumbling block of the clinical trial, some didn't want to be part of it (Regional manager)*
Every month they were supposed to provide data on attendance of the patients before the project, during the project and after the project data on social prescribing [...]. I think all of that was totally off putting for them (Regional manager)
- Delays in implementation (related to the research trial): *I can't remember how long but maybe six months or so in which there wasn't really anything to engage on, report back etc. So perhaps momentum was lost then almost (Regional manager)*
- Used to referring into other British Red Cross services: *one of our other services, the GP's automatically refer into, all the multidisciplinary team they refer through and so I think it's like breaking that (Programme manager)*

Further, responsibilities for GP practices to provide frequent attender criteria as part of the research trial, were thought to have been hampered by GP practices internal data systems: *We never really managed to get that attendance data from the surgeries to any meaningful degree initially at first one or two surgeries provided for a couple of patients and then stopped altogether. I'm not entirely sure why, but it would appear that attendance data isn't kept somewhere centrally or can be easily pulled out (Regional manager).*

On reflection, it was considered that well-established relationships developed prior to securing funding for the service might have led to a different experience with GP practices: *Most of those surgeries, we didn't have any pre-existing relationships with. It's only when we*

decided to go for this grant money and it needed to be done in real in together with the Primary Health that we went to them (Regional manager).

If we were doing it again, I'd like to do a bigger push with the GPs and sort of see right what's the issues were [with engagement]. [...]. I think going forward if we did have more funding, I think definitely GPs, yeah we would target them a lot more (Programme manager)

In contrast, engagement and buy-in from mental health teams was evident: *Engagement with the Mental Health teams has been fantastic. It has been really good and they have throughout the project continued to refer constantly significant numbers and they have been the ones that have been much easier to engage than GP surgery staff as in doctors, nurses (Regional manager)*

Promisingly, there were exceptions to the challenges presented above of positive relationships with GPs. For one link coordinator a two-way reciprocal partnership, supported by regular communication and feedback was advantageous: *I went to an MDM meeting in the [name] practice and then I got to meet community connectors, and [GP] who is really nice and approachable, and we've gotten a good working relationship. We tend to communicate, if we need to like keep them in the loop for whatever reason or if, for example, in the past a few of our clients have felt suicidal (Link coordinator)*

We had one particularly good relationship with [name] who was from the mental health team. But they moved to another surgery in the same area and we weren't able to use them because they wasn't one of our kind of regular referrers before we were permitted to open our referral pathways. Then when we were asked to start gathering information and names and things for these interviews and bits and pieces, they got back to me straight away 'I'm so disappointed I can't use you anymore, It was such a good service. I hope [link coordinators] are doing really well. I really love being able to use you. If only I could still use you (Programme manager)

Having an in-road or an established relationship within health was seen as an important factor to help engagement and buy-in:

We've got a team in the hospital and we were discussing it with lead nurses and they were saying 'oh that's great but you need to talk to so and so', and they put us onto whoever it was. To be fair to the Crisis Team, they allowed us to come and talk to them, tell them what we do and everything else it didn't take too long to do that. But again, we wouldn't have known if we had just gone cold calling knocking on the door, trying to email somebody who hasn't got a clue what we stand for anything else then it would be very difficult (Programme manager)

When referral pathways were opened up due to Covid-19 (see section below), one manager made a direct comparison to a new referral partner, who after an approach by the social prescribing service had welcomed the prospect of referring individuals:

I've had more contact and more questions asked and more referrals from [organisation] in two months of Covid, than I've had in 18 months of full service with the other GPS 'cause they really wanted to grab it and run with it (Programme manager)

Receiving and referring organisations [statutory, third sector and community]

Link coordinators had spent time developing partnerships with organisations to whom they referred to and received referrals from: *I know that they [link coordinators] definitely did build some good relationships (Programme manager)*. Subsequently, this has led to close working relationships: *We've worked really closely with [services we refer to] and there has been really good feedback back and forth (Link coordinator)*.

Communication [with referring organisation] has been really good and exploring ways to work together has been really good. The two-way contact, especially if one of the referrals come from a practitioner where the person being referred is still working with the practitioner maybe with CBT and stuff like that. [...] Its' has been really good to kind of coordinate the support for that person to achieve the best outcomes (Link coordinator)

These perspectives were echoed by organisations making and receiving referrals to/from the social prescribing service where reciprocal close partnership working was valued: *Quite often, our clients have extreme mental health conditions, agoraphobic or couldn't leave the house so they couldn't access advice from local drop-in services. So we would do home visits with [link coordinator] so we've been working pretty closely with [link coordinator] over the last two years (Receiving organisation)*.

They've [link coordinators] always been very approachable and their very knowledgeable, which is great for us, and we've just always had a really good rapport with them. [...] ...it's just been good to have people that have knowledge and know about the area that we're working in as we don't always have the same knowledge that they do. We always trust them to make the right decisions and they communicate well with us (Receiving and referring organisation)

Referral pathways between the British Red Cross service and partners were referred to as being effective and working well: *We've always had an absolutely brilliant working relationship. [...]. [Link Coordinator] always been very clear in what she's asking from us and has always been more than happy to try and get any other information if we need it. [...]. So absolutely very, very happy with the referral service and the way that we work together (Receiving organisation)*.

The referral process was extremely easy. I think it was a form and it was usually a preliminary email or call 'do you think this person is appropriate for you guys?', 'What's the wait time?', those kind of things. So I could then feed that back to whoever the service user was, and then it was just a form. A couple of times it might just be in a phone call, but generally a form or phone call. It was really, really very straightforward (Referring organisation)

One partner organisation made comparisons to other services they had worked with: *There's a couple of other agencies like [organisations]. But in all honesty, I find referring to them is a long process and the communication is not there and people receiving the service is not probably what I'd call ideal (Referring organisation).* Effective, close working partnerships were facilitated by trust, open communication and feedback: *I think in all honesty they're doing a fantastic job and the communication is fantastic, feedback is brilliant (Referring organisation)*

We've established a good working relationship in the last couple of years but what we have at the moment on both sides I think works really well and we've got a very open line of communication. [...]. We will normally let each other know, we might come back in a few weeks and say 'I don't know if you are still working with this client, but this was the outcome' (Receiving organisation).

– The impact of Covid-19

The Covid-19 pandemic led to adaptations to the service delivery model, namely a change from face-to face support to telephone support and the opening of referral pathways.

Telephone support

The move from face-to-face support to telephone support was seen as having advantages and disadvantages. Advantages included the ability to support more people, through time saved travelling to visit clients: *We've got scope to take on more clients. So for example, I've got ten clients on my list at the at the moment (Link coordinator).*

In a telephone conversation, even if it's a long one, even if you're talking to somebody for 45 minutes, that's still probably only half the time that you would spend if you drove to a service users home spent an hour with them and drove back, so that allowed us to see much more people. So that was a positive (Regional manager)

When lockdown restrictions were eased briefly in 2020, face-to-face contact resumed, before reverting to a mixture of telephone support with some face-to face support: *I think we've got a mixture of face to face now and telephone support because I know we've got a couple of service users that are vulnerable. So therefore, there's a lot of face to face, there's a lot of telephone going on but there's a mix (Regional manager).*

Responding and adapting in response to the changing restrictions of the Covid-19 pandemic, and being able to support clients face-to-face was important:

The second we could go and do face to face visits we did because we thought it was important that service users, some of them would want this support physically. See somebody on the phones, this is all well and good, but if you're really struggling, sometimes somebody even in your front garden or going for a walk, that's important. I don't think there's a single other agency that I'm aware of that was doing that, they've been using telephone support all the way through (Programme manager)

The ability to be able to visit clients for the brief period in which restrictions were eased in 2020, was evident when link coordinators highlighted the value of face-to-face support from their clients' perspective: *We had to go to a telephone support system, which is alright, but it lacked in the intervention that we could have with clients (Link coordinator).*

I've done some of the [clients] feedback and the thing that was coming up on the feedback was mostly that they didn't feel that during the Covid that they benefitted as much as they would if it was face to face, but we can't help that. But that's the thing that's mostly coming up is that they haven't had that face to face (Link coordinator)

Beneficiaries of the service also commented on their experience of receiving telephone and/or face-to-face support. Overall, there was a preference for face-to-face support; however, beneficiaries expressed positivity in the support they had received, irrespective of how it had been delivered (discussed later in this section). Nonetheless, the first extract below notes a preference for telephone support and highlights the importance of client-choice in the delivery of their support (where this is possible and practical):

I didn't want to be breaking down and crying in front of [link coordinator] crying, so for me, it worked better not having to physically see them and it allowed trust to build (Beneficiary)

[Link coordinator] was really good when restrictions came back in, and I had regular phone calls but it wasn't the same [as the face-to-face] (Beneficiary)

I was really lucky; other support that was in place was online, so having LW come to my house was good. I would have been nervous about zoom and having support at home was more comfortable for me (Beneficiary)

Participant extracts below further demonstrates the value of offering flexibility in terms of how support is delivered, and the advantages of offering telephone support, particularly in rural areas:

What we found was quite a high proportion of our clients preferred to have telephone advice because it meant that they didn't have to leave their properties, or they didn't have to travel from regions because we live in quite a rural setting. [...] So it was easier for people to be able to get the advice at a specific day and time that they could and

that was convenient, rather than having to come in on days and times that weren't appropriate, which was what we were offering previously (Receiving organisation)

They [clients] were really happy with the telephone support [...]. They were quite happy to have telephone support a couple of days a week, just to check up that they were ok, if they needed any other information, that sort of thing (Link coordinator)

In the absence of face-to-face support, providing an option of online support was suggested: *Maybe a video call would have been an option, that's kind of like half and half then face to face, so maybe that would be a good option (Beneficiary).*

For staff, disadvantages to the move to online/telephone working were raised by one manager in the context of keeping colleagues 'connected' to one another:

....we're so far apart from all the people all the time. Having to try and keep people motivated and keep people feeling valued and keep people connected to each other has been really, really difficult. That challenge wouldn't have been there had we not been going through Covid (Programme manager)

Open referral pathways

The benefits of an open referral pathway were raised by one local authority partner organisation, who prior to the change had been unable to refer to the social prescribing service:

When we started speaking to each other, I looked at referring a family that I was working with to the British Red Cross but it turned out that it was in the pilot phase and there was only two ways to access that through primary mental health and a surgery within [area]. So it meant that we couldn't access that. [Post-lockdown] I had conversations beforehand with one of the workers there that would lead to a conversation where we were able to act as a sort of referral pathway service, then into the British Red Cross, which was helpful (Referring organisation)

This change had been especially helpful for the organisation, particularly given 'limited' existing provision for mental health support and wider services:

There's limited services around that sort of mental health support in that social prescribing area, and when we spoke to the workers there, it seemed really valuable service for us to be able to tap into support families. Also, because of the limited nature of wider services available such charity organisations and what not, to have that link and have additional place that we could refer into is really useful (Referring organisation).

The opening of referral pathways was referred to as resulting in 'more appropriate referrals': *We are getting more appropriate referrals and we are getting the referrals in and supporting the people that are in need (Regional manager).*

However, the widening of referral pathways had led to an increase of referrals being received to the social prescribing service and in some cases, the use of 'waiting lists': *When Covid started, we definitely saw an increase in general referrals (Programme manager).*

The waiting list and before Christmas, it was absolutely crazy. I mean my staff to be fair, the staff were just constant, they were shattered. I had to put a waiting list in place again [...]. We still have a waiting list, there is about four I think on the waiting list at the moment (Programme manager)

In response to the increased demand in the service, British Red Cross increased their link coordinator capacity, which was welcomed by staff:

Since we've expanded our referral pathway, we've had to employ a second link coordinator and now we've got a third in [area] cos we were able to source another pot of funding until March of this year. So we've now got three because we've just been inundated with referrals and we wouldn't have had that number of referrals if we hadn't have extended that referral pathway (Regional manager)

Although there is a waiting list, they [clients] are getting telephone support so they can speak to somebody straight away almost and I think that's working well. [...]. We're busier than ever at the moment so we just needed that extra support and we're working as a team to get everything done (Link coordinator)

Reflecting overall on the changes the delivery model as a result of Covid-19, one link coordinator commented: *It just it makes the job so much more difficult to do. We've adapted to continue and keep going but I don't think there's any element of it that is working better to what it would have done before (Link coordinator).*

Nowhere to refer to [shortage of services]

The Covid-19 pandemic was recognised as leading to an increase in clients support needs: *There's been a lot more support to do with things that they need in the home and finance as well as dealing with their ongoing mental health issues and trying to support them in how they manage those as well if they've got other issues on top, which has exacerbated their mental health (Regional manager).*

However, across interviews, a significant impact of Covid-19 was the closure of other organisations leading to a shortage of other services to refer clients onto, which created challenges in delivering the social prescribing service: *A lot of what you would have been able to put in place you can't put in place because they're closed or they are limited with what they can provide at the moment (Link coordinator).*

I think that the biggest thing and the change was when everything shut down the support groups [...]. Closing down groups, support and everything else, it's been really, really difficult, and I think that's been the most difficult (Programme manager)

The closure of other services was attributed to a breakdown in communication with some external services: *...that communication with external services as well because the breakdown especially over Covid has been phenomenal. People with mental health issues, if one thing starts to go wrong, they just start, they start shutting down and then withdrawing and then they are not getting the help and then they just end up you know, spiralling downwards (Link coordinator).*

As highlighted above and in the following extracts, the closure of services and community groups was seen to have a negative impact on clients and link coordinators: *I know the link coordinators have found that very exhausting and frustrating and then they've seen a deterioration in their services users' mental health because of that (Regional manager).*

Covid has spoilt it all, if it wasn't for lockdown, I would have done other things with BRC. Subsequently, this had meant that: I went back into myself, not wanting to go out. If face-to-face had happened such as having to go to appointments, that would have pushed me to go out, but it's been too comfy, doing everything over the phone means I haven't had to go out so it's enabled me to stay in and not go out (Beneficiary).

...because of the way they [other organisations] had to change has unintentionally pushed a lot of people who would struggle away. They've kind of pushed that group of people away because they don't understand the change, or they're not that confident on the telephone. [...] There are a lot of barriers, so it's been mostly helping service users to overcome those barriers and kind of navigate this new way of working. So that they can then feel comfortable then to carry on themselves (Link coordinator)

We were getting them [clients] out and about and then Covid kicked in, it went right back to the beginning and they were all anxious and, you know, fearful really cos they didn't know what was Covid was or what was going to happen. A lot of them were on their own so it was like you had to sort of start again with them (Link coordinator).

As a consequence of other services closing, support provided had largely offered practical support and access to services such as local authority housing, and the Citizens Advice Bureau: *It has been really difficult not having those other avenues. The support groups, you know, those things that really can make a difference to them (Programme manager).*

In some cases, not having services to refer onto meant clients being supported for longer: *Some of the people we started to support, and we were still supporting when Covid started, because we weren't able to deliver a full service we were keeping them on for longer so the turnover of people we were supporting has been slower. So whereas you provide support to somebody for 12 weeks, it's a bit longer now because we might be the only source of support that person has got (Regional manager).*

It was felt that the lack of community and third sector services to refer onto or support the client to access has impacted the ability to undertake meaningful work as part of the social prescribing service, such as the 'what matters' conversations:

...the problem we've been having is these conversations talk about three goals as part of the 'what matters' conversations. [But] you can't even go to the library to get a book that you need, or you can't go there because you need to set an email address up maybe, or you can't go to a local class that's at one of the community centres or something like that. It almost becomes impossible to say any kind of meaningful. [...]. I know they've [link coordinators] been dealing with people who have been having some housing problems, but then it is just kind of, as I say, we've just turned into much more case of 'if you're vulnerable, what can we do for you'? (Programme manager)

Promisingly, despite these challenges, it was acknowledged that: *a lot of organisations are trying to adapt and change, and then we're trying to support people to be able to access them (Link coordinator).*

Post-lockdown and easing of restrictions

The easing of Covid-19 restrictions had led to an increasing availability of community support: *...more of the groups are opening up, the community connectors now are coming out and helping clients with groups (Link coordinator).*

However, considerable challenges were referred to including an increase in support needs, for example domestic abuse, substance misuse, and bereavement:

...after lockdown, we've seen such an increase in domestic abuse and family breakdowns. On top of that, a deterioration in physical health cos people haven't been going out or just generally not looking after themselves, substance misuse is on the increase, so yeah, it's really difficult to filter all the referrals we get in, to what we can manage and with the waiting list (Link coordinator)

...especially loss, you know, through grief and of course during this bad time of Covid, I've had quite a lot of people who've lost a member of in some cases two or three members with Covid and it just knocks them for six because losing one is enough but to lose two or three people in one go... (Link coordinator)

Yet, meeting clients support needs have been hampered by long waiting lists to access other services as a result of those organisations having been closed, restricted in their capacity, or continuing to work from home and only providing a telephone service: *...we'd done all we could with [client] in the 12 weeks. The case was closed but they came back to us because they'd just not heard anything from the majority of the referrals that we made. They're just on waiting lists (Link coordinator).*

...there's always been waiting lists and there's always been issues with people accessing services but there has been such a delay now because, to be honest the

majority of people that have been out especially last year when it all kicked off, the first people back out doing face to face visits were the third sector. [...] When it comes to more health side and statutory health, there's just been no visits, so there's just been such a huge backlog (Link coordinator)

...although everything is supposed to be now back to normal, there are still a lot of people working from home, which limits [clients] either if they make a call to the company to deal with something but holding on a long time [...]. ...and some of them will hang on because they really want to get the problem sorted and others put the phone down in frustration and they ring again maybe later that day or the next day and they find there's still whatever number in the queue and so they give up altogether (Link coordinator)

Long waiting lists were viewed as detrimental to link coordinators being able to fulfil their role and for clients to achieve their goals before their support ended: *We are in there to put interventions to improve that person or ease their stresses. But when all you can do is refer somebody to a service and then you've got to sit on your hands and wait and that referral is not picked up by the time you leave. So by the time my 12 weeks is up, you are kind of not reaching those goals or those interventions are not being achieved (Link coordinator).*

SOCIAL PRESCRIBING AND THE ROLE OF THE LINK COORDINATOR **(Addressing Q1, Q4, Q5)**

– Link coordinator role and skills

As part of their role, link coordinators perform a range of skilled tasks to effectively support the clients they work with: *it's basically whatever they need to make their life easier, is what we do, anything you know (Link coordinator).* At the core, is 'goal focussed' support and action planning:

[My role includes] arranging times to go out and meet them, supporting them to attend groups, appointments, helping them with paperwork, helping them with communication with accessing other services like CAB and depending on what their needs are. It's a goal focussed service so at assessment we have that conversation with them to see what it is, what stresses or struggles they are having, immediate ones that are impacting on their mental health and then try and set a plan of action to help them access ongoing support to help ease those stresses (Link coordinator)

The role and skills of the link coordinators within the social prescribing service was highly valued by senior and local managers, and beneficiaries: *I think the support and that they [link coordinators] give to the clients is amazing. The staff I got working on that team are brilliant. They would go twice the extra mile, they're really good (Programme manager).*

The provision of holistic, person-centred support was viewed as especially important:

They [link coordinators] look at the whole, they look at the person, they look at the whole surroundings, their whole family as well and things that you know where they can support [...]. ...it's about looking at the holistic picture, working with them and they are at the centre of our support absolutely. But if there are things that come to light that can support that person by doing that and getting whether the family get extra benefits or whatever else, then that's what they do. So it's an excellent all around, support, holistic support but person-centred as well (Programme manager)

Beneficiaries repeatedly referred to the support provided by link coordinators and expressed significant importance to their role in helping to make a meaningful difference to their lives: *[link coordinator] has been such a huge piece of my life (Beneficiary).*

The day [link coordinator] contacted me I was still very, very suicidal. I didn't hold much hope of them being able to do anything. I had a very negative outlook on what BRC could do for me. But within an hour of them arriving, my whole life had been turned around (Beneficiary).

[Link coordinator] communication skills were excellent, they had a calmness on the phone which gave me confidence that things can change and go in the right direction. They gave me hope that things might start to change (Beneficiary)

Key skills and aspects of support from the perspective of beneficiaries included:

- Developing trusting, reciprocal relationships: *I bonded with [my link coordinator] straight away, it didn't take weeks or weeks to build up trust*
- Feeling listened to: *...they don't offer solutions, but listen to me*
- They showed me respect, dignity, and empathy
- Providing a safe space: *...they just let me talk, it felt safe, and I knew she'd help me. Sometimes it was just to listen, [link coordinator] might be the only person I'd see that week. They never pushed me, it was all in my own time and I felt comfortable*
- Providing reassurance: *I was struggling at the time, I'd left home, wasn't working and it was nice to be able to talk to someone and have someone there for me*
 - *[that first phone call] was a very reassuring conversation, [my link coordinator] advised they were independent from other services, and everything would be in confidence. It was a scary time, and they was very reassuring from the first phone call*
- Shared problem solving: *On that first visit, every problem I came up with they said 'we can sort that', they turned on the light*
- Knowledge of other support: *The link coordinator I had was absolutely phenomenal, any problem I mentioned they knew what to say, how to say it, who to put me in*

contact with. [...]. They knew their stuff and within 10 minutes had told me more than what my GP, specialists or other organisations had

- **Reliable:** *...they would always ring on time or let me know if they couldn't make my appointment to re-arrange [...]. I had trust in them, they were reliable*

For link coordinators, balancing client dependency was sometimes a 'fine line': *... a lot of people have found the 12 weeks, they feel is not enough support. But there is a fine line in becoming independent and dependent on us really (Link coordinator).*

Some beneficiaries and partner organisations also commented on the length of support. For example, clients recalled experiencing feelings of apprehension and anxiety ahead of support ending: *I was starting to get a bit anxious; the fact the service was coming to an end (Beneficiary).*

I cried when it came to an end, I dreaded the day it came to an end, I felt nervous and on my own in the world (Beneficiary)

...the feedback I get in general that has been provided by BRC has been really positive, you know, and the support has been very empathetic and sympathetic, and there's been some really positive outcomes. I think if anything people can be a bit dependent upon that after a while and it is difficult to sever those ties (Referring organisation)

An important feature attributed to effectively managing this aspect referred to client feedback of the support received, trying to ensure follow-on support is in place, and being transparent with clients from the outset of support and giving them a reminder towards the end: *I was told at the beginning and the 10th week when support would be ending (Beneficiary).*

They [clients] have all given feedback where they've said they have been very involved in making the decisions and they have liked that because going forward it would be them making the decisions so where [Link Coordinators] would share ideas, the service user would make the choices themselves and that's worked really well (Link coordinator)

They [clients] are usually quite sad that the support is ending. They know initially that it's only for 12 weeks and when I start, I usually work out the dates, a start and end date and when I go to visit them I say 'right ok you've got support up to, you know, the 12th of November, so let's see what we can do to get things moving in that time'. [...]. What we try and do is put things in place so that we come to an end, there's something else for them to carry on with, so groups or support or something like that. [...]. We do try to do that, we don't just leave them in the lurch (Link coordinator)

Link coordinators reflected on the rewarding experience their role offered as a 'main driving factor': *I find it really rewarding to be honest after we see the individuals achieve one of their*

three goals, or all of their three goals. So that's really nice and I would say that's the main driving factor for me (Link coordinator).

It's been a rewarding experience as well because you can make a difference, not in all cases but in a lot of cases you can make a tangible difference to people. Obviously, that makes you feel that you are doing something worthwhile (Link coordinator)

Time spent building relationships and trust coupled with effective communication skills enabled in-depth discussions and understand of the issues affecting clients: *...its only until you go out and start talking to these people that you actually find out what their issues and their problems are and what support, what help they need (Link coordinator)*

When we get the referrals through, on paper they look maybe low to moderate. But when you start speaking to the person you realise then that they've been in the system for like seven plus years and there's a lot going on (Link coordinator).

As part of the assessment through communicating with them and the general assessment, you'll find that 'Oh yeah, I do suffer a bit with anxiety', or 'Oh yeah, I had depression about two or three years ago, which kind of fluctuates'. So a key part of the assessment really is more listening as opposed to writing down on the computer or writing notes and really getting to know that individual (Link coordinator)

The role of the link coordinator was equally well regarded by partner organisations. Important aspects referred to their skills, the emotional support provided to clients, and regular communication: *We got regular emails from the guys just letting us know if they are finishing with someone or if something hasn't worked and we're not involved (Receiving/referring organisation).*

[Link coordinator] carried out a number of tasks, which provided benefit to the family and with them being able to attend the family home, their level of observation assisted our role during the lockdown as they could identify the relationship dynamics within the household (Referring organisation)

There's a lot of specialist skills as well like knowing what type of support each individual needs and liaising with social care and NHS is not easy for everybody. I think with that as well is very invaluable really (Referring/receiving organisation)

[Link coordinator] was very approachable and very knowledgeable... [...]. That kind of joint working and then [Link coordinator] was very much available via email and telephone and they would attend our handover. [...]. They would attend the handover and the first thing that we would do would be to discuss the people that were under the scheme and the social prescribing, to give us an update (Referring organisation)

The link coordinators knowledge of existing support was particularly important and they were described as a 'vessel of knowledge': *The knowledge that their link workers have been*

able to sort of come up with, you know, all these local support services, that's invaluable. really. There are so many little services that you don't know out there and it can be just right for somebody and it can be hard to find them to contact (Referring/receiving organisation)

Being in a statutory service you don't quite know what's going on but that you know BRC, certainly the people I worked with they seem to be really tuned into everything that was available in in the rest of the third sector, which is really helpful. They do seem to be a sort of resource in themselves really, a vessel of local knowledge and awareness of what is out there (Referring organisation)

...you pick up different contacts and you know where to refer and what to do. I think that really helps, you know, having a massive phone book of contacts and knowing where to refer, what to refer. I think its experience really, as well as knowing (Link coordinator)

The time offered by link coordinators, to sit down and talk through and have discussions with clients, and understand their issues was a resource often unavailable to partners: *We are a short-term service, we're limited to what we can offer and what we can do. It's been really useful to be able to refer them to the Red Cross to find out what is out there for individual people and make it a bit more person centred, because it's not something we do (Referring/receiving organisation)*

I think one of the valuable elements of it [the service] is the element of time and ability to have a conversation about what it is that somebody's feeling and wanting at that moment in time. How it was described to me when we first got involved was very much 'we've got the time to go in there, to sit down, to get to know these people, get to actually understand their world a little bit, and walk in their shoes to a certain extent'. So there's an element of trust being able to be built of which sometimes is missed. I think that when you're looking at mental health and sort of those deeper-rooted issues. It's very difficult to challenge or change those things on a on a tokenistic offer without getting to know people without people and being fully appreciated and understood (Referring organisation)

– Training, development, and support

Link coordinators were recognised as often supporting clients with complex and inter-related needs: *We were seeing referrals come through for people that had really high levels of complex mental health needs, we are still seeing some of that, we are seeing more suicidal ideation now, a lot more of that (Programme manager)*. This experience was echoed by link coordinators: *The nature of the people we supported in terms of the complexities that they've come to us with has been challenging (Link coordinator)*.

Sometimes, after the crisis team, you're the kind of the first person they speak to, they're still on the waiting list for their specialist therapies and you know they still

waiting to be seen by social services. [...]. It can be quite intense at times (Link coordinator)

...we do tell people that we only work Monday to Friday 9 to 5 and that we are not professionals in the field of mental health because a lot of the referrals that come through are quite complex, you know, comorbid diagnosis, health conditions, topped with like PTSD, long term depression, anxiety (Link coordinator)

Acknowledging the need to effectively support link coordinators within their role, training plans had been developed as part of the early design of the social prescribing service. As the service developed this had included sourcing specialist training from a partner organisation:

In the planning and design, we listed that they [link coordinators] would need to have and then any other relevant training identified we would put them on. [...]. I think they've had all the training that they've needed now, they've certainly not said 'oh we've come across this and we need to have this training', not recently anyway. If they've done that in the past we've sourced it for them, either internally or externally (Regional manager)

The [external organisation] have done so much free training for us on all aspects of mental health services. You know, schizophrenia, suicide, the law and they have done zoom training sessions for our teams throughout this and they are, they are, I have to say that they've been brilliant (Programme manager)

However, one link coordinator felt more training, particularly around mental health, would have been beneficial: *I think I would have liked at the beginning to have had or spent some time at [organisation] just to sort of do a bit of training. I mean cos I haven't actually had any sort of experience of mental health before this (Link coordinator).*

Link coordinators also referred to independently sourcing training to 'upskill' and 'adapt', in order to meet the complex needs of their clients:

...the referrals that are coming through they are still very much the same and the same complexities, the same issues but I think, especially over the last year what has happened I think as a team, each link worker has developed themselves to be able to better support those people. [...] ...we have been logging ourselves onto courses internally, externally to be able to deal with the issues that we are seeing on these referrals. [...] So the complexity of the referrals into the service has remained, possibly sometimes, especially with the risks involved in some of them, gone a bit higher but we've adapted to be able to meet that... [...]. ...we've had to upskill and adapt to meet that, otherwise we'd just be turning them all down (Link coordinator)

As well as training, support for link coordinators included, clinical support from the MHCT, access to psychosocial support (provided by British Red Cross), regular one-to-one supervision, and more recently, a monthly team meeting to: *...discuss any issues or anything we suggest. So for the group, our team to share best practice, share ideas (Link coordinator)*

They have team meetings, they have one to one supervisions regularly and they support each other and they've a psychosocial support line that they can ring 24/7 (Regional manager)

[The team] keep in contact together on a regular basis, I said to you before probably once every at least a fortnight if not before [...]. I don't feel out on a limb if that's the right word, I feel I've support out there if I need it, it's there and [manager] is always available to talk things through (Link coordinator)

A link coordinator referred to the benefit of being able to access psychosocial support: *to be able to have a check in session and then we do it once every couple of months with somebody who is trained so we could talk through what we've been doing or what has affected us our own mental wellbeing is really important. [...]. The check-in sessions with the Red Cross have been amazing and they've been really worth their while (Link coordinator).*

THE ROLE OF SOCIAL PRESCRIBING AND THE BRITISH RED CROSS MODEL (Addressing Q4, Q5)

- *Benefits and Outcomes of the British Red Cross social prescribing service [clients and partners]*

The positive impact of the British Red Cross social prescribing service was referred to for both clients and partner organisations: *I get regular text messages and stuff from clients and stuff saying 'oh God I don't know what I'd do'. You know, 'you just put me in the right direction and my life has changed for this' and thank you cards, we get thank you cards as well (Link coordinator).*

Beneficiaries

The types of support provided by the service that mentioned by beneficiaries included practical (e.g. housing and benefits applications, food parcels, collecting medication), and emotional (e.g. reassurance, guidance, goal setting) and linking clients into other services and local community groups.

[Link coordinator] would give me numbers that I could contact so if there was other services I needed, I can't think off the top of my head what they were, but they had knowledge of other services that I could tap into if I needed different things (Beneficiary)

[Link coordinator] helped me with solicitors' letters, council tax, practical support, and put me in touch with [organisation] to help me to learn to stand on my own two feet (Beneficiary)

As well as the significant value beneficiaries placed on the support of link workers (referred to earlier in this section), equally, was the positive regard they held for the availability and British Red Cross provision and its impact on them, which was described as 'life changing' and 'lifesaving' by one beneficiary.

...it was a really positive 12 weeks, it had a huge impact and it's been a huge part of my recovery (Beneficiary)

Clients supported via the service expressed experiencing outcomes including increased confidence, self-esteem, and wellbeing: *...at the start everything was negative, but now I feel a bit more confident about things (Beneficiary).*

[Improving my] confidence was really important for me. I was scared of everything and I came to terms with what happened to me. My self-esteem and confidence is a big thing. [Link coordinator] offered to go to appointments with me and also supported my partner. Also, through my link coordinator, I was educating myself on what had happened to my health, my mental health to understand what had gone on and that's something I've taken forward (Beneficiary)

My optimism has gone up, I didn't think I could get anywhere, it will take years to address my anxiety, but my optimism has improved (Beneficiary)

The stress has gone. I'm not back to normal life but knowing I've got support and an income, because before I had no support. There were options out there but the other departments and organisations that I'd been in touch with didn't seem to want to mention them (Beneficiary)

Echoing the above, of vital importance were the changes clients described experiencing in their mental health and wellbeing, which they attributed to the support received:

I don't know where I would have been mentally, yeah, I don't know where I would be mentally without that service. [...] I don't think I would have come out of it as well as I did if I hadn't had [link coordinator] to talk to. I know that sounds really drastic, but that's how that's how I feel. [...]. I think I would have been a very different person now and I don't think it would have left it being a good thing. It did make such a huge difference to me (Beneficiary)

Such was the value of support received, one beneficiary commented on their desire to volunteer and 'give something back': *I'm looking at volunteering for BRC to give something back, it's really important for me to do something to help them (Beneficiary).*

Factors enabling positive change referred to the use of a 'graded approach', allowing clients to progress at their own pace:

There was one person that I supported and who hadn't long had a stroke, they had right sided weakness. They struggled with their speech quite a lot, so we linked in with the [organisation] and they do communication groups with people in a small group setting. Then we took them to the group and then we found their self-being and self-worth and wellbeing improved overtime. Towards the end of the support, we organised taxis for [so they could go to the group themselves]. We used a graded approach, we took them step-by-step through the process ending up with them fully going and attending themselves freely without any support. So that was quite rewarding (Link coordinator)

Beneficiaries drew stark comparisons between the British Red Cross service and other providers, for example, having 'to fight' for support, and feeling let down and turned away: *[Previously] I've had to fight to for it, I've had to fight to get help (Beneficiary).*

I've gone to about three or four other people in different organisations and get the feeling no one cares, the only real support I was getting was from BRC (Beneficiary)

I didn't know where to go or who to turn to, everywhere I went for help I was told 'no'. It got to a point where I didn't have anyone to speak to and was at a loss about what to do. [...]. After they [BRC] got involved it became a lot smoother and all these doors seemed to open (Beneficiary)

Being able to rely on the support of British Red Cross was an important factor: *...there is a big difference, they are reliable, they don't cancel, they ring on time and it's all done so quickly. [Link coordinator] has never let me down once (Beneficiary)*

Partner organisations

Referring organisations also referred to the positive benefits the British Red Cross social prescribing service had on the clients they had referred. Aspects highlighted included the use of an 'enabling' approach, multi-agency working, practical support and the emotional support provided: *I know particularly one lady would say that it changed her life pretty much that support (Referring/receiving organisation).*

Generally, it [client feedback] was very much a positive, very much positive feedback. People really liked the contact. The speed of the intervention and the enabling that happens (Referring organisation)

...all of it [feedback from clients] was positive. Every person of those I referred, all of them gave me positive feedback, which included about the workers, they liked that they were approachable, all that kind of stuff, they were quick to respond and they made a difference (Referring organisation)

They [British Red Cross] offered emotional support and took on the role of referring to [organisation] for financial advice, housing support and linking in with health so that [client] was able to access the relevant appointments to explore their ongoing health complications. Without this, the client's wellbeing would have deteriorated further and it would have had a negative impact on their child. Red Cross were an absolute Godsend to my role, their support was focused on the needs of the client, this meant that I could focus primarily on what was necessary for the baby [...]. British Red Cross certainly made my role less complicated, and speaking to [link coordinator] about what each of us were offering meant that we didn't duplicate our work, which can sometimes happen (Referring organisation)

Those who had received referrals from the British Red Cross social prescribing service also described positive outcomes for clients:

We have dealt with some debt issues, so clients for whatever reason have found themselves in debt. We have been able to either negotiate token payments, more regularly we have used a detrimental health evidence form to supply to creditors to say that the client has mental health issues and ask for 'write off' of some of those accounts instead which have been successful numerous times. So we've had quite substantial amounts written off (Receiving organisation)

Link coordinators also described the feedback they had received from clients following referral to other services: *They've [organisation] have been a great help to some of the service users. [...].[they say] 'oh right that was fantastic, they helped me so much and I'm so relieved I can go to bed and I slept last night for the first time in days (Link coordinator).*

The beneficial impact of the British Red Cross social prescribing service itself was also a feature amongst organisations. A referring organisation referred to the service as providing 'an additional tool' to support clients: *[BRC] seemed ideal for the needs of the people that we're seeing. [...] ...having the social prescribing availability then meant that people who needed that extra intervention to just get things sorted and was really beneficial. So to one extent it offered you, I suppose almost an additional tool (Referring organisation).*

Other receiving organisations further highlighted the benefit of working in partnership with British Red Cross enabling them to support clients effectively, which was echoed by a link coordinator: *...there was some really positive ones [outcomes]. We've worked really well with [organisation] to help people get their finances sorted and we've managed to be that go-between for people (Link coordinator).*

It was definitely helpful from our point of view to have another agency involved and working very closely because they were able to be there on a regular sort of weekly basis. It meant that we had regular access to the client for information that the client wouldn't necessarily have given to us of their own accord, or wouldn't have been able

to engage with us on their own. You know, if they had quite high-level mental health issues [...] ...especially if the client didn't feel like they could come do it on their own, or if they weren't able to call agencies by themselves, or if they didn't feel like they wanted to do it with us (Receiving organisation)

– *Embedding social prescribing [including challenges]*

Despite the benefits for clients and partner organisations noted above, it was acknowledged that further work is required to embed social prescribing²¹, which included a need to increase general understanding and awareness of ‘*what social prescribing is and how it works*’:

Perhaps a bit more as we go forward, if the projects that are actually under this social prescribing service really step up to the plate and they can see it does work, then there's no reason why you can't develop further (Programme manager)

Beneficiaries reflected on a lack of awareness/promotion of the service: *I didn't know it existed, perhaps more advertising would be good to help others know its available (Beneficiary).*

There isn't enough awareness, you don't see anything in the doctors, I didn't know what it was before my GP referred me. It's important that anyone needed support knows about the service (Beneficiary)

In terms how well the British Red Cross social prescribing service had embedded within the areas they were operating, one manager attributed a lack of ‘*pick-up*’ from the local authority as being due to more familiar mental health services to refer to: *I wouldn't say there's been any real pickup from local authority for this work, no matter how much we push it. [...] ...for mental health it's mainly [organisations] those sort of things that they tend to go to for, so anything to do with mental health (Programme manager)*

Similar reasons were also attached to embedding the service within the third sector: *We haven't embedded ourselves within that sort of third sector as a go to as it were for the mental health services that we do. They know about it, but I don't think they you know it's like ‘Oh yeah, that's something, Oh yeah, I forgot about that’, you know (Programme manager).*

However, changes to how well embedded the social prescribing service had become were noted, which were recognised as a result of opening referral pathways:

It's [the service] getting more and more embedded, which is why I think it's going to be very difficult when they see it go. [...]. We have worked with [statutory service], we've had midwives now come into us. [...].because we've opened the referral pathway it

²¹ Within the two BRC team areas the services are operating

has kind of spread. We are getting more and more inquiries from within, like the statutory services. So I think it's quite embedded the services and of course some of these service users that we're working with as well they have social workers and they have support workers with other services (Link coordinator)

Finally, one link coordinator highlighted that social prescribing does not operate in silo, and its success is also reliant on the availability of other services in the community: *....you're limited by the services in the community itself. Building community resilience would be good, but you're governed by what's in the community to start off with (Link coordinator).*

Challenges associated to fully embedding the British Red Cross social prescribing service, and social prescribing in general included:

- Concerns from organisations about future sustainability: *Very often you will hear a comment from health or social services like 'what's the point, because you are here today and gone tomorrow'. 'If I start getting reliant on you, what do I do when you're gone tomorrow'? (Regional manager)*
 - *if it's a service that's just going to come and go within the year, why are they going to put that time and effort into listening properly or using it when it's not going to be there? Trying to integrate yourself as a service into statutory NHS and social care takes a huge amount of time and huge amount of effort to build that trust with them and then you come to the same conclusion, you know, it's going to be ripped away (Link coordinator)*
- Short-term funding arrangements: *Although this project has been longer than most, being three years. But usually with shorter periods than that it's just not long enough for everybody to become aware of the benefits and actually have first-hand experience of the benefits it has (Regional manager)*
- The time taken to fully establish and implement the service: *a three-year contract is not long enough... [...]. It's a difficult service to set up, it's a difficult service to gain confidence and respect for and the community, so set up takes an awfully long time. We weren't supporting the numbers of people that we should have been supporting or could have been supporting because of the set up, so you know, to see the impact and benefits of the service it needs to be a lengthy contract I think (Regional manager)*
- Duplicate/similar services: *there were community connectors employed by [LA] and they kind of do very much similar role to be honest as the social prescriber with the linking of people in with activities in the community (Link coordinator)*

Yet, with regards to similar service being offered by community connectors, differences were highlighted: *The community connectors were good, but the only thing that makes us*

different from them is I would say we're more client centred and more holistic (Link coordinator).

I think the difference with this service to what they [community connectors] do is the length of time we can take and the practical support that is given and the fact that we have been working with those intensity users (Link coordinator)

SUMMARY – RECOMMENDATIONS FOR THE FUTURE OF SOCIAL PRESCRIBING (Addressing Q3, Q4, Q5)

Reflecting on the future of social prescribing, several recommendations were offered by British Red Cross staff:

- Ensuring the ‘buy-in’ of all stakeholders ahead of commencing delivery: *Ensure that all your stakeholders are on-board before you actually roll it out. We thought we had everybody on board in the beginning and it turned out that perhaps we didn’t (Regional manager)*

With the exception of one example, challenges to secure the buy-in and engagement of partners, in particular, GPs were a central feature in interviews with staff that were highlighted as affecting the number of referrals received. Issues were also noted in general engagement with the service overall, for example, low attendance from referring and receiving organisations at the projects steering group.

- Well-funded, reliable, and sustainable social prescribing services.

The need to ensure that social prescribing is well funded, reliable and sustainable was seen as an important aspect to address what was described as a ‘massive need’ and help to fully embed social prescribing:

If we could get it [social prescribing] right, we could take a massive pressure off the NHS. [...]. There's a huge opportunity and there's a massive need. But I don't think anybody will find the kind of money that would be needed to really do it properly. (Programme manager)

Short-term funding was considered problematic; limited to address immediate needs, rather than ‘systemic need’ or offering ‘sustainable solutions’:

[short-termism] is no way to fund any sustainable service, perhaps it addresses an immediate need, but it doesn't really address any systemic need. It doesn't really make any systematic solutions or sustainable solutions, so I would say not short-term funding definitely (Regional manager)

Partner organisations and beneficiaries reemphasised the issue of short-term funding. A reliance on third sector services which then close due to loss of funding negatively affects

trust, relationships, and continuity of support: *...just when you think you're getting help, it goes. You start to feel hopeless, that you're not worth the effort. You think it's going to change but that gets ripped from underneath you, you start to give up (Beneficiary)*

I've been in statutory services quite a long time I think we're always mindful that any third sector organization could suddenly disappear. [...] ...sometimes you can have a relationship with somebody and then you don't need to talk to them for six months and then they've suddenly disappeared. You know, and you didn't know about it or it's because they've run out of funding or whatever (Referring organisation)

- A 'scaling up' of social prescribing

Increasing the scope and reach of social prescribing services, was viewed as an opportunity to support more people and develop effective referral networks:

They shouldn't think about it [social prescribing] as within individual health boards. They should think about it as a far bigger larger scale project than that, because if we do what we're talking about now and support a handful of people, we're never going to get anywhere with it. So really, a scaling and then from there that will allow us to build the right referral network and it will allow us the time to work properly with service users (Programme manager)

- Co-producing future social prescribing services

Co-developing and designing social prescribing services with stakeholders (organisations and clients), was proposed as a means to utilise the skills and experiences of stakeholders, and build strong partnership working.

I think coproduction would be massively important to getting this service right because we're relying on the local community in terms of who we refer to and who helped you and how we link up with each other. [...]. I think it's important that those people with lived experience are involved in the kind of design and running of the service, particularly something like social prescribing (Programme manager)

- Holistic/shared delivery of social prescribing services

Shared responsibility amongst statutory (health and social care) and the third sector to promote and deliver holistic social prescribing services and aid partnership working amongst these sectors was offered as a means to increase stakeholder engagement and buy-in.

Given the difficulties we had in engaging with getting the GP surgeries engaged, perhaps the funding needs to, even if it's with the third sector organisations, it needs to be sort of more of a holistic thing involving health, social care and the third sector,

which is really what the Social Services and Wellbeing Act says and the Future Generation Act says, but we're not quite there yet (Regional manager)

A referring partner, who raised the question as to where social prescribing might be best placed, echoed the above sentiment:

We are reactive naturally, we go to the situation we put something in. There is a reaction to it rather than a sort of preventative measure. In a sense, it is preventing escalating further again, but at the same time, where is it best accessed? If a service is based within a preventative area, then it can still be accessed half the time by statutory services or that higher tiered surface, like a GP. They can always say 'well you can go to here for this', whereas you can't always get that from the GP (Referring organisation)

CONCLUSION

This report has presented primary data collected from the Process Evaluation, and the Outcome Evaluation:

- Link coordinator reflective diaries
- Outcome service data
- Interviews with stakeholders of the British Red Cross social prescribing service.

In this concluding chapter, findings are framed using the four questions of the re-programmed evaluation, and end with question five; *What conclusions might we draw from the implementation phase?*

1. WHAT CAN WE LEARN ABOUT THE DELIVERY OF THE SOCIAL PRESCRIBING INTERVENTIONS FROM THE EARLY IMPLEMENTATION OF THE BRITISH RED CROSS SOCIAL PRESCRIBING SERVICE?

- *How did the project teams plan and prepare for the delivery of the service from the outset?*
- *How did the wider context affect the project?*

Taking the three questions together, findings show that much work had been undertaken to plan and prepare for the implementation and delivery of the British Red Cross social prescribing service. Activities included:

- Early preparatory work to understand the local context of the areas to in which the service would be delivered from, identifying *'where the needs were'* through utilising available data, e.g. service data, NHS Wales, Welsh Government, the Welsh Audit Office.
- Joint meetings and consensus agreement between project leads in terms of the design and implementation (referral pathways, criteria, engaging with stakeholders).
- Establishment of a project steering group with internal and external stakeholders of the service, to discuss the project and its progress.
- Development of the job role and remit of the link coordinator post, including training/induction, provision of a supportive environment, and link coordinator recruitment.
- Developing understanding of the requirements of the trial (in discussion with WIHSC).
- Developing partnerships with referrers and receivers.

- Spending time meeting primary care staff, such as GPs etc. to agree referral pathways and encourage the referral processes.
- Work to develop accessible networks with statutory, third sector and community services.

Overall

- The role of the link coordinator is a core component to the model and its delivery. The development of training and induction at the outset of the project has supported link coordinators in their role, allayed anxiety, and provided a positive role experience. Training programmes are not static and evolved to source additional training as the project has developed. Link coordinators valued features such as access to clinical and psychosocial support, and regular supervision.
- The criteria to receive ‘frequent attenders’ had implications on the delivery of the service, with low numbers of referrals being received (see question three).
- Factors affecting the project primarily centre on partnerships in general. For example, securing attendance from referring and receiving organisations at the project’s steering group has been difficult. Issues also concerned referrals from the Welsh Ambulance Service Trust (WAST), such as incorrect referral information and referrals that did not fit the criteria for the service.
- Despite attempts to build and develop partnerships (letters sent to surgeries, attempting to arrange meetings, attending multi-disciplinary team meetings), challenges to secure the on-going engagement of stakeholders referring into the service, in particular, GP practices, ensued (see question two, and three).

2. WHAT WERE THE EXPERIENCES OF PROVIDING A SOCIAL PRESCRIBING SERVICE AS PART OF A RESEARCH TRIAL?

- *What impact did the development of the research trial have on project implementation and delivery?*

Impacts of the research trial on the projects implementation and delivery referred to throughout the course of this evaluation included:

- Time taken to secure the required ethical permissions from the USW committee and the NHS Research Ethics Service, to ensure compliance, led to delays in the project implementation and delivery.
- In turn, delays to implementation combined with the procedures associated to operating the trial were attributed to hampering the buy-in and engagement with GPs, which in turn was seen to affect the numbers of referrals received. For example, the duties and tasks of the trial itself and the expectation for surgeries to provide regular data.

For British Red Cross staff, delivering the trial meant gaining understanding of the duties and processes required. It also meant being responsible for data collection and site file management; tasks that were described as ‘daunting’. Preparatory activities included revising paperwork, undertaking training e.g. GCP and securing research passports.

Overall

- Given the range of duties and tasks associated to the trial, the provision of internal and external training to support staff was an important feature.
- Concerns raised by British Red Cross Staff relating to the waitlist design of the trial and its potential impact on clients, were not realised. However, given the short period of the delivery of the service in combination of operating the trial, it is not possible to be sure of this.
- The closure of the research trial (due to Covid-19) and removal of its conditions, resulted in opening referral pathways, which led to an increase in the numbers of referrals, received.

3. AS THE SERVICE PROGRESSED BEFORE THE RESEARCH TRIAL, DURING THE RESEARCH TRIAL AND INTO THE POST-COVID-19 PHASE, WHAT LESSONS WERE LEARNED AND WHAT CHANGES WERE MADE TO THE SERVICE DESIGN?

- *What were the factors that influenced referral rates in the service?*
- *To what extent did the project reach its intended target groups?*
- *How does the original model compare to the adapted model that was delivered in response to the Covid-19 pandemic?*

Considering all of the questions above together, findings highlight that as the British Red Cross social prescribing service progressed from implementation to delivery, there were several ‘lessons learned’ and adaptations were made to the service design pre and post Covid-19.

Pre-Covid-19 pandemic, adaptations to the service design were:

- Expanding the remit from supporting ‘frequent attenders’ referred from WAST and GPs to included referrals for ‘non-frequent attenders’. This change was prompted through low numbers of ‘frequent attenders’ received by the service and recognition that there were numbers of ‘non-frequent attenders’ who had a ‘genuine need’ for the service.
- The source of referrals accepted by the service was expanded to include the Mental Health Crises Team. Referrals from GPs, and WAST had posed challenges:

- Low numbers of referrals received from GPs (attributed to the time and capacity of GPs, the trial, and dependency of referring into other British Red Cross services)
- Lower numbers of referrals received from WAST than had been anticipated, coupled with '*governance issues*' (during the research trial), incorrect referral information and inappropriate referrals e.g. level of client complexity higher than the intended target of individuals with mild/moderate mental health problems and/or emotional wellbeing disorders

During Covid-19 and subsequent restrictions, changes to the service model of the pandemic included:

- The closure of the research trial leading to the widening of referral pathways. The restrictions of the trial were seen as a factor inhibiting the amount of referrals received. This change resulted in increased numbers of referrals, and in some cases, the use of waiting lists.
- A move from face-to-face support to telephone support, and in some cases where clients were particularly vulnerable, a mixture of face-to-face and telephone support.

Post Covid-19 lockdown restrictions

- A return to face-to-face support.

Overall

- Good relationships with WG enabled '*responsive*' discussions to revise the original service design and adapt the model e.g. expansion to include non-frequent attenders, receiving referrals from the Mental Health Crises Team.
- Changes to the referral pathway to include the Mental Health Crises Team were highlighted as having '*much easier*' engagement than '*GP surgery staff*', resulting in increased numbers of referrals.
- Opening referral pathways was welcomed by referring organisations such as statutory services who had previously been unable to refer to the service.
- There were advantages and disadvantages reported in the move from face-to-face to telephone support. Time saved visiting clients enabled more people to be supported, however, telephone support lacked the '*intervention*' that face-to-face support offers. Overall, interviews with beneficiaries also expressed a preference for face-to-face support.
- However, the importance of client-choice in the delivery of their support (where possible and practical) was highlighted with some stakeholders highlighting a preference for telephone support and/or online support.

- The high level of client complexity (complex medical needs as well as complex mental health issues) that link coordinators often work with was a feature throughout the delivery of the service pre to post Covid-19, with the Covid-19 pandemic recognised as leading to an increase of clients support needs. This highlights the importance of providing a sustainable supportive learning environment but also raises questions about the intended remit of the service (and role/remit of the link coordinator) to support individuals experiencing ‘mild/moderate mental health problems and/or emotional wellbeing disorders’.
- A fundamental effect of Covid-19 has been the closure of, or limited provision offered by organisations that would usually receive referrals from the social prescribing service. This has created challenges in the delivery of the service (limitations to developing social prescriptions and the ‘what matters’ conversations, supporting clients for longer), and has led to a ‘*deterioration*’ of clients mental health.
- Whilst the lifting of Covid-19 restrictions has led to increasing availability of community support, ongoing challenges for link coordinators include an increase of client support needs, and long waiting lists to access other services that were attributed to those services either being closed or operating on limited capacity. Long waiting were viewed as hampering link coordinators ability to fulfil their role and support clients to achieve their goal within the timeframe of the provision.
- Changes to service delivery pre, during and post Covid-19 demonstrate that the British Red Cross Social Prescribing model is responsive and adaptable to challenges. The flexibility to provide a mixture of telephone and face-to-face support for very vulnerable clients and increasing link coordinator capacity to manage increased numbers of referrals are some examples.

4. OVERALL, WHAT WORKED WELL, OR LESS WELL, FOR WHOM AND WHY?

- Reflecting on the experience, how effective do you think the service model was?
- Reflecting on the experiences of the social prescribing service overall, what (if anything) could have been done differently and why?
- How well embedded in the social prescribing service alongside the health and social care system and the wider voluntary community sector in the two areas it is working in?

Taking into account all of the questions above, factors that worked well are:

- The adaptability and flexibility of the British Red Cross social prescribing model enabled the service to respond to various challenges throughout its delivery, for example:
 - The research trial e.g. responding to the requirements of the trial, training, securing research passports

- Expanding the referral criteria to include ‘non-frequent attenders’
 - Expanding the referral pathway (pre and during Covid-19)
 - Moving from face-to-face to telephone support, and a mixture of each where needed
 - A return to face-to-face support once Covid-19 restrictions had eased
 - The supportive leaning environment has evolved to the needs of the link coordinators e.g. sourcing of external training, monthly team meetings, and supervision
- The impact of support provided to clients through accessing the service, and the outcomes they have been enabled to achieve. Link coordinators, referring, and receiving organisations, highlighted benefits of the service for clients, such as increased wellbeing and being able to respond to new life challenges. These positive outcomes were echoed by beneficiaries who cited the significant value they placed on the support they had received and referred to experiencing aspects such as improved confidence and self-esteem, increased optimism and a better awareness of their mental health and well-being. Similarly, improved outcomes were demonstrated via the service data backed up by statistical analysis e.g. scores for all three measurements tools indicate improvements to clients’ mental health and well-being. The differences reported by participants against the validated tools (EQ-5D-5L and WEMWBS) across time are all statistically significant.
- A key feature underpinning the benefits experienced by clients is the role and skills of link coordinators:
- Developing trusting, reciprocal relationships
 - Communication skills
 - Demonstrating respect, dignity, and empathy
 - Balancing dependency
 - Providing reassurance and a safe space
 - Providing holistic support
 - Knowledge of other support
 - Use of a graded approach enabling clients to progress at their own pace
- For external stakeholders, the social prescribing service offered an ‘*additional tool*’ with which to support clients. Once more the role and ‘*specialist*’ skills of link coordinators, which were described by one partner organisation as ‘*invaluable*,’ underpinned benefits that were highlighted:
- The time offered by link coordinators to work with clients was a feature often unavailable to referring partners
 - Use of an enabling approach

- Established feedback loops and updates about clients progress
- Close reciprocal partnerships with effective referral pathways
- Knowledge of existing support

In addition, the move to open referral pathways as a result of the Covid-19 pandemic was considered particularly helpful in the context of *limited* existing provision for mental health.

Factors that worked less well were:

- The buy-in and engagement of partners, such as GPs. Despite securing early agreement with GP surgeries, with the exception of one GP surgery, this had not been realised and was attributed to the low numbers of referrals being received, which only began to change when referral pathways and the remit were extended.
- Similar issues of engagement with external partners' attendance at the project's steering group were also highlighted.
- Referrals were received to the service with a higher level of client complexity than the service was designed to support and there was some ambiguity experienced by link coordinators as to the level of complexity they should be supporting.
- The research trial (and its associated procedures) was seen as delaying the delivery of the service.
- The numerous changes brought about by Covid-19, resulted in difficulties such as not being able to engage and support clients as fully due to *'anxiety and medical conditions'*, limitations delivering the service, e.g. lack of services to refer onto or long waiting lists, an increase in client support needs, coupled with home working and difficulties for teams to stay motivated and connected.

Overall

- Strong working partnerships developed with all stakeholders, but in particular GPs, prior to securing funding and delivering the service, were thought to have the potential to offset some of the challenges encountered.
- It was felt that having a better understanding of the procedures of a research trial from the outset, would have allowed staff to feel more prepared.
- Whilst increased referrals to the service from the wider sector might indicate that the social prescribing service is embedding within the communities they are situated, factors relating to the impact of the Covid-19 pandemic cannot be discounted. Having an additional resource of support for their clients was referred to positively by referring organisations, who until Covid-19 had been unable to refer to the service. However, increased referrals could also be related to the limited number of services available as a consequence of Covid-19.

- Factors highlighted as limiting the extent to which the service embedded within their communities included:
 - Concerns about the sustainability of the service (and what happens when the service they become reliant on no longer exists)
 - A continued dependency of organisations to refer into other well-known mental health services
 - The time taken to fully establish and deliver the service (associated to the trial)
- It was considered that more work is required to embed social prescribing and facilitate better understanding of '*what social prescribing is and how it works*'.

5. WHAT CONCLUSIONS MIGHT WE DRAW FROM THE IMPLEMENTATION OF THE MODEL?

When considering all of the questions above (1-4), there are several conclusions that we can draw from the implementation of the British Red Cross social prescribing service.

The British Red Cross prescribing model was adaptable and resilient to change, for example, difficulties such as the initial focus on 'frequent attenders' and issues with referrals from WAST were recognised and responded to. This was supported by effective discussions with WG about these challenges. Further changes to the service delivery as a consequence of Covid-19 were also initiated. Whilst these changes have not been without their challenges, findings show there was the ability to adapt and cope with the changes needed.

There was considerable preparation and planning during the early implementation of the model including internal meetings to agree the role and remit of the service, and with external stakeholders to agree referral pathways. Despite frequent attempts of engagement and early agreement of 'buy-in' with GP partners, securing on-going engagement was problematic. In contrast, good working relationships were highlighted with the Mental Health Crises Teams, and organisations receiving referrals from the service. Preparation in anticipation of the research trial took up considerable time during the early implementation phase.

What is evident from these finding is that the role, skills and experience of link coordinators are a central feature of the model and its delivery. Link coordinators feel supported in their role via the suite of training, developmental and supervision that is provided. However, given the complexity and interrelated needs of clients they are supporting, considerations are:

- A sustainable supportive learning environment with multiple opportunities to meet their learning and developmental needs
- Clarification of the link coordinator role and remit with regards the level of complexity they should be working with

- Ensuring the referral criteria is at the ‘right level’ for the cohort the service is designed to support

There is more work to do to fully embed the British Red Cross social prescribing services within the communities they serve. Positively, there is evidence of increasing awareness of the service evidenced by the increasing numbers of referrals received from stakeholders, including statutory services. However, to what extent the Covid-19 pandemic might have also increased this number (due to the lack of availability of other services) is unclear. Restrictions to fully embed the services referred to include the impact of the trial, time spent setting up the service, and sustainability/reluctance for other organisations to become dependent on a short-term funded project.

APPENDICES

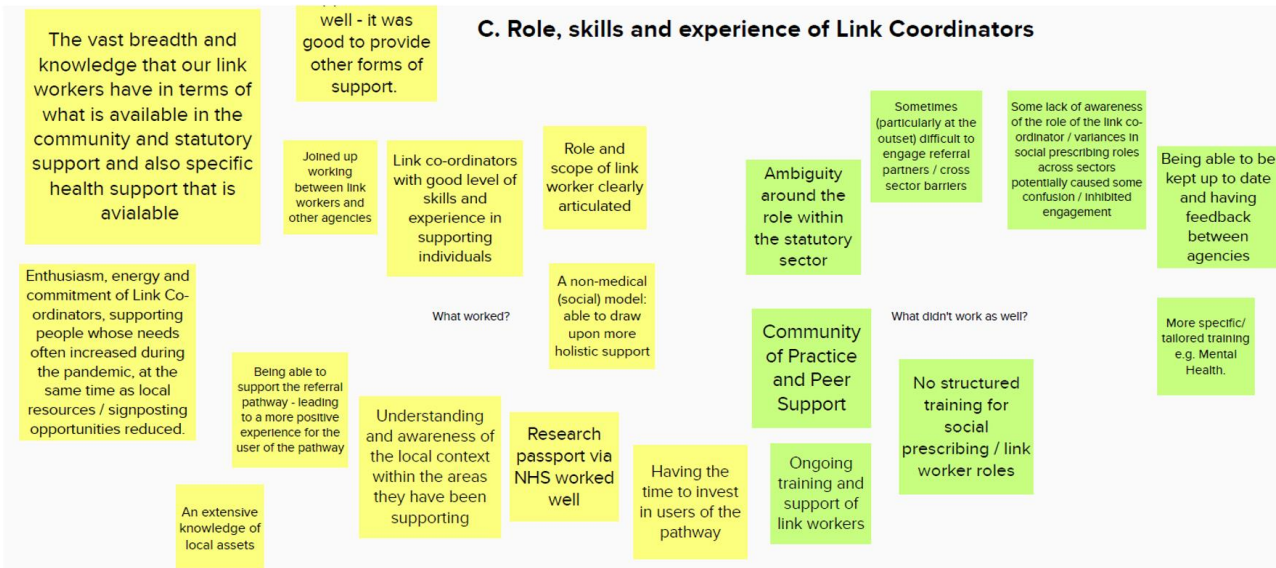
MULTI-STAKEHOLDER WORKSHOP



B. The impact of Covid-19



C. Role, skills and experience of Link Coordinators



D. Partnerships and engagement



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PROCESS EVALUATION QUESTIONS

1. What can we learn about the delivery of social prescribing interventions from the implementation of PROSPECT?
2. How did the project teams plan and prepare for the delivery of the service?
3. How did the wider context affect the project?
4. What were the experiences of providing a social prescribing service as part of a research trial?
5. What were the factors that influenced the referral rates into the service?
6. As the service progressed before the research trial, during the research trial and into the post-COVID phase, what lessons were learned and what changes made to the service design?
7. What impact did the development of the research trial have on project implementation?
8. To what extent did the project reach its intended target groups?
9. Overall during the implementation phase, what worked well, or less well, for whom and why?
10. Reflecting on the experience during the implementation phase, how effective do you think the service model was?
11. How does this compare to the adapted model that you are delivering in response to the Coronavirus pandemic?
12. Reflecting on your experience of the implementation of the social prescribing service overall, what (if anything) could have been done differently and why?
13. How well embedded is the social prescribing service alongside the health and social care system and the wider voluntary community sector in the two areas it is working in?
14. What conclusions might we draw from the implementation phase?

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

