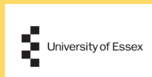
Toolkit for Social Prescribing: Lessons and Recommendations from a Cross-Sectoral International Social Prescribing Project



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How to use this Toolkit

For whom is this Toolkit designed?

This Toolkit has been created to offer guidelines as to how a social prescribing programme can be designed, managed, delivered, and evaluated. It is meant to be a resource for those looking to implement a social prescribing programme locally or in coordination across different localities.

The guidance offered here can serve as a reference point for individuals and organisations across a wide range of social prescribing services and communities. It should be useful to those considering adopting social prescribing, as well as those already delivering, and even those reflecting on programmes that have ended.

On what is this Toolkit based?

We describe activities that comprise the *Connected Communities* project, including planning, management, delivery, decision making, outcomes, and evaluation. We reflect on the challenges and successes of our cross-sectoral and cross-border collaborative efforts to implement social prescribing in Suffolk (lead partner), Kent and Medway in the United Kingdom (UK) and L'Eure in France.

The guidance we provide in this document are based on a variety of data collection mechanisms, including observation, document analysis, interviews, and surveys. We collect and describe this data to offer examples of ways of working across localities, as well as advice on how to navigate intersectoral, inter-authority, and international partnerships, and recommendations on coordinating different approaches to delivery across collaborators.

What is the best way to use the Toolkit?

Each section is meant to stand alone, such as an entry in a reference book. We give definitions in section **What is *Social Prescribing*?**, so if you are new to social prescribing as a concept, you may wish to begin here. The section **What is *Connected Communities*?** describes the Connected Communities programme in terms of reach and remit. Subsequent sections are aligned to components of social prescribing delivery that may or may not be relevant to you.

For example, the section **Ways of Working** outlines potential benefits of co-production in social prescribing and offers Connected Communities' partners' thoughts on its benefits and drawbacks. The **Volunteer Strategy** section details how different partners have approached developing a volunteer strategy, each method serving as an example of what an organisation may wish to consider when developing their own.

We suggest that you read through each section as you have the time or interest in it, and that you refer to it in the future as you consider your own social prescribing design, delivery, or evaluation.

What is *Social Prescribing*?

A definition of social prescribing

Social prescribing is an asset-based, collaborative approach to addressing health and wellbeing needs of a population through community-based solutions.[1–6] The model unites health and social care professionals, local agencies and organisations to offer a range of local, non-clinical services. Social prescribing delivery professionals are called various names, including social prescribers, link workers, community connectors and community navigators. These professionals receive referrals, and then work closely with individuals to identify a range of community services that could help improve their health and wellbeing.[7] Individuals can also self-refer.

Social prescribing seeks to address people's needs in a holistic way. Schemes delivering social prescribing can involve a range of activities that are typically provided by voluntary and community sector organisations, which provide a wide range of support for social, emotional or practical needs. [8]

The most recent definition that the experts in Muhl et al 2022[7] study agreed upon is the following:

> "*Social prescribing is a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections.*"

Social prescribing in the United Kingdom

As the social prescribing movement gained momentum across the globe, the need for an agreed conceptual and methodological approaches led to experts from 20 countries working together to contribute to the developments in this field.[7]

Figure 1 illustrates the some of the significant events in social prescribing in England since the 1990s until today. Social prescribing has been practised in some parts of the UK National Health Services (NHS) for decades. [9,10] In 2018, the UK government's Campaign to End Loneliness[11] announced its backing of the idea that social prescribing should be universally available. Early the following year, the NHS included social prescribing in its Long-Term Plan 2019 policy[12]. The NHS's commitment to personalised care meant that by 2024, 1000 new social prescribing professionals would be hired to facilitate more than 900,000 referrals to social prescribing programmes.

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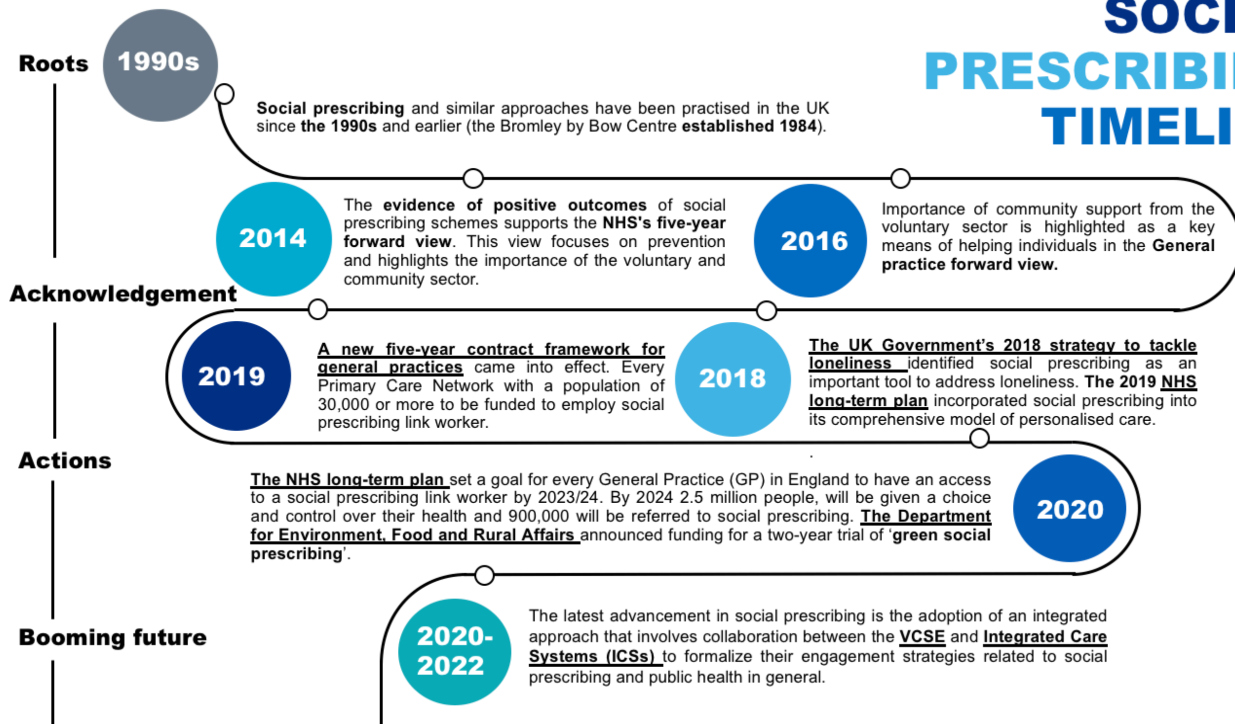

Figure 1 Illustrative timeline of significant events in social prescribing in England (1990s-2020s)

Source: Compiled by authors from multiple sources[8,12,13,14]

Since 2019, national NHS policymakers have committed to expanding social prescribing across England by investing in new social prescribing 'link workers' in primary care. GPs and other health care staff can identify patients who may benefit from non-medical support and refer them to a link worker. The link worker assesses the patient's needs, develops a plan to meet those needs, and supports the patient to access relevant social services, such as job centres or legal supports.[15,16] Some social prescribing models include co-location of health and social services. For example, in Derbyshire, Citizens Advice Bureau advisors are placed in most GP surgeries to help patients with social and financial issues.[17]

Social prescribing in France

In France, local authorities have made significant effort to prevent a loss of autonomy by integrating health and social care sector services.[18] The National Solidarity Fund for Autonomy (CNSA), since its establishment in 2004, has been leading the promotion of an integrated, person-tailored care model to support individuals to live independent and fulfilling lives.[19] The *évaluation gérontologique multidimensionnelle* (EGM—*multidimensional gerontological assessment*), an interdisciplinary diagnostic method, is used by local authorities, medical institutions and/or organisations in France to assess a level of fragility of elderly individuals and to develop a personalised health plan to address existing needs and reduce future health risks.[20,21] As a part of the EGM assessment, individuals are informed of the benefits of proposed health plan actions, expected positive changes in one's health as well as potentials to reduce usage and reliance on medical and social care services.[20]

Fondation de France, MONALISA and similar initiatives provide access and information needed to engage elderly in adequate social activities to improve their physical and mental and social interactions.[22,23] Despite significant steps being taken at the institutional and community levels, loneliness and social isolation are still a serious public health issue in France. May 2021 report by Luc Broussy, President of France Silver Eco and gerontology specialist, concludes that the levels of loneliness and social isolation in France are alarming, identifies a number of socio-economic determinants and proposes solutions to effectively tackle these issues.[24] The report emphasizes the loss of independence that comes with loss of personal transport and the adaptations that an individual and a community needs to consider to prevent mobility-related social isolation.[24,25]

What is *Connected Communities*?

Location

Connected Communities is a pilot social prescribing initiative implemented from 2019-2023 by four local authorities in England (East Suffolk Council, Suffolk County Council, Kent County Council and Medway Council) and one in Normandy, France (Department du L'Eure), and evaluated by the University of Essex (UoE; Figure 2). It is a cross-sectoral, cross-border initiative involving representatives from public health, public protection, and communities' teams, as well as service development teams, social care providers, and other local authority departments.

Figure 2 Connected Communities Partners: Geographic Locations

Funding and Remit

The Connected Communities Programme has been funded by the Interreg France-(Channel)-England scheme. It has been designed to deliver an innovative social

prescribing plus (SP+) project in which Community Connectors (Connectors/Link Workers) assist lonely and socially isolated individuals to re-connect with their communities and improve their health, focusing on people aged 65+ in England and 60+ in France.

Purpose

The fundamental purpose of the Connected Communities programme is to address loneliness and isolation among elderly individuals in the East and South of England and Normandy, France. Addressing loneliness has been part of the public health agenda in the UK and France since before the COVID-19 pandemic. Linked to numerous physical and mental health conditions, adverse effects of loneliness have been observed in educational, workplace and wider community settings. Loneliness is also linked to increases in health and social care usage due to increased mortality, blood pressure, depression, and anxiety, and decreased mobility and quality of life.[26,27]

Connected Communities takes mobility-related issues into account by visiting beneficiaries in their homes and communities, making this social prescribing initiative well-equipped to address this and other social isolation and loneliness risk factors. Connectors that visit lonely and socially isolated individuals provide one-to-one consultation to better understand needs and *what matters to a person*, with an aim to provide access to community activities and resources to improve one's health and wellbeing.[25]

Delivery Structure

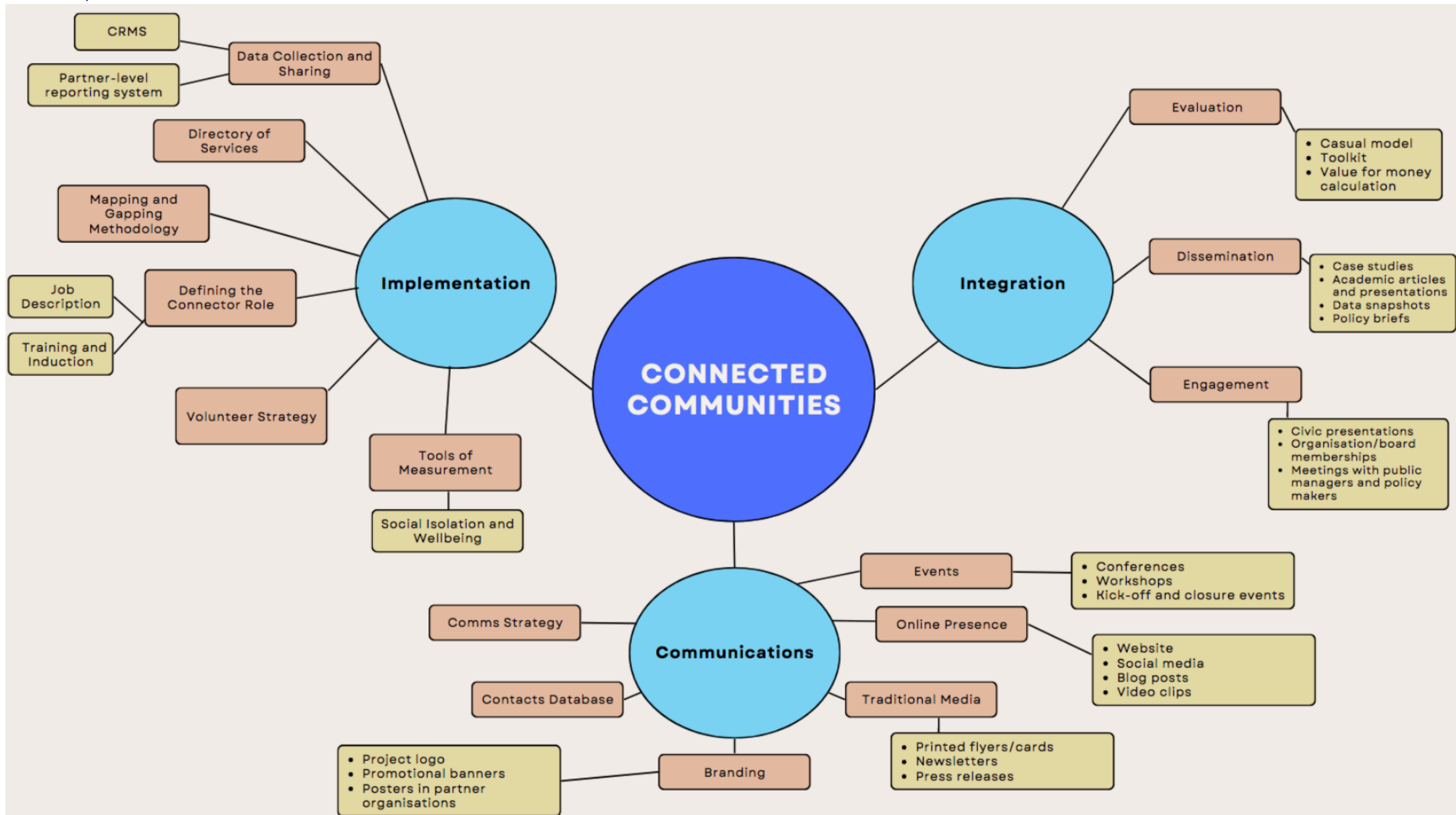

Figure 3 Delivery structure of Connected Communities

To achieve the intended outcomes, all aspects of delivery, as seen in Figure 3, need to be aligned and implemented in a timely manner to ensure programme success. Social prescribing programme delivery is a complex process, including various aspects of implementation, communication and integration. For instance, mapping and gapping of community needs and resources will greatly depend on the relationships that the Connectors have with the voluntary and community service enterprise (VCSE) sector, the extent to which information on services is developed and available in their community (Directory of Services), the systems available to collect, store and analyse outcome data, the communication channels and Connectors' experience utilising various media sources to promote their services, and the way in which programme managers disseminate findings and engage with other stakeholders in the field. All the decisions made at the delivery stage will impact evaluation and programme outcomes.

Intended Outcomes

Connected Communities is a person-centred social prescribing model, where the Connectors assist lonely and isolated elderly individuals to understand their needs and the resources that exist in a community to help them improve their own health. The aim is to positively impact individual health, health and social care usage and community engagement. Figure 4 illustrates how the Evaluation Team expect Connected Communities to achieve outcomes. This logic underpins the design of the ultimate evaluation of Connected Communities throughout the project.[25] [28,29]

By participating in the programme, beneficiaries are meant to become less lonely, more socially connected, and more trusting of others. As they improve their health and wellbeing, these individuals are less likely to rely on health and social care services and more likely to become engaged in community activities. The Evaluation Team then expect these beneficiaries, as well as other people living and participating in engaged, connected communities, to be less likely to feel lonely and more likely to be trusting of others.[25] Our Connectors focus on building supportive, trusting and strong relationships with beneficiaries, which enables them to discuss sensitive issues such as health, social relationships, housing or financial issues, all of which are linked to and contribute to feelings of loneliness and isolation.

Timeline

Connected Communities Programme delivery was scheduled to launch in March 2020; however, the COVID-19 pandemic caused significant delays. Some partners began delivery in June/August 2020, while others launched delivery in March and October 2021.[25]

Launching during the pandemic required significant changes in service delivery, shifting from one-to-one in-person meetings to employing digital means to engage and interact with beneficiaries during periods of social distancing. Since the launch, partners have engaged with numerous beneficiaries, community organisations and services to deliver the programme.

Following funder guidelines, all delivery of social prescribing services ceased no later than 31 December 2022. Since delivery ended, the partners have engaged in final data sharing, including contributing to this Toolkit, Final Closure Conference and the Final Evaluation Report.

Ways of Working

Co-production

Co-production is a way of working together to create a service or to come to a decision regarding the way in which a service is designed, commissioned, or delivered. The output of any co-production effort is meant to be a decision or a set of decisions which work for all involved to achieve a common goal or set of goals.

Co-production has been fundamental to the development and implementation of the Connected Communities programme. Local authority staff (programme managers, community officers) and the UoE team (research staff and academics) have been involved in co-producing the programme from the inception of the funding proposal to how to manage data, from service development to determining evaluation mechanisms, and from reaching out to new collaborators to disseminating insights.

Insights

There are many views on co-production and what it means in research and practice.[30–33] The Evaluation Team asked the Connected Communities partners to describe what co-production means to them. Here are some of their responses:

> "Engagement where everyone is included, information is accessible to all who are involved in co-production. Clear understanding of outcomes and ways to reach those in a collaborative manner."

> "Working with partners /to share best practice, learn from each other, have honest conversations to produce or develop a service or toolkit or whatever the deliverables might be."

> "Co-production addresses the intrinsic power imbalance that comes with service delivery. So often projects fail because they are ill informed on the reality of life for members of the community, they are good ideas but not the right ideas. That leads to trust breaking down as services don't meet the need as well as wasting scarce resources."

The overall view of the Connected Communities team members is that they have found co-production to be a positive experience. Most partners would like to be involved in a similar co-production approach again. One partner states:

> "Co-production means trusting that people know best how to improve their own lives, it benefits the organisation through lived experience which improves effectiveness, and it benefits the individual as it can increase confidence and build skills. I'm not naive, co-production is hard work and doesn't always work but the payoff is worth the risk!"

There is also awareness that co-production can be a costly and risky endeavour when implementing social prescribing. Partners acknowledge that COVID-19 emergence and a poorly regulated expansion of the social prescribing programmes across the UK has resulted in a less effective co-production experience. When asked whether being a part of the Connected Communities programme has affected their organisations'

costs, 2 partners indicate that costs have increased as a result of their participation, 3 report neither an increase nor decrease in costs, 1 reports a reduction in costs, and 1 is undecided.

Recommendation

Recommendation: Develop a strategy on co-production specifically in relation to social prescribing.

A co-production strategy is needed to have a greater understanding of the roles, activities and mechanisms for sharing the knowledge throughout the duration of collaborative social prescribing initiatives. With Connected Communities, community members were primarily consulted on the service delivery and community outreach. Community members were not formally involved in programme design or development, which partners found to be a drawback when it came time for engaging the community to co-produce delivery and outreach.

Multi-sectoral approach

Social prescribing requires multi-sectoral efforts and involvement to deliver a holistic, person-centred programme. In the UK alone, there are four sectors associated with social prescribing interventions. First, primary care general practitioner (GP) practices within the health sector are meant to be actively engaging link workers to accept referrals and work individually with people and families. Second, organisations in the voluntary and community service enterprise (VCSE) sector work individually with people and families and supply an array of innovative and engaging activities for them to access for support and connection. Third, social care services offer complementary support to vulnerable and elderly people and families by developing the market for social prescribing, by commissioning and funding community activities, and by supplying social prescribing via local authorities and/or councils. And finally, departments such as those dealing with public health, public safety, housing, and family services provide social prescribing as they seek to enhance the health of the population as a whole. These departments provide evidence on the position and quality of public health and fill gaps in the availability of services. One person might therefore encounter social prescribing via any one of these sectors, or via an integrated care system that combines these sectors to offer a holistic approach to care and wellbeing.[25]

To reduce future health costs a stronger focus on collaborative commissioning of services and interventions is needed which will involve the strategic promotion of mental wellbeing, mental capital, creativity, and resilience as outcomes. It is important to make connections with a far wider range of stakeholders than previous traditional health models have encompassed, and where partners might include community services, such as business, culture, education, and leisure sectors, in addition to local third sector and voluntary agencies. Through identifying local provision, community resources can be expanded and developed to address many social, health and wellbeing issues. Museums and galleries, for example, as community resources are well-placed to promote health and wellbeing activities in non-traditional audiences (Camic & Chatterjee, 2013) as are other cultural, arts, and environmental activities.

Insights

Medway Council approached working across sectors based on experience from previous projects. This partner held a social prescribing symposium in 2019 where 56 stakeholders discussed how to collaborate better. Participants created a 5-year plan to identify existing activity, aspirations, system dependencies, and risks. An ongoing forum was then formed to ensure services work collaboratively, to support frontline link workers/social prescribers, to identify new opportunities for social prescribing, to provide a space to share information and knowledge, and to receive peer-to-peer support and access training.

Medway have responded to this challenge by creating partnerships across health and social care services, commissioners, voluntary and community sector enterprises (VCSE) and others involved in implementing social prescribing initiatives. They have established a set of standards, competency and governance frameworks to facilitate social prescribing work in the region and to mitigate any potential risks to the providers and to the service beneficiaries (see Governance Structure, below). The network Medway have created has enabled them to be better informed about the wider context and to effectively respond to the emerging changes across the sectors.

Recommendation

Recommendation: Devote time to ensuring the delivery of social prescribing is coordinated across sectors, so as to make delivery sustainable and make outcomes easier to evaluate.

Despite the multi-sectoral approach needed to make social prescribing successful, the structures to track which agencies are involved in delivering a programme and their individual impacts on programme beneficiaries are not being examined and documented in a systematic manner. Dr. Kate Mulligan, Director of the Canadian Institute for Social Prescribing, agrees that such documentation is very much needed in the field of social prescribing.[34] Without it, we will not only remain unable to deliver social prescribing in terms of multi-sectoral coordination, we also remain unaware of whether social prescribing is actually delivering intended outcomes across sectors.

Evaluation

Although many people think of an impact or outcome evaluation as being the final element of a public sector programme, in truth evaluation should be an ongoing process that begins before service delivery. The Connected Communities Evaluation was designed when drafting the funding proposal and creating the ideas of Connected Communities and *social prescribing plus*. *Social prescribing plus* is unique feature of the Connected Communities programme, which enabled Connectors delivering social prescribing to go into communities and actively seek and identify individuals who could benefit from the programme rather than waiting for referrals to come in from health and social care or other sectors. Elements of evaluation therefore underpin each component of the programme. For this reason, we begin our presentation of

programme components with the section on Evaluation. We conclude by providing recommendations on how to approach evaluation.

The Evaluation Team (ET) for Connected Communities resides at the University of Essex (UoE) in the UK. The UoE Evaluation Team did not engage in direct delivery of social prescribing to beneficiaries, and therefore served as an internal observer of programme activities. In particular, the Team was responsible for developing the evaluation logic (also known as a causal model or theory of change), choosing outcome measures, auditing data collection and storage systems, analysing data collected by the partners and Connectors, assessing impact, and sharing findings with external funders and organisations (dissemination and integration). Through managing these elements of the programme, the Team also contributed to drafting the Connectors' job descriptors and training manual, selecting social prescribing providers for those partners who commissioned provision, and communications.

Evaluation Logic

One of the first tasks in creating the evaluation was to develop the logic underpinning the theory of change. Figure 4 illustrates the theoretical and empirical links between individual health and public outcomes and the complex ways in which they relate to each other. Though the evaluation logic is fully explained in previous reports,[25] we summarise it briefly here.

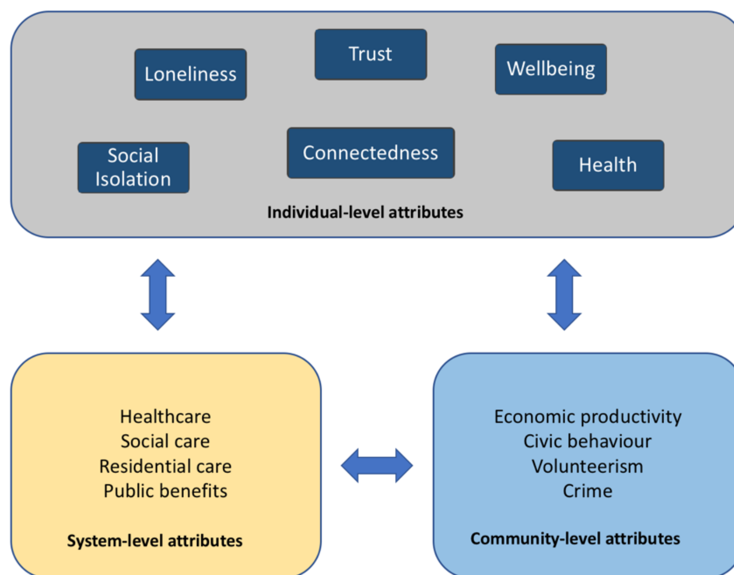

Figure 4 Connected Communities Evaluation Logic

Individual-level Attributes: Loneliness, Social Isolation, Connectedness, Trust, Wellbeing, and Health

Loneliness is a feeling experienced when there is a cognitive mis-match between the quality and quantity of relationships one has versus those that one wishes to have.[35] Loneliness is a subjective feeling of a lack of companionship that can be experienced even when surrounded by others.[36] Loneliness differs from *social isolation*, which is an objective, quantifiable measure of the number and the quality of contacts that one

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has. While related to loneliness, *social isolation* is a distinct phenomenon, as socially isolated individuals do not necessarily experience loneliness, and lonely individuals do not necessarily have low levels of social contact with others.[37]

Social connectedness is the sense of belonging and experience of relating to others. A perceived or real lack of connectedness can lead to loneliness, social isolation and numerous health issues.[38–40] Loneliness, social isolation, and connectedness are linked to trust. *Trust* is the belief a person has that someone else has both the competence and the willingness to act in that person's best interest. Trust is the bedrock on which people build connections with their communities, and with Community Connectors.

The Connected Communities programme evaluation was designed to examine and capture the complexities of these distinct related phenomena. An individual needs to have a basic ability to trust another if they are to be able to create meaningful relationships. Social isolation can make it difficult to develop these fundamental trust levels, and difficult to create the relationships that might resolve feelings of loneliness. Being lonely often makes one isolate themselves, can be an outcome of disconnectedness, and can reduce one's trust in others. Studies show that low levels of trust are associated with increases in loneliness over time[41] and that increases in levels of interpersonal trust can help reduce loneliness and social isolation.[42] Trust is therefore central to understanding experiences of loneliness, social isolation, and connectedness and ways in which individual and community-level interventions can be designed to enhance it, and in turn, how conditions in a particular community impact one's levels of trust, loneliness, social isolation, and connectedness.[42]

Wellbeing, a subjective sense of satisfaction with one's life, including feelings that life is worthwhile and feelings of happiness and anxiety, is linked to health and longevity.[43] Loneliness, social isolation, connectedness, and trust are linked to a variety of physical and mental health conditions, such as the need for residential care, the practice of preventive health, and , as well as an overall sense of wellbeing.[36,44,45] Links between health and wellbeing add to the complexity of exploring the effects of an intervention such as Connected Communities. Physical and mental health influence wellbeing, while, in turn, wellbeing is also found to have an impact on various aspects of physical and mental health such as immune system, longevity, cardiovascular health, and mental health outcomes.[46,38]

System-level Attributes: Health care and social care

Individuals who experience loneliness, social isolation, disconnectedness, and low levels of trust and wellbeing are more likely to utilise health and social care services, including memory care and residential care.[41,45,47,48,49] In the UK, some reports estimate that the cost of severe loneliness, observed through its overall impact on wellbeing, health and productivity, is £9,900 per person, per year.[50] Negative impacts of loneliness and social isolation are likely to increase with age,[51] resulting in a greater loss of autonomy and greater dependence on public services. Reports suggest that in France, a loss of autonomy and related health expenditures in older populations was estimated to be near €30 billion in 2014.[52]

The idea that positive improvements at the individual-level could impact ways in which individuals interact with health and social care systems is fundamental to the logic

behind the adoption of social prescribing. Social prescribing is seen as a model that could help address and reduce the demand on health and social care by positively impacting an individual's understanding of their health needs and ways to improve their health. When individuals take charge of their own health and wellbeing, the expectation is that their demand for health and social care will be reduced. Thus, social prescribing and similar models are intended to address individual health and reduce pressure on health and social care systems.

Community-level Attributes: Productivity, Civic Behaviour, Volunteerism, Crime

Social prescribing is thought to affect how connected one is to one's community, and more connected communities are seen has having multiple benefits. Communities that are connected (those with residents who have a sense of belonging, social networks, mutual support) are observed to have greater resources (more voluntary and community opportunities for engagement, new community organisations), as well as increases in productivity and civic engagement, and decreases in crime.[53] Social prescribing beneficiaries report engaging more in community activities following their participation in a social prescribing programme,[54] feeling a greater sense of belonging,[55,56] and being more aware of the services and support available to them.[57]

Linking Individual-level, System-level, and Community-level Attributes

Thus, the posited link between individual-level and community-level attributes is cyclical. In one direction, as those participating in social prescribing initiatives such as Connected Communities become less lonely, more socially connected, more trusting of others, and as they improve their health and wellbeing, these individuals are likely to become more engaged in community activities and contribute more to their communities. In the other direction, people living in and contributing to engaged, connected communities are less likely to feel lonely or untrusting.[58]

Health benefits of social connectedness have been found in recent studies showing that by engaging more in community activities, an individual could potentially increase the size of their social network, develop a greater sense of community belonging, and feel less lonely, and consequently reduce their usage of health and social care services.[55,56] By providing community-based alternatives to improve health and wellbeing, connected communities may reduce demands on health and social care services.[48] Additionally, individual health is likely to improve as individuals establish new and improve old ties with neighbours or community groups, learn how to better manage their health, and become able to rely on others for help and social needs. Thus, healthier, better-connected individuals are posited to be more likely to become and remain productive and engaged community members.

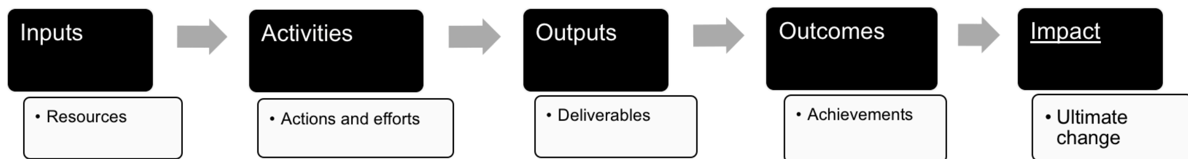
Recommendations

Co-designing evaluation is a critical aspect of being able to plan and execute a thoughtful research design that can assess outcomes and impacts. Doing so can help reconcile the goals of stakeholders from beneficiaries and funders to implementers and evaluators. These groups have some goals that overlap, and others that do not. Striking the balance between the data collection and analysis requirements, on the one hand, and the needs of delivery professionals and beneficiaries on the other is not easy. All projects have to confront these tensions, and resolving them early on helps everyone work toward the same outcomes.

> **Recommendation**: Dedicate time to co-designing the evaluation at the same time the project itself is designed.
>
> If the evaluation cannot be designed until after delivery has begun, co-production is no less important.

Developing a theory of change and co-producing evaluation requires systematic tracking of all the inputs (resources), activities (actions and efforts), outputs (deliverables), outcomes (achievements) and impact (ultimate change). In order to establish a baseline, document a progress and assess a change following a social prescribing programme implementation, an inventory of resources, actions and efforts is needed to document a journey of:

- a programme to reach its deliverables (ex. number of beneficiaries, referrals, etc);
- individuals involved in a programme who reflect on learnings and achievements (outcomes) and assess benefits of their participation as a direct result of the programme deliverables;
- evaluation steps taken to ascertain if and how ultimate change (impact) occurred, based on the evidence provided.



(Reinhardt and Vidovic, unpublished work)

> **Recommendation**: Develop a system to systematically track all the inputs (resources), activities (actions and efforts), outputs (deliverables), outcomes (achievements) and impact (ultimate change).

Measuring Outcomes

The Evaluation Team was principally concerned with measuring outcomes and impact of Connected Communities by investigating the extent to which noticeable changes in individual wellbeing, system-level demands, and community connectedness occurred and could be associated with Connected Communities implementation. The Team therefore designed mechanisms to measure elements of the evaluation logic model. These mechanisms were designed to track project progress, compare the Connected Communities and SP+ development process between partners, and ultimately offer evidence regarding the extent of impact Connected Communities and its component programs have had on individuals, on health and social care systems, and on communities, in partner locations.

Data Sources

The Evaluation was designed to examine changes and linkages between and among individual-level, system-level, and community-level attributes by examining two key types of data: 1) data collected from individual beneficiaries during social prescribing plus (SP+) interactions; 2) data collated by partners regarding economic activity, health and social care usage, crime and other relevant economic activity in their geographical areas. The Evaluation intended to demonstrate the extent to which change occurs in each of the three levels during Connected Communities development and delivery by comparing information collected pre-intervention to that collected post-intervention.

Known Limitations

It is important to note a few limitations to the Evaluation design that were known from the onset. Establishing causality via an internally and externally valid research design is a common problem encountered by those studying social prescribing initiatives[53,59], and Connected Communities is no exception. While the Connected Communities evaluation could examine the extent to which a change has occurred following the Connected Communities programme delivery, it could not be designed to establish that the change was due specifically to the Connected Communities programme.

In other words, while an individual might feel less lonely following their participation in the Connected Communities programme, or there may be a reduction in the demand on medical health services, these changes might be attributable to other factors. The Evaluation Team never had the capacity resources needed to account for and/or rule out all potential alternative factors, nor was programme delivery based on a research design that would enable definitive causal inference. Contextual factors such as national and international changes in health care provision and working relationships will affect social prescribing outcomes regardless of individual delivery (see **Broader Context of Implementation** section below). While multiple methodological and contextual factors preclude us from establishing a causal connection between individual-level changes and changes at the system and community levels, the Evaluation Team are still able to report the extent to which changes occur at each of the three levels.

Choosing Measures

Choosing outcome measures requires consideration of exactly what impact a programme is intended to achieve. To measure potential changes in the attributes above, the UoE team proposed to the partners to adopt the standards recommended by the UK Government in relation to measures of loneliness and wellbeing.[60,61,62,63] This decision was based on several benefits: 1) adopting a standard form of measurement makes indicators comparable across the UK and wider EU community[64]; 2) the standards are based on years of work done to date on measuring the concepts around the world, so are well-founded, consensually valid, and proven to be associated with concrete outcomes; and 3) the scales of the measures have been associated with costs and value-for-money when people move up or down on the scales.

Loneliness

To measure loneliness, UoE team recommended the use of the 4-item UK loneliness battery. The UK Government Office of National Statistics (ONS) have assessed a wide range of loneliness measures and provided recommendations on the basis of validity and reliability of the measures to be used to ensure consistency and comparability across various loneliness related studies and programmes.[60] After extensive discussion, the measures for loneliness were reduced to one question, presented in Table 1:

Source of wording	Question	Choices/options
Community Life Survey	How often do you feel lonely?	Often/always, Some of the time, Occasionally, Hardly ever, Never

Table 1 Loneliness measure

This question asks about loneliness directly, rather than asking questions that measure loneliness without specifically using the word "lonely". Kent partners, concerned that the direct question would be too intrusive, striving to meet UK national standards, and hoping to learn more nuanced information about loneliness, opted to keep the full 4-item battery recommended by UoE.[65]

Social Isolation

To measure social isolation, the partners selected 4 questions from the Duke Social Support Index (DSSI).[66] Medway Connectors already used the DSSI and found it easy to administer. The four questions are listed in Table 2. These questions on social isolation do not differentiate between various modes of communication, and only refer to telephone contacts. The UoE team suggested that the question be rephrased to ask about other modes of communication (telephone, text, social media platforms, zoom, etc.).

Source of wording	Question	Choices/options
Duke Social Support Index (DSSI)	Other than members of your family how many persons in your local area do you feel you can depend on or feel very close to?	None,1-2 people, More than 2 people, Beneficiary refuses to answer
	How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together?	None, Once, Twice, Three times, Four, Five, Six, Seven or more times, Beneficiary refuses to answer
	How many times did you talk to someone (friends, relatives or others) on the telephone in the past week?	None, Once, Twice, Three times, Four, Five, Six, Seven or more times, Beneficiary refuses to answer
	About how often did you go to meetings of clubs, religious meetings, or other groups that you belong to in the past week?	None, Once, Twice, Three times, Four, Five, Six, Seven or more times, Beneficiary refuses to answer

Table 2 Social Isolation measures

Connectedness

From the Community Life Survey, the partners elected to measure connectedness in terms of community engagement.[67,68] Table 3 lists these connectedness measures:

Community Life Survey Civic Engagement component	Select activities that this beneficiary has participated in over the past month.	1. Contacted a local official such as a local councillor, MP, government official, mayor, or public official working for the local council (Please do not include any contact for personal reasons e.g. housing repairs or contact through work). 2. Attended a public meeting or rally, taken part in a public demonstration or protest 3. Signed a paper petition or an online/e-petition 4. Voted in local elections 5. Participating in a voluntary group or organisation 6. Volunteering for a local charity or group 7. Helping out a neighbour or friend in need. 8. Did not do any of these things. 9. Not discussed. 10. Other: please explain

Table 3 Connectedness / Civic Engagement measures

Trust

The items chosen to measure trust are listed in Table 4:

ANES Report Community Life Survey	On a scale where 0 (zero) is not at all and 10 (ten) is completely, in general, how much do you think people can be trusted?	A scale of 0 to 10, with added option 'refuse to answer'
	On a scale where 0 (zero) is not at all and 10 (ten) is completely, in general, how much do you think public officials can be trusted?	A scale of 0 to 10, with added option 'refuse to answer'

Table 4 Trust measures

Wellbeing

Wellbeing is measured by the UK Office of National Statistics standard 4-question battery, a decision with which all UK partners agreed (Table 5):

ONS4	Overall, how satisfied are you with your life nowadays?	on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".
	Overall, to what extent do you feel the things you do in your life are worthwhile?	on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".
	Overall, how happy did you feel yesterday?	on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".
	On a scale where 0 is "not at all anxious" and 10 is "completely anxious", overall, how anxious did you feel yesterday?	on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".

Table 5 Wellbeing measures

Health and other attributes

Connected Communities asks beneficiaries to report on a number of health conditions that they are experiencing, ranging from asthma and cardiovascular health conditions to mental and emotional health concerns. This data is collected at the start of a person's participation in the programme to have a clearer understanding of health conditions that could potentially contribute to an individual's experience of loneliness, social isolation, connectedness, trust, and wellbeing, and then are updated as needed to indicate changes in health.[25]

We collect information in this way for two key reasons. First, clinical health is not the main target of SP+; rather, the scheme is designed to help empower and enable people to pursue the goals that are most important to them. Focusing on clinical measures of health distracts from interactions with the Connector. Second, although Connectors and local authority partners do not seek to collect this information continually, a baseline knowledge of health factors is necessary to contextualise an individual's circumstances and discern patterns of change in outcomes.

In addition to health conditions, the Connected Communities programme records a variety of other information that could influence one's experience of loneliness, social isolation, connectedness, trust, and wellbeing, such as information on critical life events, housing and financial circumstances, education and employment status, ethnicity, hobbies, and habits.

Recommendation

> **Recommendation**: Remember that social connectedness is a key component of social prescribing, and choose measures that can help assess the outcome of connectedness, as well as the effects of connectedness on individual loneliness and wellbeing.

Measures of loneliness, social isolation, and wellbeing have been studied and validated for decades. Yet even though social prescribing is rooted in the idea that building social connections can drive outcomes in those individual attributes, very few studies actually measure social connectedness.[53] Social networks are critical to a variety of health and life outcomes and overall wellbeing. If social prescribing is meant to create a sense of connection and community, we must strive for a systematic way to measure it.

Methodological Challenges

Social prescribing is a part of a wider effort to address social determinants of health in the UK and other parts of the world.[5,17,69] The social prescribing model is increasingly being viewed in other countries as a way to address social factors that impact health.[10,69–72] Some estimates show that social needs account for 20% of general practice (GP) appointments in the UK and 30% in the Netherlands.[45,73–75] Reports have argued that 15 million GP appointments in the UK during 2020-2021 could have been better addressed via personalised care, advice services and community-based support.[76] The pressure on the health care services and the tireless campaigning and work by the organisations in the UK such as the Campaign to End Loneliness, Jo Cox

Foundation, Mental Health Foundation, Age UK, Coop and the British Red Cross has brought social prescribing to the forefront of the debate on improvements in public services and tackling complex health issues such as loneliness.[15,16,77–79]

This increase in the interest in social prescribing has led to great efforts to evidence the impact of social prescribing on individual and community health as well as health and social care systems. While a number of studies report improved health and wellbeing outcomes at the individual level and positive impact on the health care systems, the robustness of the evidence is brought into question given the type of the evidence that is currently being collected.[59,73,53,80] This is partially due to the diverse nature of the social prescribing interventions, a lack of common framework to be used to capture the evidence and the time needed to observe the impact of social prescribing.

One of the well-known social prescribing initiatives in the UK, Ways to Wellness, a 7-year project, has successfully documented its impact by successfully negotiating with a funder to expand the time over which to observe the impact of the project on people living with long-term conditions in the Newcastle upon Tyne.[81]

Recommendation: Identify and communicate to the funder at the outset and during the programme duration the time and resources needed to capture short and long-term impact of the project you are proposing.

We call for a system-wide approach to track programmes that are being implemented, one that enables the evaluation of pathways, outcomes and impact by detailing programme type, length, region/s being implemented, referral pathways, number of beneficiaries and observable health and wellbeing indicators. A unified approach would enable the field of social prescribing to develop a common framework that would guide organisations in impact evidence collection. It would also give a deeper understanding of the types of impact that social prescribing can have on individual, system and community health and wellbeing.

Implementation

As the Connected Communities programme moved into the implementation stage, partners were eager and enthusiastic to reach out to their communities and deliver social prescribing across localities. Medway reports that other social prescribing projects have been very supportive and have referred eligible clients into the Connected Communities programme.

> "It has been great to see that the interventions I'm putting in place for my clients are having a positive impact on their wellbeing. It's always exciting to see the progress they make throughout their time in the service. Seeing the improvement within my client's [lives] has made me more motivated and confident to complete the programme with new clients."
>
> *Catherine Drew, Connected Communities Connector in Medway*

Governance of *Social Prescribing Plus*

The positive response that Connected Communities received in Medway was due to an extensive effort by the Medway team to bring together a network of professionals who work across public health, the local authority, Clinical Commissioning Groups (CCG), and local voluntary, community and enterprise sector organisations (VCSE) to discuss how to work collaboratively to deliver social prescribing.

Our partners in Kent report that they relied on the governance structures and networks already established through the Community Warden system, a long-standing service in the county. Community Wardens work to strengthen community resilience, support the elderly and vulnerable, assist community members to navigate public services and foster community cohesion and wellbeing.

Kent kew that their Community Wardens already have much of the knowledge and skills required of a 'Connector'. With the trust of their communities already established, placing Wardens into the Connector role reduced the time needed to establish governance structures, to train and retain staff, and to attract referrals to the social prescribing programme.

Kent did seek additional training to develop their Community Wardens into Connectors. Choosing the training and topics was somewhat of a trial-and-error process as there was no clear guidance in the field of social prescribing at the time. During the programme duration Kent refined their training plan for Connectors and how have established their training protocols to align better with the needs of their staff and their community members. Kent reports no concerns with staff recruitment or retention. Connectors have experienced huge job satisfaction working in their new role.

Structure

While Kent relied on existing structures, Medway co-developed a 5-year plan, *Medway and Swale Social Prescribing Plan 2020-2027,* to govern their programme implementation.[82] The plan describes a common understanding of *social prescribing*, *existing activity*, *aspirations*, *system dependencies*, and *risks*. It also lays out the governance structure of social prescribing in the area ().

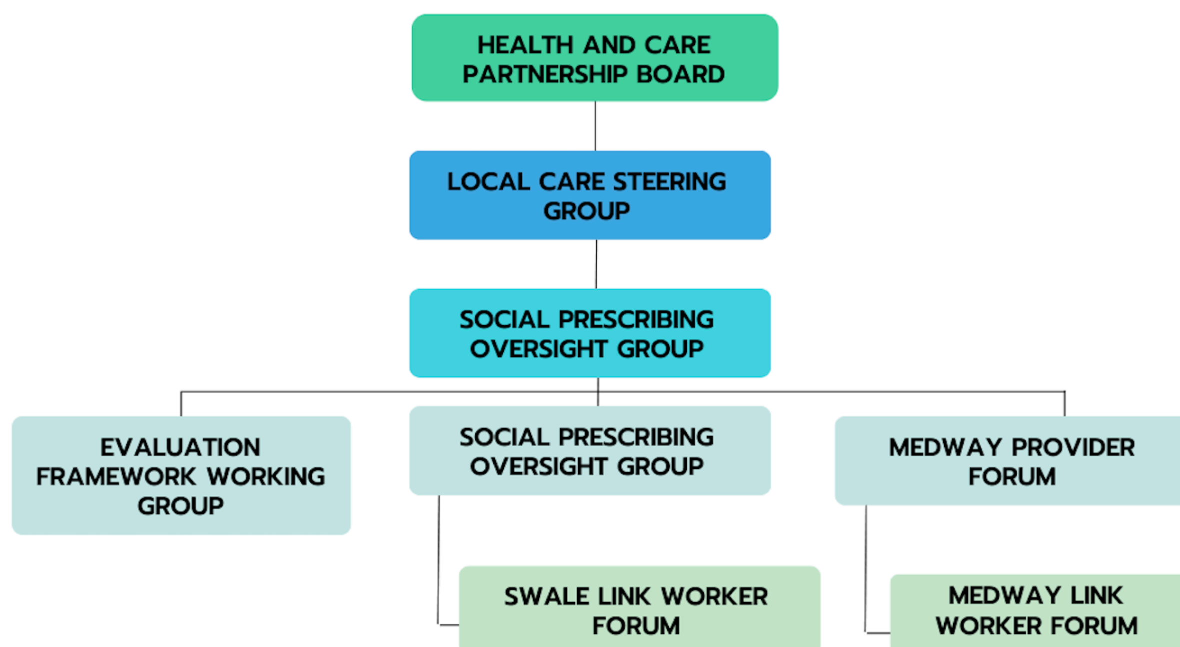


Figure 5 Social Prescribing Governance (Medway and Swale)

A key component of Medway's social prescribing governance depends on working groups created to oversee and track progress. One of the groups is a Link Worker Forum (Connector Forum) which provides a space to share information and knowledge, receive peer-to-peer support, access training, and generally enhance the competencies of the social prescribing workforce. Table 6 documents the roles and responsibilities that each group has taken to successfully deliver social prescribing in Medway and the number of organisations across sectors that are needed to be involved to successfully implement social prescribing.

By working with others to build the network and governance structures for social prescribing in Medway, the team has successfully met the challenges that came with an increase in the number of social prescribing programmes being delivered in the UK[12] and a lack of guidance from the statutory bodies regarding social prescribing.

The rapid expansion of social prescribing in the UK within a short period of time has led to challenges in terms of training Connectors. As Kent also noticed, there was no universally agreed set of guidelines for training social prescribing professionals. While the NHS England[83] and other organisations[84] in the field were starting to develop quality training modules, the standards were only being set as the Connected Communities Connectors were about to start their work. Without centralised training standards, it is likely that the quality of the services being provided across Connected Communities could be inconsistent from provider to provider.

Further, Medway has noted that due to the massive increase in the number of people being referred to social prescribing providers throughout the area, the complexity of the needs among beneficiaries far exceeded the professional competency of the current workforce. Medway identified a potential way to meet this challenge by developing training modules that can help others make more appropriate referrals in

the future[82]. Medway has established a Locality Review Teams to discuss complex cases and refer individuals to services that could help address their needs.

GROUP NAME	RESPONSIBILITIES	ORGANISATIONS	MEETING SCHEDULE
Local Care Steering Group	• Hold system accountable for social prescribing • Ensure sufficient funding in place • Flag social prescribing strategic risks to executive board	• Health service • Social Care • VCSE • Primary Care	Monthly
Social Prescribing Working Group	Ensure 5-year plan is delivered	• Commissioners • Public Health • Clinical Directors • VCS • PHM • Primary Care Networks	Quarterly
Provider Forums	• Sharing SP system challenges • Ensure consistent outcome measures are reported	• Commissioners • Public Health • SP Providers • Primary Care Networks	Quarterly
Link Worker Forums	• Peer support • Sharing best practise • Feedback on system risk and dependencies • Receive SP system level updates	• Front line link workers • Public Health	Monthly
Evaluation sub-group	• Agree a consistent measure of wellbeing is recorded and reported • Develop a health economics model to evidence the financial impact of SP	• Public Health • Commissioners • SP Providers • OHID • NHSE	Task and finish

Table 6 Responsibilities in governing social prescribing in Medway

Suffolk has since identified challenges with the recruitment and retention of social prescribing staff due to the expansion in the social prescribing programmes across the UK.[85]

Management

Turnover and attrition within partner organisations resulted in delivery and management of the Connected Communities programme by people who had not been a part of programme creation. In some cases, attrition led to a lack of coordination and collaboration among units within partner organisations, resulting in the inability to fulfil project components required for inter-partner collaboration and coordination. This situation posed challenges for continuous attention to collecting, managing and sharing data. Establishing protocols to address data security and legal complexities that come with commissioning agencies to deliver social prescribing requires

sustained attention, as does collecting data on individual beneficiaries. Changes in staffing can delay these processes.

Recommendation

Recommendation: Identify organisations and individuals across the sectors needed for successful implementation of your social prescribing initiative. If the network is not already available, establish a network and a governance structure similar to Medway.

Client Record Management System (CRMS)

CRMS development

Partners originally agreed to co-develop a common Client Record Management System (CRMS) and a protocol for its use. The scoping work included identifying information requirements in relation to programme beneficiaries and identifying outputs required for the purpose of evaluation in order to:

- record and manage clients needing services;
- enable coordination across providers;
- avoid costly and time-inefficient cross-referrals within statutory agencies;
- provide a single, secure source for data and information needed for monitoring and evaluation.

An evaluation dashboard was meant to make it easy for each Connector to access their individual caseload and track attendance, adherence and outcomes. Evaluators would then be able to access anonymised data for all participants and draw down tranches semi-annually.

During the first 6 months of Connected Communities, partners decided that each would choose its own data recording platform, instead of developing a unified CRMS. This decision was based on two key factors. First, each local authority partner was subject to its own rules and protocols of data curation and protection, including pre-existing means to track individuals. These separate means of tracking individual data meant that sharing a data system with another local authority would require the adoption of a new data system by the Connected Communities managers within the local authority that did not match the pre-existing data system.

Second, CRMS software was much more available at the time of Connected Communities beginning than it had been at the time the programme was proposed. This meant that the money costed into the original proposal to create a unified system, which would have been funded by each partner pooling a portion of resources, could now be spent by each partner separately to acquire whatever system it preferred. Combined with the desire to streamline data collection within each local authority, this liberation of expenditures made these partners decide to use separate data platforms.

Insights and Recommendations

Though two partners ultimately chose the same CRMS provider, the decision not to use a single unified CRMS by all partners had profound implications for evaluation and data quality. Below, we summarise our actions, decisions, outcomes, and

recommendations for those considering acquiring and using a CRMS. We also offer recommendations based on UoE's evaluation observations, as well as observations from Medway and their own CRMS commissioning process.

Actions and Decisions

Building on Medway experience of designing and managing CRMS to deliver Public Health services and interventions in the past, the team employed lessons learned and existing workflows to develop CRMS.

UoE provided a set of evaluation questions as a baseline, with all the partners providing input and agreeing upon the final version. The questions were designed to extract the necessary data from service users, via a set of conversations. These were designed to make the service user feel at ease whilst ensuring we obtained as much information as possible for the evaluation.

Medway worked with the supplier to design and build a data recording and data reporting structure that would provide the information necessary for the Connected Communities evaluation. The goal was to be able at the end of each recording period to extract the information to a CSV file, which could then be submitted to the UoE.

When the initial proposal for Connected Communities was created, the partners proposed and agreed to develop a joint CRMS system. Subsequently, during the delivery stage, each partner decided to develop in-house data recording platforms instead of a unified CRMS.

Medway commissioned a supplier which could provide both the CRMS and a directory of services (DOS), as an integrated system, to enable Connectors to have a single point of access to record data and make referrals into VCSE. The aim was to ensure efficient data recording, storing, sharing, and reporting of data and efficient referral pathway. Suffolk followed the lead and utilised the same provider as Medway, however, with different outcomes as Medway commissioned the provider for a more encompassing CRMS and DOS system.

Kent build in-house CRMS system. L'Eure recorded data using an Excel spreadsheet.

Outcomes

Having no unified CRMS was detrimental to data collection and impact evaluation. The data extraction for both Medway and Suffolk did not proceed smoothly based on the specifications provided by the supplier. All partners provided the data with differing variable names and recording procedures.

All partners then agreed to create a unified data recording format using Excel spreadsheet and a codebook to structure variable names, data recording and analysis.

Medway continued to work closely with the supplier and were able to make changes and recommendations to improve the system, which were implemented across all their

platforms. The supplier received positive feedback from other customers following these developments.

Recommendations

While a joint CRMS would be hugely beneficial for data collection and evaluation, developing a joint CRMS system across more than one partner comes with additional challenges. Chief of these challenges are following all partners' protocols for data storing, access and sharing. A clear pre-set specification and criteria must be agreed upon in advance, with any future developmental work discussed and approved as a partnership. Even if some partners are delivering slightly different intervention models, a joint CRMS is ideal.

It is important when budgeting for a system such as a CRMS to ensure that there is sufficient allocation for future developments. Projects evolve and changes are often required to keep the system relevant, up to date, and flexible to consider potential ever-changing needs of a social prescribing initiative.

Ensure you know what information you want to extract from the system before designing/commissioning it. It is important to prioritise reporting and do not allow this to become an after-thought, otherwise there is a risk of costly adaptations or not being able to extract the needed data as the functionality hasn't been built in up front.

There are many 'off the shelf' CRMS available now. It is therefore crucial to carry out market research on each supplier and their system to ensure it is fit for purpose. Speaking to other organisations who are already using these systems will provide valuable insight into the functionality of the system as well as the quality of service offered by the supplier. In particular, the ability to customise or acquire a bespoke system can be critical. Standard templates, if they do not match the needs of data collection or evaluation criteria, can be confusing to Connectors and others trying to enter or extract the data. Confusion breeds errors, and leads to some Connectors refusing to record data at all. Without some sort of data, no programme can be evaluated. It is therefore time and cost effective to deliver a social prescribing programme utilising an integrated system that can provide both a CRMS and a DOS, delivered and managed by the same provider.

Community-level data

In terms of community-level data, partners were able to provide varying levels of information. Suffolk and Medway provided monthly-level data across on short and long-term care for the following services: learning disability, mental health support, physical support, sensory support, support with memory and cognition, reablement, residential care, nursing care, supported accommodation, home care, direct payments, respite. Additionally, Suffolk shared MOSAIC data classifying households based on demographics, behaviours, lifestyle and attitudes.[86] Similarly, Kent shared MOSAIC data for their locality. Kent also shared monthly level data for direct payments, home care, nursing care, residential care and supported living, with each of the categories indicating the type of the support received (learning disability support, mental health support, physical support, sensory support, support with memory and cognition, other) and the data that they have available for enablement. L'Eure provided yearly-level data on taxes (2017), revenue (2017), the number of elderly people in

nursing homes and expenditures (2019), and the number of people receiving APA (Allocation personnalisée d'autonomie) and expenditures for the whole territory of L'Eure (2019).

Data sharing

Despite the initial commitment of all partners to the unified and centralised plan for data collection, storage and analysis, Data Sharing Agreement (DSA) negotiations with each partner extended for up to two years. This is partially since the process for deciding data sharing agreements varies widely across partners, even though all local authorities conform to the same data sharing laws. DSAs govern data usage, transfer, security and maintenance, all of which require careful consideration and extensive cross-sectoral cooperation. The Evaluation Team data collection, storage, and security plan underwent ethical institutional review in May 2019, which was approved by the University of Essex Review Board in September 2019. The last DSA between the University and Connected Communities partners was signed in December 2021.

In addition to the DSA, social prescribing projects, as many other projects that include human subjects, should also take into consideration the issue of consent and willingness of public to share their personal data with them. *Data sharing* is viewed more negatively when compared to “collecting/storing” data, with individuals trusting the data sharing process less.[87,88] Citizens are least likely to trust sharing their data with researchers (24%), when compared to general practitioners (98%)[89], which presents serious barriers for health innovation. Low public approval and awareness of what data sharing entails and the inconsistency in data sharing mechanisms are identified as some of the major challenges.[90] Gaining participant approval to share data with the research team can therefore present considerable challenges and should be taken into consideration by those seeking to implement and evaluate these types of programmes.

Another issue arising when seeking to evaluate the impact of a social prescribing initiative at the system or community level is the availability of public sector data at levels granular enough to evaluate the effects of a singular social prescribing programme. There have been some improvements in the UK in recent years to address this issue, with the creation of the Public Health Profiles platform[91] to improve data sharing. In France, however, there is precious little data available at the ward level, or with any frequency other than annually. Such aggregations make it nearly impossible to compare outcomes between areas that do have social prescribing versus those that do not, or to track changes in delivery and non-delivery areas over time.

Recommendations

Recommendation: The social prescribing sector should advocate for an infrastructure needed for cross-sectoral data collection, transfer and management, and work toward a greater understanding of the cross-sectoral data privacy, security and analytic technologies.

Recommendation: The social prescribing sector should engage with the public regarding data sharing by consulting and informing the public about data quality assurance, benefits of data sharing, and associated trade-offs.

Directory of Services (DOS)

Connected Communities aimed to establish a comprehensive and accessible Directory of Services (DOS) in each partner area. This DOS would be produced using a co-designed asset *mapping and gapping methodology* of how to identify existing local community assets and needs.

Insights

Kent and Medway worked jointly beginning in 2019, and launched their DOS platform in March 2022.[92] Before the platform launch, there were a number of separate digital platforms, each with its own DOS, often containing duplicating information. Medway Council chaired the group which implemented the changes to create a joint DOS platform, which included VCSE representatives, NHS, faith groups and Integrated Care Board members.

The joint Kent and Medway platform is designed to be:

- *Integrated*: build on what is in place by bringing together and developing existing digital platforms.
- *Co-ordinated*: simplify access for the public and referrers who will be able to search a single directory of services for the whole of Kent and Medway and provide the infrastructure for a single referral.
- *Equitable and accessible*: Improve accessibility for the whole population by putting in place a public facing digital platform across the whole of Kent and Medway including areas where it does not currently exist.
- *Consistent*: avoid duplication of information and quality assurance of community assets by harmonising existing systems.
- *Economies of scale:* develop software so a user can use one login to make referrals across the whole of Kent and Medway.
- *Population health outcomes*: Provides a consistent way of measuring and reporting on population health outcomes across multiple levels such as: integrated care systems (ICS), integrated care board (ICB), Health and Care Partnership (HaCP), and primary care networks (PCN).
- *Future-proof*: Enable linkage to other products such as the Help to Care App and NHS 111.

In Suffolk, the Connected Communities team utilised an established DOS called Suffolk Infolink[93] which provides information on VCSE and statutory sector services across the whole county. Suffolk team acknowledges that a common CRMS and DOS platform across all partners would have provided benefits for referral and evaluation

purposes. They do believe, however, that for a social prescribing initiative to be implemented successfully, it is more critical to develop close collaborative relationships with VCSE, health and local authority representatives than it is to have a co-produced DOS.

L' Eure has also been working to develop a network of neighbours and build a DOS that would inform people in the area about the opportunities that exist in their area. These would range from daily activities such as dog walking and socialising to neighbours supporting each other with daily tasks (hospital appointments, home repairs, etc). The project is still in the development phase due to data protection and legal regulations.

Recommendation

Recommendation: Connectors and residents will need to access the DOS regularly, so it should be user-friendly and easy to update over time.

Mapping and Gapping

Mapping and gapping is an approach to gathering and understanding community based assets and needs. For Connected Communities, mapping and gapping was directly linked to the development of the DOS.

Insights

In Suffolk, the team utilized the Stephen Abram approach to community asset mapping, identifying where assets exist, what each asset offers to the community, and where the 'gaps' remain.[94] Figure 6 offers a depiction of Abram's framework.

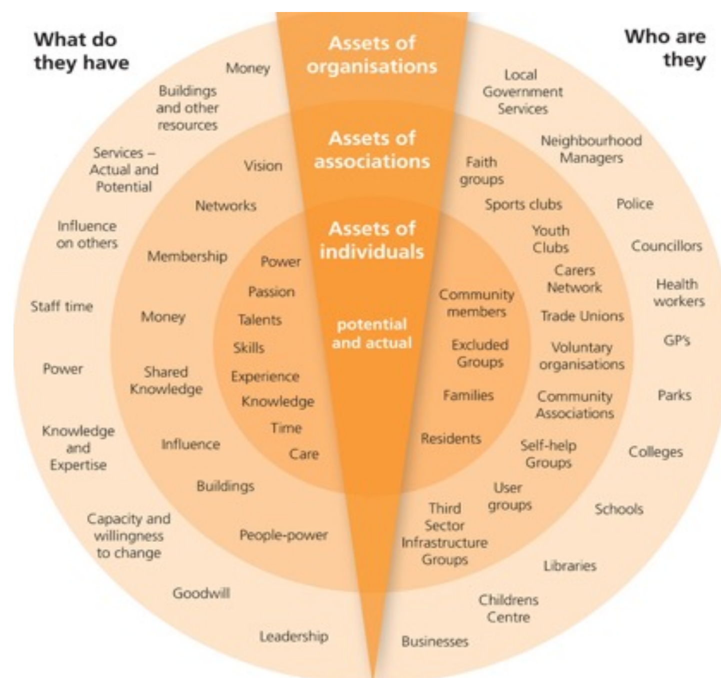


Figure 6 Stephen Abram's approach to community asset mapping[94]

In Medway, the team reached out to the local VCSE, local authority representatives and Medway Voluntary Action (MVA)[95] (Medway's local voluntary and community infrastructure organisation) to work in partnership to identify resources and needs in a community. Medway developed a community asset mapping methodology to document their work and share their knowledge with other organisations in the area. In their methodology document they offered: a definition of community asset mapping, a why asset map, instructions on how to map a locality, instructions on how to map a provision around a particular demographic, and their approach to building relationships and creating networks. This methodology, and the information it produced, was a fundamental component of their Better Connected Service.

According to the Medway Connected Communities Team, when speaking of their Better Connected Service:

> *"Community asset mapping is a way of discovering and documenting the strengths and resources in a community. This can include individuals, community organisations, faith groups and local services as well as physical spaces and resources. It is a strength-based approach to development; focusing on what a community has rather than what it lacks, and in doing so, potentially uncovering solutions to issues the community may face from within. It is a key component in community asset-based development, taking an empowering and community led approach to problem solving."*

> *"Going beyond creating documents to map the assets in our locality or around the support available for a particular demographic, building relationships has been key to our projects success and to maintaining an up-to-date resource that can be used by our social prescribing link workers.*
>
> *A natural part of building these relationships has also been introducing key people and organisations to each other. Once we know the value of an asset in the community, whether an individual, community group or VCS organisation we have been able to create links by introducing people to each other and encouraging partnership working."*

Medway saw asset mapping as a positive, sustainable approach to building connections and keep track of ever-changing resources. It empowers individuals and community members to understand their capabilities and potential.

In Kent, Connectors were already well connected with the local VCSE sector organisations and were able to map resources and needs by relying on those connections. In their role as Community Wardens, Connectors already attend meetings and serve on boards of local groups such as Community Safety Units. To accomplish mapping and gapping for Connected Communities, Connectors unitised Kent's digital database of assets. This database is hosted online and only available to the Kent staff who provide Connected Communities service in Kent.

Kent' digital database includes information on physical and social assets. It served as Kent's DOS prior to Kent and Medway coming together to create a joint DOS in March 2022. The challenge with mapping and gapping during the COVID-19 pandemic, as

many established groups and clubs were either paused or ceased completely. Connectors worked hard to keep the DOS up to date and also identify and fill gaps that emerged during and after pandemic restrictions were lifted. This meant that the Connectors were able to set up groups based on need and work collaboratively with local VCSE organisations to do so. Continual mapping and gapping in Kent helped to ensure that the new social groups and activities set up under Connected Communities can continue to run in local communities and support residents beyond the life of the Connected Communities programme.

L'Eure worked closely with social care centres, nurses, official registers of vulnerable individuals, neighbours and many others to map community needs and resources and reach out to community members who needed support. While English partners engaged with the VCSE sector, L'Eure focused more on engaging with social care centres, as is more common in France when working with individuals in need.

Recommendation

Recommendation: Involve community organisations and representatives in mapping and gapping, using the asset mapping itself to forge ties and collaborative relationships that will aid in service delivery.

Without a clear and transparent asset mapping methodology, community members cannot trust whether the Directory of Services reflects the reality of the activities and services on offer in their community. A methodology that reflects community involvement in the process of asset mapping provides the added bonus of forging partnerships and trust among the very organisations that will be called upon to provide activities and outlets for social prescription.

Defining the connector role

Partners agreed to jointly develop a job description and specification for the role of the community connector, with Medway and L'Eure as leads. The Connector would need to be knowledgeable about the local community and accessible within that community. The Connector would spend time with a person to understand their needs and work jointly with the beneficiary to identify their goals and what matters to them, and to link them with appropriate support. Once a job description was agreed upon, partners would then proceed with recruitment and hiring of Connectors to their own organisation.

To facilitate the recruitment and the training of the Connectors, UoE produced a Connector training manual in January 2020 that focused on the Connector's role as a collector of data to track impact and outcomes. Though each local authority partner provided training on health, safeguarding, and other aspects of delivering social prescription, this portion provided by UoE detailed the need for collecting information to track outcomes, challenges associated with collecting information, and strategies for overcoming those challenges. It also carefully outlined data protection needs, including the requirement to achieve beneficiary consent to share their data before allowing UoE evaluators to access it.

UoE shared this training document with all partners and provided training sessions for the Connectors before they commenced their work. The training session was well received and valued by staff as reported in follow-up conversations and emails. The training mirrored several aspects of training developed by other Social Prescribing bodies.[14]

Fundamentally, a Connector and a beneficiary need to co-produce a personalised care and support plan. This plan should detail *what matters to the beneficiary,* which the Connector can help the beneficiary discern as they discuss priorities, interests, values, and motivations. The Connector then helps identify community groups and services the person can utilise to achieve or maintain what matters most to them, and what resources the beneficiary has to draw on to maintain wellbeing and remain active. These resources might be family, friends, hobbies, skills, and dreams.

Through the conversations that identify this information, the Connector and beneficiary develop a positive, trusting relationship. The position therefore requires excellent listening and communication skills, empathy, emotional resilience, the ability to work in a person-centred, non-judgemental, holistic way across diverse communities, and trustworthiness.

Insights

In their job description profile, Medway team specified needed qualifications, experience, skills, and personal qualities. They provided information on the job context, line management for the post, and the emotional and physical demands and financial responsibilities linked to the role. Figure 7 displays information from the Medway post regarding experience and personal qualities. Overall, the post holder would be tasked with providing personalised support to those 65 and over to reduce social isolation, empower people to take control of their health and wellbeing, live independently and improve their health outcomes. The role required a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies.

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Experience

- **Essential**
  - Experience of supporting people through a behaviour change, in a group or one to one setting using motivational interviewing and CBT principles
  - Experience of engaging and collaborating with communities and individuals to deliver health improvement projects.
  - Experience of organising events and/or meetings requiring communication and coordination of a range of people and/or agencies.
  - Demonstrate a working knowledge of public health/health improvement contemporary issues and theory, and up to date knowledge of local and national priorities.
  - Experience of working with a range of IT software, including Microsoft, Outlook and online databases
- **Desirable**
  - Experience of working in social prescribing

Personal Qualities

- **Essential**
  - Ability to demonstrate an understanding of how teams work with other services and takes a proactive approach towards supporting and enabling vulnerable adults.
  - Commitment to the principles of independent living, service user choice and control.
  - Ability to inspire and motivate others into action through motivational interviewing.
  - A flexible approach to work with a commitment to flexible working arrangements.
  - Ability to demonstrate the importance of team work, within the social prescribing team as well as the wider Public Health Directorate and Medway Council.
  - Demonstrable experience of taking responsibility for own actions and development opportunities, maintaining high levels of integrity.
  - Commitment to equality and diversity, accepting differences and treating everyone fairly.
  - Excellent customer service skills
  - Strong emotional resilience

Figure 7 Experience and personal qualities sought in Community Connector in Medway

In their job advertisement (Figure 8) Kent sought Connectors who had already served as Community Wardens and had previous experience working in the service delivery area. Both Kent and Medway specified the need for staff who would be able to work as a part of a larger team delivering social prescribing. Also, both partners emphasised the importance of being able to make decisions, accept responsibility for actions taken and motivate others into action by displaying confidence and professionalism.

Kent employed Community Wardens, a long-standing service in the county, which already has developed many trusting partner relationships over the years. They are also well-known to and trusts by the residents. The role of a Community Warden is to; Strengthen community resilience to ensure 'Stronger, Safer Communities'; Support the elderly and vulnerable; Foster community cohesion and wellbeing; and Assist residents to navigate public services.

Wardens were contracted part-time into the new Community Connector role, effectively working 50% as a Community Warden and 50% as a Community Connector. The two roles interlink seamlessly as the Wardens already work with

residents who would benefit from social prescribing, and also have experience of assisting residents to navigate services and engage with their community.

Kent's Community Wardens sit on Multi-Disciplinary Teams (MDT), multiagency boards and vulnerability forums. This position equips them well for complex and sensitive cases and gives easy access to further support and collaboration with partners. Furthermore, the Wardens have a good working relationship with many local agencies and VCSEs, enabling them to call upon support and signpost to these agencies with ease. With their expertise closely aligned to a social prescribing-like service, the staff did not require extensive training. They did attend several of the courses provided by the social prescribing bodies in the UK such as the National Association of Link Workers and the NHS Digital social prescribing platform.

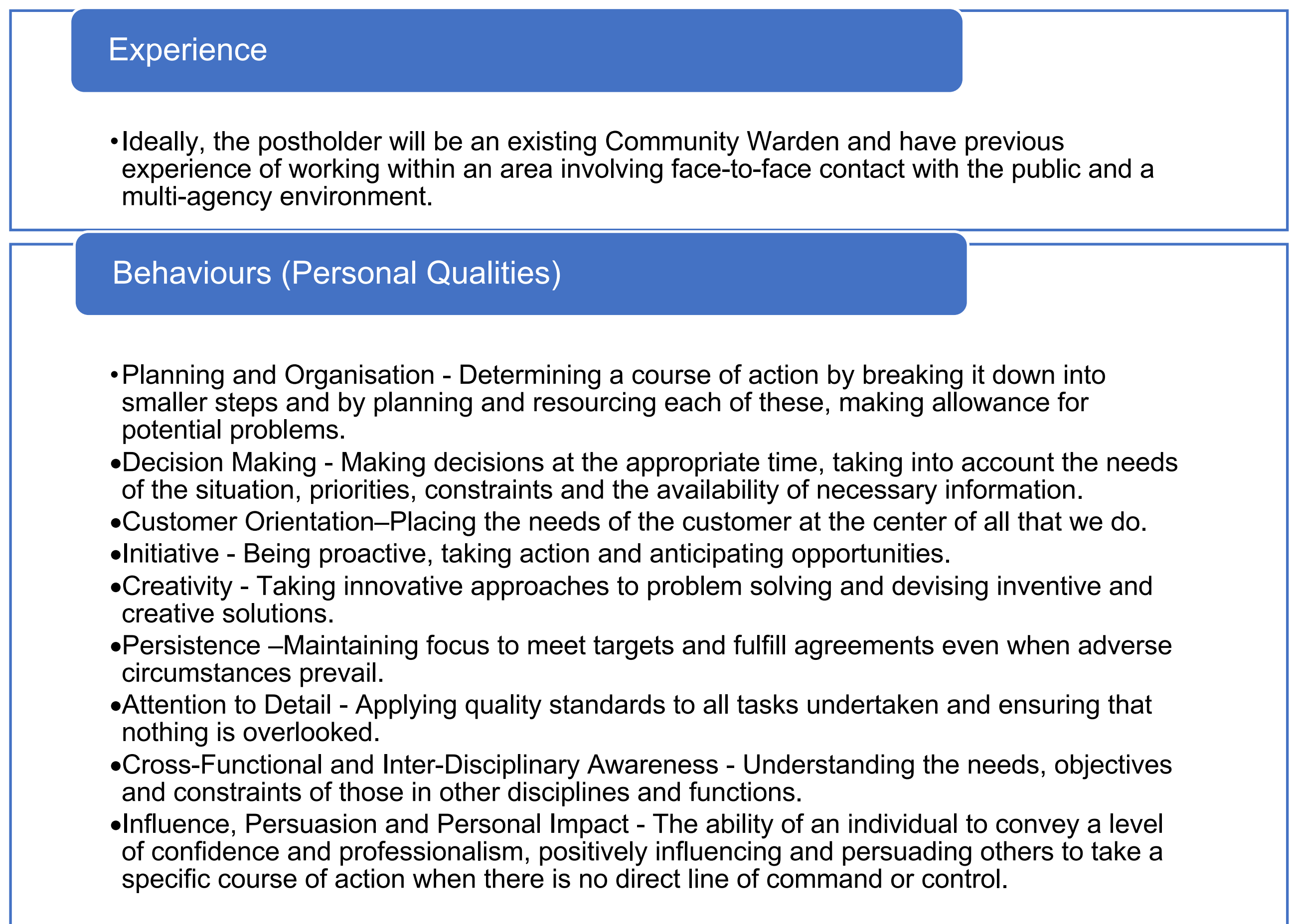


Figure 8 Experience and behaviours (personal qualities) sought in Community Connectors in Kent

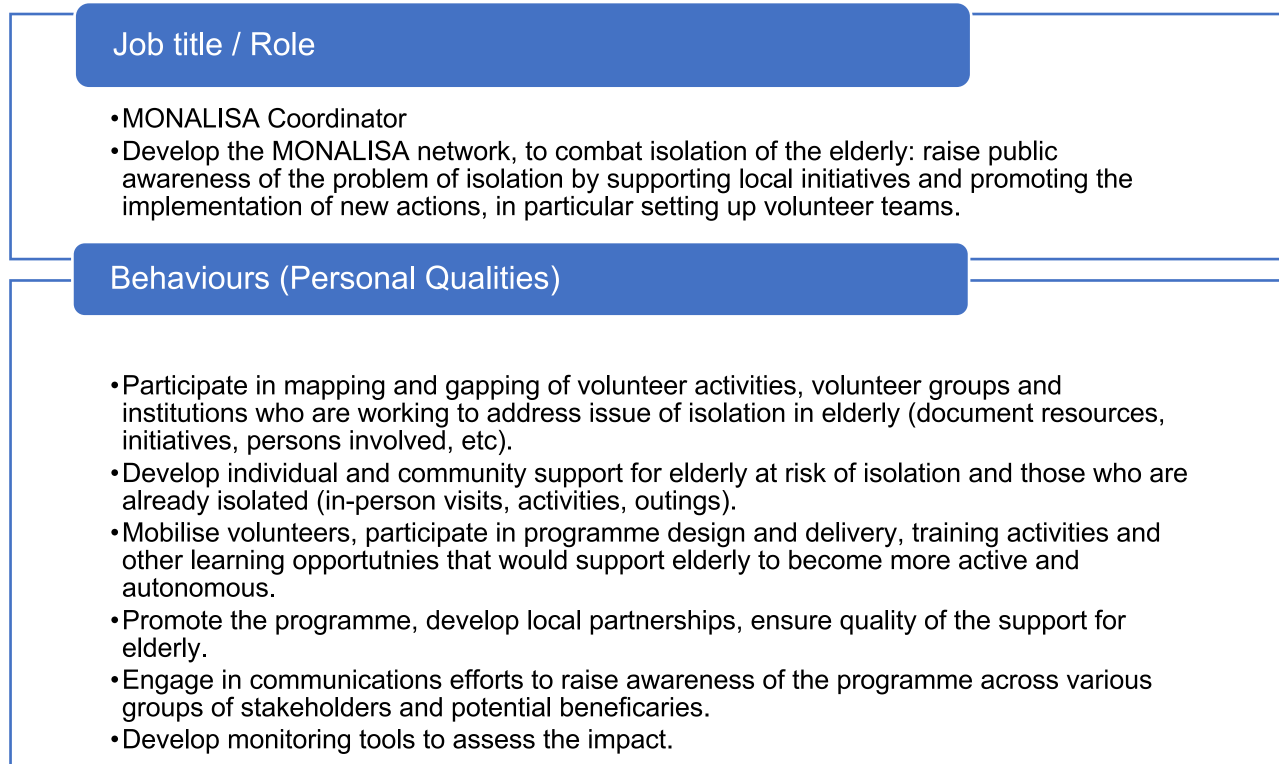


Figure 9 L'Eure Job Qualifications

L'Eure sought to employ Connectors who would work closely with MONALISA programme (see Figure 9 for job qualifications sought in L'Eure). MONALISA (MObilisation NAtionale contre L'Isolement des Agés/National Mobilization against the Social Isolation of the Elderly), established in 2013, is a national-level collaborative platform designed to bring together citizens, public authorities and community organisations across France to promote community engagement and reduce loneliness and social isolation. L'Eure also specified that they are looking for Connectors who are able to engage in mapping and gapping of activities, develop action plans with beneficiaries and track the impact. Similarly to other partners, L'Eure sought Connectors who are able to work as a part of the team and motivate volunteers and others to join action to deliver and/or receive social prescribing in L'Eure.

In order to facilitate the work of their Connectors, Suffolk undertook internal 'Lunch and Learn' in-person and virtual training sessions for their staff regarding the project as well as presenting on occasions to external groups or organisations. They have run in-house workshop days for the Connectors to share ideas and come up with solutions to any challenges the team were facing.

Recommendation

Recommendation: To recruit Connectors, consider tapping an already established service within the local authority, such as Community Wardens, who have long-established and trusted relationships in the community.

Recommendation

Recommendation: Provide Connectors with easily identifiable insignia, such as badges or uniforms, to ensure that beneficiaries feel safe and can easily distinguish between the service you provide and potential fraudulent attempts to exploit vulnerable individuals.

Volunteer Strategy

All partners have engaged in a number of voluntary, community and social enterprise sector (VCSE) activities, and have attended and organized events to promote Connected Communities service in their locality. Originally, the partners intended to engage community volunteers to become an integral part of delivering Connected Communities. However, due to COVID-19 emergence and resulting complexities of gathering people together for training or other voluntary activities, volunteers were not recruited to participate in the service delivery.

Still, volunteers are a natural part of working with the voluntary sector, and the voluntary sector is integral to delivering *social prescribing plus*. Each partner therefore implemented its own strategy surrounding voluntary sector engagement. Volunteer strategies were developed to serve as guidelines for volunteer recruitment, management, and handling of social prescribing referrals at the first stage of delivery. The aim of this engagement was to raise the profile of volunteering, enable community members to become more engaged in their community, engage employers and business leaders in providing volunteering opportunities, and build social capital and local capacity.

Insights

Suffolk team worked closely with Community Action Suffolk, community infrastructure body to ensure inclusion of the VCSE perspective in the implementation of the Connected Communities. Suffolk Volunteer Strategy provides an overview of the benefits of volunteering for an individual, organisation and a community, resources in a voluntary sector, ways to support individuals and organisations to volunteer and engage in their community and steps to be taken to raise the profile of volunteering in Suffolk. Suffolk team will continue to work closely with the Community Action Suffolk and other stakeholders to realize volunteering potential in Suffolk and contribute to the improvements in social, cultural and economic conditions in their community.

Medway team took a sustainable community asset-based approach. Rather than recruiting volunteers to join their Connected Communities service (Better Connected), a fixed term funded project, they worked on an organisational level to create lasting change that could sustain long-term efforts to strengthen the Medway community and reduce social isolation for older people. Medway worked with other organisations in their area to map out and develop assets and strengthen social relationships, and to build community resilience that would outlast the span of the Connected Communities programme (see Figure 10).

Medway engaged with grassroots organisations, led by individuals who have inner knowledge of the communities in which they live and work. This engagement has

helped them to connect micro-assets to the macro VCSE networks and larger community assets such as faith groups and educational institutions. Medway also engaged with the community members and used their input through focus groups and event attendance to gather insights about the service design, delivery and outreach.

> "*A major benefit to getting out there in the community to visit local activities and groups has been getting to talk face to face with service users and volunteers who are able to provide a unique insight into the value of what their organisation is providing for the community and the difference it is making to their lives.*" – Medway Connected Communities Team

Key questions we consider when getting to know a group or organisation

- What support do they currently provide to the community?
- Who can access this support?
- Who are they aiming to reach?
- What are their support needs as an organisation?
- What is the vision of the organisation and what might they need to achieve this?
- What support can we provide?
- What support do they have from the community?

How do we engage with the VCSE & build relationships?

- Attend to organistions' services and activities
- Regular check ins via phone calls and emails
- Attend regular community meetings
- Hold networking events for VCSE
- Put on useful free training according to needs
- 1-1 meetings and catch ups with key staff and volunteers, particularly with organisations you refer to most often

Figure 10 Medway Team approach to engaging with the VCSE

L'Eure team has participated the events dedicated to the volunteers in their region, which bring multiple organisations together to share volunteering experiences and opportunities. The team also relied on the services provided by the CNFPT (Centre de Gestion de la Fonction Publique Terroriale), an organisation that provides training specifically designed for public service employees to engage with the voluntary sector.

Recommendation

Recommendation: Develop volunteer recruitment, management and training specific to social prescribing model. Listening and building relationships with the VCSE is the first step in developing effective Volunteer Strategy.

Communication

Connected Communities teams employed a variety of communication tools and strategies to promote their service in the community and to communicate service outcomes to wider audiences (See Figure 11).

Figure 11 Communications in Connected Communities

One of the first steps was to agree upon project branding and develop promotional banners, logos, leaflets and posters. Each partner designed promotional materials to conform to funding guidelines and align with their own local authority branding guidelines and aesthetics. The designs complemented each other and displayed the funder's logo.

With service promotion and marketing, each partner made decisions to utilise various communications tools based on what best fit their needs. Some focused on video production and distribution and radio commercials while others relied on social media, leaflets, and newsletters. Figure 12 shows portions of newsletters and leaflets from each partner.

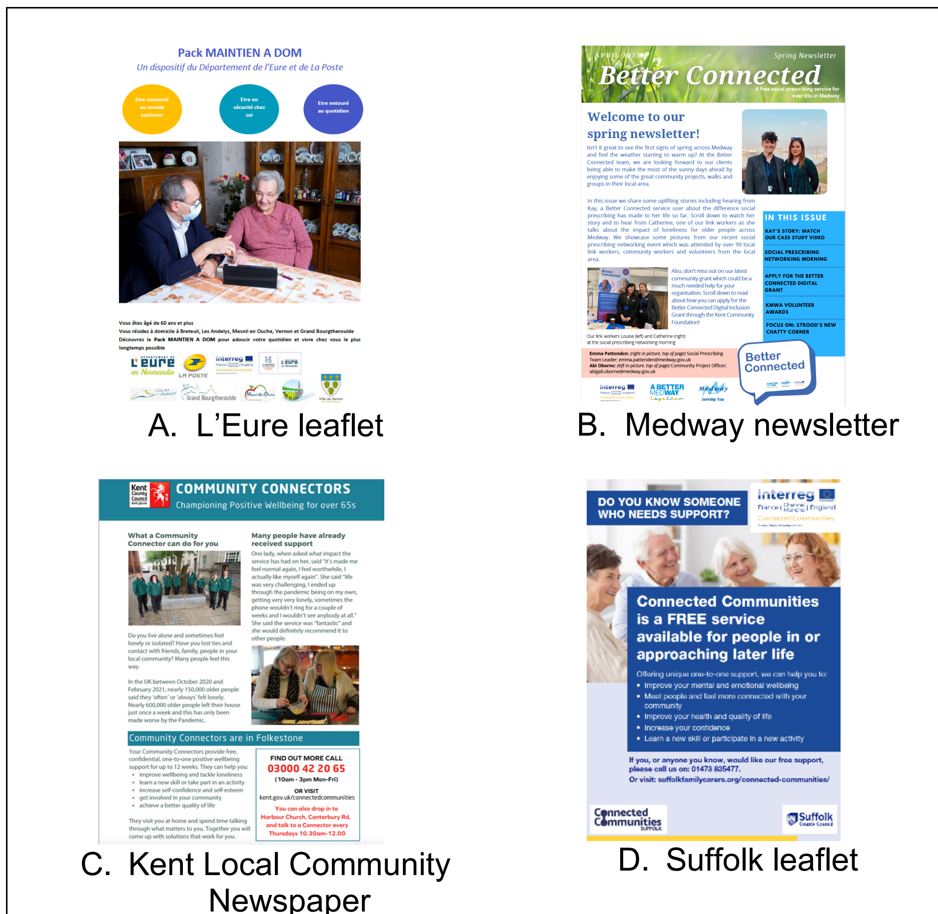


Figure 12 Partner marketing materials

To facilitate external communication, Lead Partner Suffolk created a contacts database and produced a communications and stakeholder engagement strategy. The programme also included within-project communications channels, with partner meetings serving as an essential tool for knowledge exchange and information sharing.

All these efforts contributed to the programme becoming recognised in local communities and the wider social prescribing field in the UK and France. Conference attendance, workshops and community events have helped promote both the service and the outcomes.

Strategies

Each partner had a different marketing strategy that fit within their own organisation's protocols. Here we demonstrate some commonalities and differences among partners. Please consult the Evaluation Report for information regarding the effectiveness and reach of these strategies.

Medway created a marketing requirement briefing where they kept track of project objectives, budget, target audience, internal communication, activities, and engagements in the community and their social media analytics (Table 7). The system required extensive management and documentation from the project leads and demonstrates the dedication to cross-sectoral collaboration within the programme.

Methods of Engagement	Type of Delivery	Actions	Outcomes	Recommendations
Project branding and recognition	• Service Name • Logo • Staff Uniforms	• Held focus groups to gain feedback on potential service names • Designed a logo to be included on all our materials. • Staff had the chance to pick and design their uniforms before the service launched	• Better Connected came out as the preferred name due to its synergy with Public Health's strapline 'A Better Medway'	• The use of focus groups to come up with the service name means you are more likely to have something that the people you are trying to target will engage with • Having a logo provides the service with an identity and allows you to market your programme quickly and easily just by having your logo on something. • Staff to have a uniform that clearly states what service they are from. This is especially important when working with older people, and/or carrying out home visits as this identifies them as professional and 'safe'.
Design of marketing materials	• Imaging and messaging on service materials	• Held focus groups to gain behavioural insights and inform us on what approach we should take with our advertising. A questionnaire was conducted with social prescribers already working in Medway and members of the public who met the Connected Communities demographic	• Images that evoked positive feelings were preferred over images of sad older people. • Avoided the terminology 'social prescribing' as people may not know what this is • Used images of real people over animations or cartoons	• Carrying out focus groups with potential service users and those who may work with potential service users is a useful way to gain feedback and help inform the direction to go in with your marketing and communications
Service promotion and marketing	• Leaflets, posters, postcards • Videos • Case studies • Promotional events • Social Media • Giveaways	• Designed a variety of resources that could be used in any media to promote the service	• Included a leaflet for the programme in the yearly council tax letters resulted in the largest influx of referrals. • Invested in giveaways to handout at events or training	• For maximum reach you need a variety of promotional techniques. However, if you are looking to specifically reach older people, printed resources work best. Particularly if they are delivered through their door.

	• Pull up banners	• Included video, images, and quotes from previous service users • Designed and posted social media posts to coincide with national campaigns • Worked with service users to create case studies • Designed and invested in freebies such as pens, notebooks, hand sanitisers, and tote bags, that we could give away at events and training to promote the service	to remind people of the service, to facilitate referral, to further advertise the service • Designed and purchased three pull-up banners to display at locations such as libraries and community centres to have a consistent presence and to build relationships with staff and volunteers	• The use of QR codes on branded giveaways such as pens or notebooks, provides a quick and instant way for people to refer into the programme. • Postcards/leaflets that include a pre-paid self-addressed envelope removes barriers and encourages self and/or family and friend's referrals • Case studies that show the real-life impact on someone's wellbeing have much better responses than generic service adverts • Short video clips achieve more engagement than static images on social media
Communicating with external stakeholders	• Training • Team meetings • Presentations • Newsletters	• Identified organisations, services and groups that may engage with our client demographic and offered free training, the opportunity to attend our team meetings as well as we attend theirs, a service overview and to be added to our newsletter distribution list. • Designed three training modules, all three made use of case studies to demonstrate the impact social prescribing can have and included an overview of all social prescribing	• Attending team meetings meant that we were able to put together tailored information for that organisation as well as take away relevant information that could benefit our clients. We also invited other teams to our meetings and was a good way to share information in a more meaningful way • Over the course of the project, we trained 1,129 people. This enabled us to promote the Better Connected service across various organisations, as well as	• Attending services team's meetings allows you to tailor your message and ensure it is fully relevant for the attendees. It also means you are generally in smaller groups, making it easier to engage with all members and have more meaningful conversations. You are more likely to get a 10-minute slot on a team meeting than have all that team attend an hour's training, so it is useful for those harder to engage with teams/services. • Providing training that included case studies is a great way to engage large numbers of people across all different sectors. Delivering a session once a month to 15-20 people can be more

		services available in Medway, with particular emphasis on Better Connected - The first was a 1-hour introduction to social prescribing in Medway - The second was a 2.5 hour masterclass which was delivered as part of the Public Health a Better Medway Champions programme - The third was a 1-hour e-learning module including an assessment at the end of the video • Designed and distributed a Better Connected newsletter, which was sent out three times per year. This was aimed at potential referrers as well as VCSE organisations that they could refer beneficiaries into.	introduce social prescribing to as many sectors as possible. Building on our whole systems approach here in Medway. The training resulted in an increase in referrals • The newsletter provided the platform to remind referrers of the service and highlight case studies which showed the impact the service had. It also created opportunities to build on the relationships with our VCS, having a 'spotlight on' section where we could promote and shout about the great work that they were doing helped to engage them in the topic of social prescribing.	effective than trying to contact each person individually. • A newsletter is a visual way to remind referrers what the service offers and how to refer. It provides a way of showcasing case studies and outcomes from the support you are providing. It keeps the service relevant and provides an opportunity to be personable – include photos from the team and a first person narrative from the writer, helping to maintain the relationships you've built without having to contact the readers individually.

Table 7 Medway Models of Communication

Source: Amie Kemp, Medway Public Health Directorate

Suffolk Family Carers, the agency commissioned to deliver social prescribing in Suffolk, led a campaign to drop leaflets to over 10,000 households. Leaflets were given to local businesses, services, and centres to raise awareness of the programme. Suffolk Family Carers also produced a monthly newsletter during the project. The newsletter was distributed to all their local contacts and connections digitally, and hardcopies were given to people Suffolk Family carers visited. All of their leaflets/forms/newsletters can also be found on our website, Connected Communities | Suffolk Family Carers.

Suffolk Family Carers also developed *Keeping In Touch* cards for people to self-refer or express an interest in the service. These cards were distributed and collected at drop-in locations and groups, by both the Connectors and by Community Officers. They also utilised social media and their webpage to advertise the service, including a 2-minute video/webinar presentation about their work.

Kent created a Local Communications plan that identified aims and measurable objectives, brand properties, target audience, stakeholders and tone. Communications channels were identified, and success measures agreed. From this a tactical plan was created to meet objectives and manage campaigns and budgets. Detailed campaign briefs were created for larger campaigns. Weekly and monthly communications reports were produced to ensure that the overall aims and objectives were on track.

To achieve communications targets, Kent planned and budgeted for a Social and Digital Media Assistant (SDMA) to assist with the delivery of the project and to manage reporting. Kent utilised social media scheduling tool analytics to track their engagement.[96] Figure 13 illustrates the marketing approach that Kent has developed to bring awareness about the Connected Communities programme in their community and reach individuals who could benefit from the service.

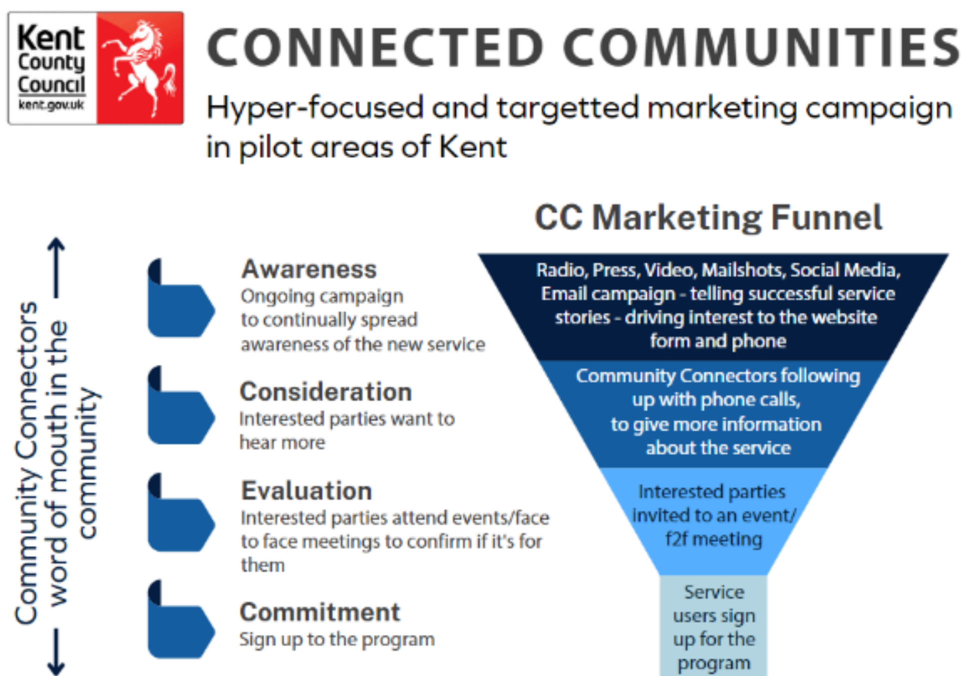


Figure 13 Kent Marketing Approach

Recommendation

Recommendation: Develop a marketing and communications plan to publicise and normalise the programme throughout the community. Establish mechanisms to track engagement which clearly identify the purpose of monitoring, what is being monitored and how it will be monitored.

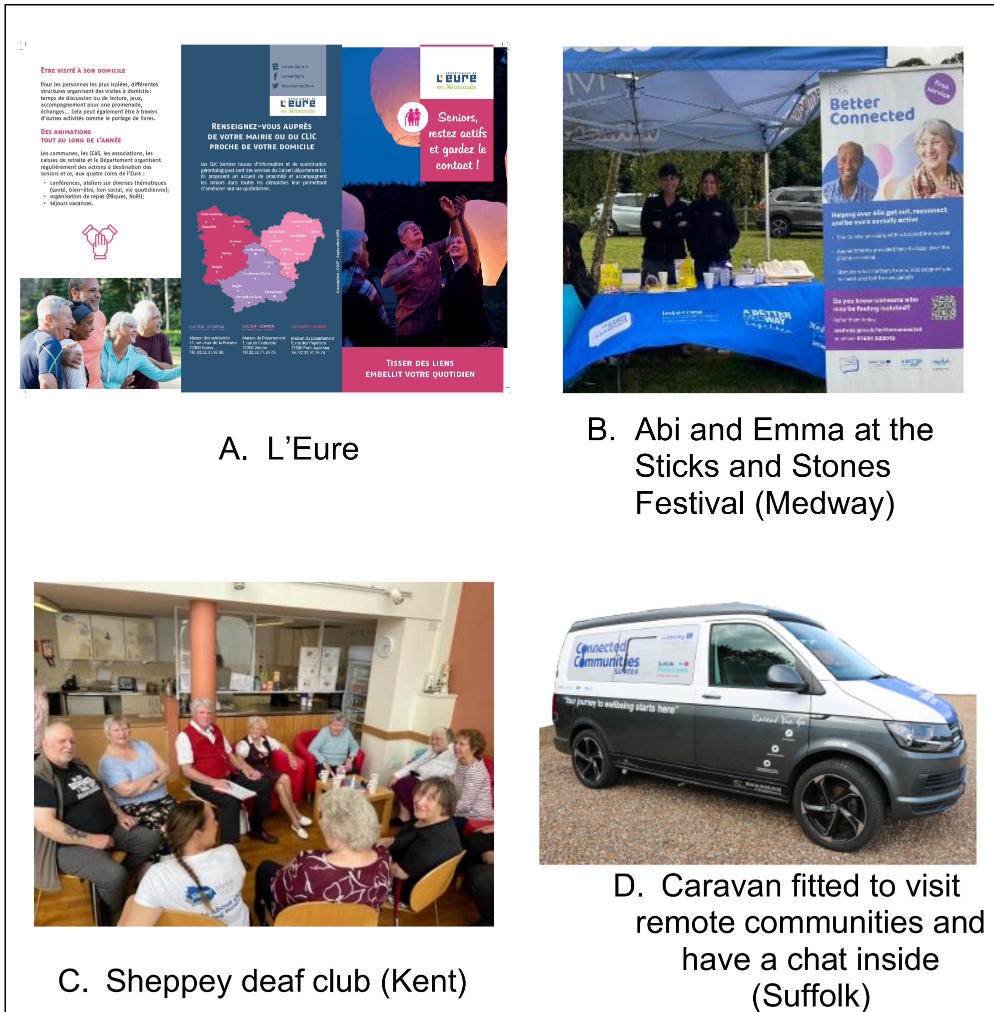
Community Engagement

All local authority partners engaged extensively with their local community by attending and/or organising community activities. Partners also provided micro-grants to local VCSE groups.

The community chest fund provided by the team in Medway enabled 15 organisations to establish or expand groups and activities run within the community. The opportunity created capacity for 1,420 residents to access these services. Suffolk worked in cooperation with local parishes to showcase local projects and revitalise services that were interrupted during the COVID-19 pandemic, providing funds for arts, cooking, singing and community gathering activities. Building on the mapping and gapping work, Kent identified the need for certain new groups and clubs to be set up. Kent Connectors set up and participated in numerous community events, from social gatherings (ex. Spots and Spades group; Our Tea Group club; Sheppey Deaf club), cooking and art classes, to wide-scale community events.

Kent also provided funding to 7 organisations to provide facilities and establish or expand groups and activities run within the community. During the project the funding has supported and benefitted over 1,000 residents who access these services every week. These organisations are now well equipped and are able to sustainably support residents who are socially isolated or lonely beyond the life of the project.

Figure 14 shows some of the engagement activities partners undertook. These activities across partner locations have helped Connectors get to know their community members better and become better informed about their needs. In turn, Connectors are better able to help individuals and organisations connect with each other and utilise services provided by programmes such as Connected Communities.



A. L'Eure

B. Abi and Emma at the Sticks and Stones Festival (Medway)

C. Sheppey deaf club (Kent)

D. Caravan fitted to visit remote communities and have a chat inside (Suffolk)

Figure 14 Partner engagement events

Recommendations

Recommendation: Tracking the distribution of the communication channels and outputs is essential for an individual project and the wider community, as it provides knowledge about programme reach and ways in which information about social prescribing is being consumed.

Recommendation: Engaging hard-to-reach community members can be a difficult task. It is important to ensure that a social prescribing service, new or existing, has the dedicated skills, resources and knowledge needed to support the project promotion.

Dissemination and Integration

We employed a variety of approaches to disseminate our work and integrate our efforts across our project partners and stakeholders (Figure 15). Periodic Evaluation Reports were designed to evaluate Connected Communities activities throughout the project duration and inform decisions and refinements moving forward. The University of Essex employed both process and impact evaluation. Reports provided an assessment of whether a process was taking place as originally proposed, which decisions had led to the outcomes, and which elements of the process were performing better or worse in terms of achieving outcomes. The Team also conducted analyses of qualitative (case studies) and quantitative (pre and post-survey) data to test whether changes were occurring in the outcome variables given in our original evaluation logic and the extent to which any observed changes could be attributed to Connected Communities (impact evaluation).

Figure 15 Dissemination and Integration

Insights

The insights gained from the evaluation and partner meetings have been used to develop and inform policy briefs, webinars, workshops, snapshot reports of the data and results, academic articles, conference presentations, policy and practitioner interactions (such as advisory board meetings), and civic presentations.

Figure 16 **Royal Society for Public Health, Twitter post** congratulating Evaluation Team on citation award

Our publication on loneliness and social prescribing has been recognised by the Royal Society for Public Health as one of the most cited papers in *Perspectives in Public Health* in 2021.[9] Figure 16 shows the journal's twitter post about the award. This work and another systematic review[53] of the impact of social prescribing on wellbeing, connectedness and social isolation have given us a greater understanding of the variabilities and complexities of this model in public health and the social sciences. Our work has further motivated us to examine the links between loneliness, connectedness and civic engagement, with an aim to provide insights into the links between health and ways in which people engage in community life.

Policy briefs and case studies were helpful tools used to consolidate research knowledge and practical insights gained from the field to effectively participate in numerous practitioner and policy maker meetings and to contribute to developments in the field. As an example, the Team attended the East of England All Party Parliamentary Group meeting to participate in the discussion "How Integrated Care Systems will help Tackle Health Disparities." The meeting was attended by the local and national government representatives, University of Essex scholars, the East of England voluntary and community sector, and practitioners. During this event the Team had the opportunity to hear about the challenges facing coastal communities and innovative proposals being developed to address them. This work also informed academic and civic presentations, such as those given to Woodbridge and Medway Rotary Clubs.

Team efforts led to further engagement, such as partnering with the National Social Prescribing Network to co-host the Fourth International Social Prescribing Conference (2021),[97] participating on numerous social prescribing advisory boards in the East of England, and presenting work to social prescribing managers and providers across the UK, Canada, and the US.

As a part of dissemination and integration efforts, the Team created a working group organised a series of webinars that attracted more than 30 members from fields such as psychology, sociology, health and social care, VCSE, and politics/government to work on advancing our collective understanding of social connectedness. The working group attracted a lot of attention and brought together participants across the UK and abroad to:

- Identify and examine the gaps in the current research and practice.
- Collaborate on best practices to advance our understanding of social connectedness.
- Actions to be taken at the research and policy levels to facilitate the work in the field.

We took a staggered approach to our dissemination and integration activities, with each output serving as a stepping stone for future activities, carefully building and curating a network of individuals interested in public health and social prescribing.

Recommendation

Recommendation: In order to maximise integration and dissemination output impact, identify common and distinctive elements of each so that the outputs complement each other.

Value for Money Assessment

To assess value for money, UoE focused exclusively on the intended outcomes in terms of the beneficiary (individual), the system (healthcare), and the community where Connected Communities would be delivered. The Evaluation Team gathered data from multiple sources to derive cost/savings estimates of reducing loneliness and isolation.[45,48,70,98–102] First, we detail the formula used to forecast what the value for money would be. Then with some important qualifications, we use that formula to estimate what the value for money has been.

Forecast healthcare savings

The costs to healthcare generated by loneliness are vast.[45] We used estimates of the cost of loneliness in terms of primary care, emergency care, residential care, memory care, and short/long term health care. At the time of proposal development, the Evaluation Team estimated the figures as given in Table 8 (in 2018 EUR).

	UK	FRANCE
Cost of loneliness and isolation per person over 3 years	€2775	€3053
Potential per-person reduction in healthcare costs due to an effective intervention that reduces loneliness (6%-17%)	€167 - €472	€183 - €519
The total number of expected direct beneficiaries of *social prescribing plus*, based on number of full-time Connectors to be employed	900	1,300
TOTAL SAVINGS IN HEALTHCARE COSTS DUE TO LONELINESS REDUCTION OVER THREE YEARS	**€150,000 - €425,000**	**€220,000 - €623,000**

Table 8 Estimated healthcare savings due to Connected Communities, forecast prior to programme implementation

We first learned that the estimated average cost of loneliness and isolation in terms of healthcare over 3 years was €2775 in the UK.[45] The Evaluation Team used this figure and an increase of 11% (derived from data accessed via the French Public Service[103]) to estimate the same cost in France to be €3053.

Estimating that a successful social prescribing programme could reduce loneliness by approximately 6%-17% per participant,[45] the Evaluation Team then derived the potential savings per beneficiary to be €167 - €472 per person in the UK and €183 - €519 per person in France.

Partners determined that a fair estimate for the expected caseload of one fulltime (FTE) Connector in one year was 100. The Evaluation Team therefore decided that a conservative estimate of 100 directly treated individuals per Connector over 3 years would be appropriate. Given that a total of 9 FTE Connectors would be employed by Connected Communities in the UK and 13 would be employed in France, the Evaluation Team estimated the total number of beneficiaries served to be 2200 (900 and 1300, respectively).

Multiplying the potential per-person savings times the number of beneficiaries gave us ranges of how much might be saved in total in each country over 3 years. These ranges were €450,000 - €1.27 million for the UK and €660,000 - €1.87 million for France.

Forecast non-healthcare savings

According to the Centre for Economics and Business Research[48], an increased sense of community that arises from greater connectedness can be associated with a 1-3% reduction in crime. This reduction comes from community connectedness 'acting as a social control and providing a set of norms of behaviour that residents (and visitors) are expected to abide by'.[48] Connectedness can thereby reduce crime and demands on policing, as well as provide local alternatives to public services, such as neighbourhood watch groups. Considering the most conservative estimate of a 1% reduction in crime in 2018 crime estimates for each country, the Evaluation Team calculated a savings of €3.48 per person per year in the UK and €3.76 per person per year in France across a community due to crime reduction if an unconnected community were to become connected.

Oswald[99] and the Centre for Economics and Business Research[48] argue that people living in disengaged communities are less productive than those living in engaged communities, and estimate that heightened engagement can be associated with a 12% rise in overall community productivity. These changes would be due to having a stronger network of social capital to draw from for help, and to lower stress, higher self-esteem, and health and lifestyle improvements that can be associated with community involvement. Granovetter[101,102] further argues that higher levels of connectedness can provide employment guidance, including information about open positions, job search skills, and employment, and a reduction in sick days or personal leave.

The Centre for Economics and Business Research[48] gives estimates for other social costs that a community incurs due to a lack of connectedness. Using their estimates and similar calculations to those for crime/policing, the Evaluation Team estimated the potential savings due to increased neighbourliness, increased happiness and self-esteem, increased physical exercise, and decreased stress levels, on a per-person per-year basis.

Connected Communities was expected to spread interactions with beneficiaries over the course of three years of delivering *social prescribing plus*. By programme end, beneficiaries who took part in the project early on would have therefore been connected to their communities for a longer time than those beneficiaries who participated later in the life of the programme, meaning the community-level benefits generated by the participation of the later beneficiaries would be lower. Estimating the community-level effects over 3 years needed to account for this difference, as well as for the increasing number of connected beneficiaries that would accumulate in a particular community over time. To account for these cumulative and diminishing effects simultaneously in our estimate for 3 years, the Evaluation Team follow guidance from the Centre for Economics and Business Research[48] and increase the per-person estimate for one year by 11%. Our final estimates of non-healthcare related benefits per person living in a connected community over 3 years are in Table 9.

	UK (per person, 3 years)	FRANCE (per person, one year)
Benefit of increased neighbourliness	€240	€260
Benefit of decreased crime	€3.48	€3.76
Benefit of increased happiness	€203	€219
Benefit of increased physical exercise	€5.30	€5.72
Benefit of decreased stress and increased self-esteem	€1.77	€1.91
TOTAL NON-HEALTH COST (ROUNDED SUM)	**€454**	**€490**

Table 9 Estimated per-person non-healthcare savings due to Connected Communities, forecast prior to programme implementation

Suffolk County Council · East Suffolk Council · University of Essex · L'Eure en Normandie · Kent County Council · Medway Serving You

Forecast community size

To estimate the size of the community for a group of treated individuals, the Evaluation Team took guidance from UK census classifications,[104] where geographies are divided into output areas. One middle layer super output area (MSOA) contains 5,000-15,000 people. Each Connector would ideally serve 100 beneficiaries by helping them connect to their wider community, so the MSOA was used to estimate community size.[1] The MSOA lower bound is 5,000, so the Evaluation Team took that as a conservative estimate of how many people in a community might be affected by an intervention targeted at 100 users. Dividing 5000 by 100, the Evaluation Team estimate that each treated individual may spread benefits of connectedness to 50 others.

Estimating 1-to-50 individual-to-community ratio for 2200 treated individuals, Connected Communities was therefore predicted to affect up to 110,000 people (45,000 in the UK and 60,000 in France), saving €20,43 million (UK) and €53,9 million (Fr). Table 10 lists the estimates used to make this calculation.

	UK	FRANCE
Total non-health benefit to living in a connected community (rounded sum)	€454	€490
Total number of people benefiting from living in a connected community	45,000	60,000
Total non-health related cost of savings of 3-year programme	**€20,43 million**	**€53,9 million**

Table 10 Estimated total non-healthcare savings due to Connected Communities, forecast prior to programme implementation

Forecast total cost savings

To predict the final cost savings benefit due to Connected Communities, the Evaluation Team then added health-related savings to non-health related savings (Table 11).

[1] The lower layer super output area, LSOA, was not chosen because the population of an LSOA can be as low as 1,000, meaning one Connector would deliver to 10% of that population. It is not realistic to assume the percentage of disconnected elderly residents of a community would be 10% of the overall population for every treated area; in short, the LSOA is too small to estimate full community reach.

	UK	FRANCE
Total non-health related cost savings of 3-year programme	€20,43 million	€53,9 million
Total health related cost savings of 3-year programme	€150,000 - €425,000	€220,000 - €623,000
TOTAL HEALTH RELATED COST SAVINGS OF 3-YEAR PROGRAMME TOTAL ESTIMATED SAVINGS OF CONNECTED COMMUNITIES	**€20,58 million – €20,86 million**	**€54,12 million – €54,52 million**

Table 11 Estimated total savings due to Connected Communities, forecast prior to programme implementation

Totalling the estimates for the UK and France, the Evaluation Team forecast the total savings due to Connected Communities to be in the range of €74,7 million - €75,4 million (in constant 2018 euros).

Applying the formula

Applying this formula to actual Connected Communities delivery is straightforward but should come with a few important caveats. Critically, the formula calculated above is only based on the *social prescribing plus* component of Connected Communities. It does not account for any of the other benefits realised by the partners. Throughout this Toolkit, these benefits are described in greater detail.

For example, both Kent and Medway underwent an enormous amount of learning and refinement in terms of managing and delivering social prescribing in general. Kent developed a detailed and thoughtful Client Record Management System (CRMS) that they will be able to use effectively and safely to collect and manage beneficiary data going forward. Medway put no less time and energy into co-producing a governance structure for social prescribing across their geographic area, and the community of governance that they built is now a powerful network able to deliver a holistic and integrated approach to health care. Aside from the legacy of the concrete tangible mechanisms of the data collection system and governance network themselves, the insights learned from undertaking these processes can now be applied moving forward. Yet they are not represented in any way in the formula above.

Other benefits from Connected Communities include insights learned from the partnership structure. Time spent negotiating data protocols, working together to design projects, and coordinating reports has taught all partners that even within the same region, each local authority has unique ways of working. Working together with partners across the Channel and navigating the departure of 3 partners prior to delivery has given us all insights into the opportunities that differing local authority structures and community cultures can offer. These benefits are also not represented in the value for money formula, and they should be.

Finally, there are numerous activities delivered by partners to people who did not receive coaching from a Connector, but who still reaped many potential benefits by participating in events. The outreach conducted by Kent and Medway drew in hundreds of participants. The warm handover in Suffolk funded VCSE organisations

who multiplied the monetary value received by making adjustments to accommodate ever increasing referrals. These benefits should have been included in the value for money formula, as well.

Spread throughout this Toolkit are Recommendations the Connected Communities partnership offers based on 4 years of working together to deliver this important project. In fact, the Toolkit itself is a resource valuable to the legacy of Connected Communities in that it carries forward insights to readers who may be designing or delivering social prescribing or other cross-authority or cross-national projects in their area. The Evaluation Team therefore acknowledge that our original value-for-money formula was naïve and far too narrow in focus.

Further, the formula does not account for changes in delivery context, which is described in the **Broader Context of Implementation** section. For example, it is likely that the number of people any beneficiary could connect with was greatly constrained by COVID-19 management protocols.

That said, we can apply the formula based on the number of beneficiaries ultimately served by the remaining partners.

		UK	FRANCE
A	Potential per-person reduction in healthcare costs due to an effective intervention that reduces loneliness (6%-17%)	€167 - €472	€183 - €519
B	Total non-health benefit to living in a connected community	€454	€490
C	Total number of direct beneficiaries of social prescribing plus	182	204
D	Total number of people benefiting from living in a connected community	9,100	10,200
E	Total health related cost savings of 3-year programme (A x C)	€30,000 - €86,000	€37,000 - €106,000
F	Total non-health related cost savings of 3-year programme (B x D)	€4 million	€5 million
G	**TOTAL ESTIMATED SAVINGS OF CONNECTED COMMUNITIES**	**€4,03 million – €4,09 million**	**€5,04 million – €5,1 million**

Table 12 Connected Communities Total Estimated Savings

Broader Context of Implementation

Here we discuss factors that pertain to the broader context in which a social prescribing programme is implemented. The design, management, delivery, evaluation, dissemination, integration, and communications of Connected Communities have faced multiple challenges, including factors at the national and international level. [85,105,106]

National Context

We first note that the national policy context in which social prescribing is implemented will affect how it should be managed and delivered. While the total number and the exact nature of social prescribing initiatives being implemented in the UK and France is currently unknown, a launch of a Global Social Prescribing Alliance in February 2021, in cooperation with the World Health Organisation, illustrates the spread and the relevance of social prescribing at a global level.[107] A report by the La Fondation de France mentions close to 1000 initiatives currently underway in France.[108] It is possible, therefore, that systems and communities where Connected Communities' SP+ programme is being implemented could be reaping benefits from programmes with nearby or overlapping coverage areas.

With the NHS announcement, every primary care provider in the UK was required to add social prescribing to its standard offer. This rapid expansion of social prescribing schemes in the UK since 2019 has posed a major challenge for implementing Connected Communities. Primary care surgeries immediately began contracting and commissioning social prescribers, without standardisation of exactly what was required in terms of delivery, or how it would be evaluated. Our partners in Medway report that the number of social prescribers in their area went from 11 to 45 in the course of one year.[105]

Our partners have also identified staff recruitment and retention challenges due to the rapid expansion of social prescribing initiatives in England. Kent's decision to utilise already established professionals, Community Wardens, has proven a successful way to avoid this issue. Prior to Connected Communities, Community Wardens role consisted of providing community safety, assisting vulnerable individuals to navigate community services and improving community resilience. Once they joined in implementing Connected Communities, the Wardens became trained to not only provide solutions for individuals, but to enable them to find solutions for themselves via a social prescribing 'what matters to you' model. Community Wardens were already embedded in the communities, are well-known and trusted members of their communities. They are recognised by the uniforms and the official Kent County Council insignia which provides a sense of comfort and safety for those receiving service. This has resulted in greater continuity in the staff members delivering the programme and the ability to utilise already established relationships. Furthermore, by having skills to deal with more complex cases (safety, mobility, etc), Kent Community Wardens were equipped to address more complex cases who required help that is beyond the social prescribing model. Through the Community Warden Service, our partners in Kent have engaged with numerous community organisations to develop and implement Connected Communities. The success of the Community Warden Service was well documented by Rebecca Law, Public Protection and Business Development Manager in Kent, at the Local Government Association platform.[109]

Similarly to Kent, our partners in France have chosen to employ a well-known agency to deliver their services, La Poste workers. La Poste workers are also well-known and trusted individuals with a wide reach, being in contact with individuals of all backgrounds. La Poste workers were trained to deliver social prescribing in L'Eure which has resulted in continuity in service delivery and success in engaging hard to reach individuals. L'Eure has also noted a great interest by the Connectors in France to work collaboratively across 5 pilot towns in the region to identify individuals who could benefit from the programme and to deliver the service in collaboration with others who work in this field, primarily staff from the MONALISA project.[23,106]

Furthermore, the expansion of social prescribing greatly highlighted a lack of government investment to help the VCSE accommodate the increase in demand due to the success of social prescribing. Kent noticed that the lack of investment in VCSE organisations at the local and national level presents significant challenges for social prescribing field. Our partners who have experience working directly with the VCSE have observed that the investment from the Government has predominantly focused on developing and implementing social prescribing services and not followed through to the VCSE organisations delivering the support. Without greater investment in VCSE, it is possible that social prescribing interventions might not succeed in eliminating underlying needs, but rather shift the demand from health services to the VCSE without proportional shift in resources. Many of the existing VCSE services are already oversubscribed and underfunded, limiting the capacity within the sector to receive and effectively address referrals to VCSE services. Underfunding VCSE services is likely to have a detrimental impact on those needing to access services as well as the organisations trying to deliver them.

Suffolk County Council Suffolk responded to this situation by developing the "warm handover" system. With this system, 90 VCSE organisations were given the opportunity to bid for up to £10,000 each. If acquired, the funding could be used to expand services, expand range, or develop new ways of working. This funding was meant to aid VCSE organisations in accepting the handover of social care provision from statutory authorities and public sector providers.

Recommendation

Recommendation: Organisations that seek to implement social prescribing should devote time and resources in their project plan to identifying and tracking changes in the public health policy, in VCSE, in local authorities' management and priorities, and in any other bodies relevant to social prescribing implementation.

Taking advantage of the proliferation of social prescribing around the UK to collaborate with other social prescribing projects and organisations in a locality has greatly helped to our partners to lessen the impact of this particular challenge. Additionally, working on developing training modules and/or identifying existing training resources and attending those also helped making others aware of the Connected Communities service, which has helped with reducing overlap in service delivery.

We note that without awareness of the entire social prescribing offer in a particular area, it is possible for a new social prescribing service to duplicate services or overlap geographic areas. It is therefore possible for a lack of uptake to be due to potential beneficiaries already working with pre-existing or better publicised providers, rather than reflecting a lack of need or use in an area.

International context

We also note that global factors, such as geopolitical changes or widespread crises, will affect how public health programmes such as Connected Communities are delivered.

Global Crises

The COVID-19 pandemic highlights only some of the challenges Connected Communities experienced in delivering the originally proposed programme. As a programme, we were faced with changing delivery mechanisms due to social distancing protocols related to COVID-19.

COVID-19 has had a profound impact on all aspects of the service. It delayed the service delivery launch for more than 6 months and resulted in one of the French partners (L'Oise) leaving due to unprecedented pressures on public health services. L'Eure, our remaining French partner, reports significant hindrance to the MONALISA programme during the pandemic as well as the official programme launch. Medway's programme launch was scheduled on the same day that the first lockdown was announced in England. Similarly, all other partners were aiming to begin service delivery in March 2020, which happened to be the beginning of the COVID-19 related social restrictions period. For those partners who were implementing Connected Communities from within their own public health unit, local authority staff's primary focus became addressing urgent and basic welfare needs, thereby redirecting staff availability and resources. Some staff was redeployed to test and trace centres, others to facilitate COVID-19 vaccinations or to call and check on vulnerable residents.

Despite these challenges, Medway reports that during this period they were able to support over 730 residents with various needs and develop stronger links with the VCSE, all of which they were able to build upon once their started delivering Connected Communities Service. Our partners in Kent report that COVID-19 also impacted staff capacity and increased health-related absences, resulting in social prescribing appointments being missed and/or rescheduled due to either staff or beneficiary sickness. Medway and Suffolk teams report that COVID-19 pandemic resulted in an increase in social anxiety, so that even when services began to open, many beneficiaries did not feel safe or confident enough to engage in face-to-face interactions. Many VCSE services closed during the lockdowns, which presented challenges for knowing which community resources were available for referral. An increase in the need for mental health services created further challenges for the Connectors, as those that were being referred showed complex health needs that were out of the scope of the social prescribing service. In Medway, this resulted in long waiting lists of 6 months or more for individuals to access mental health services. All this has had an impact on the project teams meeting project participation targets.

Our partners responded to this challenge by using the time they could not meet with beneficiaries to build other strengths needed for eventual delivery. These responses included:

- Building strong links with the VCSE, community members and organisations;
- Adapting to digital methods of communication and engagement, such as a digital loan scheme for digitally excluded individuals to be able to access tablet computers and other means of communication;
- Developing and/or attending e-learning training modules;
- Building a remote dissemination network when in-person networking was unavailable;
- Continuing with mapping and gapping procedures, so as to have up-to-date information on available services when Connectors were able to begin.

Geopolitical changes

Brexit-related uncertainties led to the departure of 2 French partners from the programme, Seine Maritime and Manche. When followed by the departure of L'Oise due to managing COVID-19, the total French partner departure resulted in L'Eure being geographically isolated as the only partner to continue in its area or country.

Both of these challenges are the types of the changes that are difficult to predict in real time, however, it is important to recognise and discuss with the funding bodies and when the project is being designed the risks of unprecedented social and geo-political changes and how best to ameliorate those.

Recommendation

Recommendation: Develop risk management plan to address potential large-scale national and global changes.

Social Prescribing Success and Sustainability: Connected Communities

For a social prescribing programme to be sustainable and continue to be supported by funder/s such as a local authority, VCSE, or public health bodies, the programme needs to be able to demonstrate its benefit in one or more of the following ways:

- *To current and future programme beneficiaries*: health, behavioural change, engagement in a community, individual connectivity with others; individual productivity.
- *To individuals involved in programme delivery*: expertise, skills.
- *To multi-sector collaborative networks:* partners working together equitably, emphasising shared ownership.
- *To the VCSE*: resourcing, capacity building, a seat at the policy making table.

- *To other sectors affected by the intended changes caused by the programme*: health, social care, public benefits, public health.
- *To the wider community*: value for money, financial sustainability, community engagement, community connectedness, community productivity.
- *To the academic community:* building upon existing work in the field of social prescribing, advancing the field by testing and improving tools and measurements used to assess social prescribing impact.

For more information on the suitability and impact of social prescribing initiatives, NASP provides extensive resources and analysis of various programmes across the UK in regards to impact and sustainability.[80]

Infrastructure

Transport

Lack of transport across localities has affected people's ability to participate and be engaged in community life. Transport across Kent's four pilot areas has remained a concern through the duration of the project delivery, the lack of and ongoing reduction in public transport continues to exacerbate the problem of social isolation and loneliness.

Figure 17 is a screenshot of Kent County Council's Facebook advertisement for the service and subsequent comments from residents surrounding the recent changes to transport routes across Kent. All 5 comments on the Facebook post express extreme concern surrounding the current available bus routes, and how these changes / cancellations have impacted on their ability to connect.

Suffolk County Council EASTSUFFOLK COUNCIL University of Essex L'Eure en Normandie Kent County Council Medway Serving You

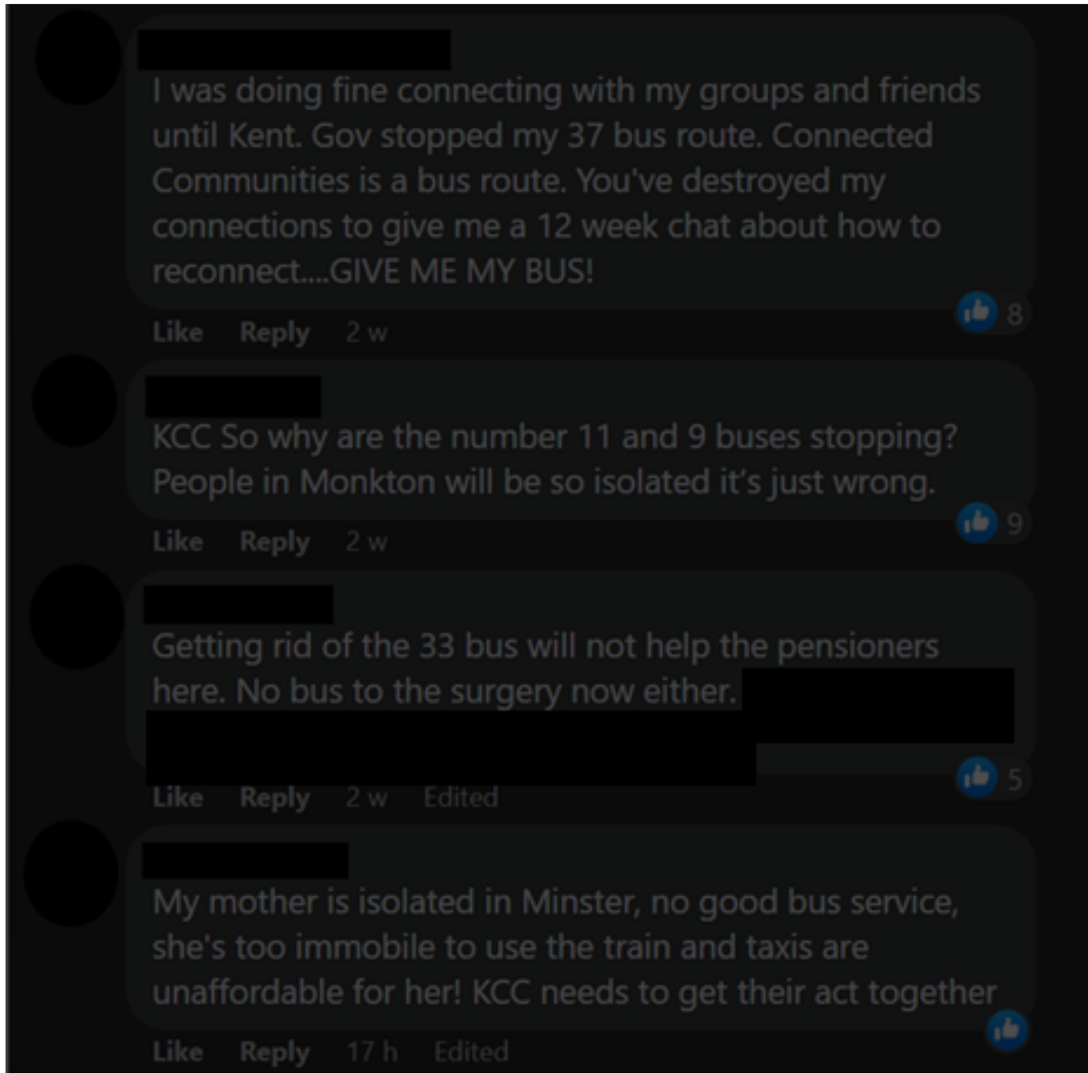


Figure 17 Screenshot of social media posts in Kent

According to the Kent team, as of April 2022)[110]

- 33.9% of Positive Wellbeing service users in Kent experienced mild transport issues,
- 32.2% of service users in Kent experienced moderate transport issues,
- 33.9% of service users in Kent experienced severe transport issues.

Mild: Service user have access to their own vehicle and do not rely on public transport. However, should they lose access or ability to use this transport method, their reliance on public service might be limited due to how frequent and affordable the transport is in their area.

Moderate: Service user has access to public transport using a bus pass. Other methods of travel, such as a train or a taxi, are unaffordable. The service user is dependent on frequent availability of public transport and has trouble when routes are cancelled or changed.

Severe: Service user has limited / no access to public or charitable transport due to distance / difficulty reaching the bus stop, availability of the service and cost. Unable to pay for a taxi due to cost.

Other observations as reported by Kent Connectors and other VCSE organisations in the area:

- Public transport options are limited, geographically far apart from the service user's address, expensive and infrequent.
- Buses in some parts of the pilot areas do not run past 6pm. This limits a service user's ability to attend evening clubs and classes. Some activities in the community do not start until 6pm.
- Private hire firms are often beyond the financial means of our service users. For example, a taxi from the east of the Isle of Sheppey to the west is £20 each way, resulting in a £40 round trip. Our service users are generally retired individuals mostly in the lower income bracket.
- There are none, or few, supporting VCSE organisations providing transport to service users at no or reduced cost.
- Some service users are unable to get to their closest bus or train station due to physical limitations. This is an issue for service users even if the transport routes are available within one mile of their home. Complex health needs are a common barrier to service users when it comes to making good use of public transport.

Partners in Medway have also identified transport to be an issue in their locality. For the community members in Medway that cannot access public services or afford private transport, alternative means are limited. Although support is available for those needing to attend medical appointments, the same provision is not in place for non-clinical appointments, such as a prescription to an art therapy group to reduce isolation and improve mental health.

Therefore, transport has been identified in the Medway and Swale 5-year plan as a risk to the Social Prescribing system and something that is to be raised as part of a wider issue in Medway.

Maximising Untapped Community Resources

A greater understanding of how individuals and organisations connect to improve public health and deliver social prescribing initiatives such as Connected Communities would provide much-needed insight into both overtaxed and underutilised community resources. There are a number of hubs that implement elements of social prescribing, with examples such as Herts Help and Help Hub having close to 70 member organisations which work together to process social prescribing referrals, to help individuals find community-based solutions, and to track the activities of organisations and individuals who seek help. In addition to helping deliver social prescribing, these types of networks work to address and understand different organisational and ideological approaches across the sectors, and likely hold valuable insights about the distribution of community resources. In-depth study into these areas would help make a social prescribing model sustainable and able to reach its maximal potential.

In the UK, integrated care systems (ICSs) have been expected to formalise and embed voluntary and community sector organisation engagement in decision-making beginning in July 2022, further emphasising the idea that taking a whole system

approach is the way forward for good public health. A *whole system approach* would require the involvement of local authority units, health and social care services, VCSE, researchers, policy makers, public health representatives and other relevant bodies working in partnership to build sustainable social prescribing. As these developments start to emerge, we will have a clearer picture of the untapped resources that can help improve health and wellbeing.

Community Researchers

We view two types of the community researchers as currently underutilised in the social prescribing field: community members with lived experience and academic researchers.

A case study from our Kent partners, Mrs B, illustrates the potential of community members and academic researchers to contribute to the evaluation and integration of social prescribing. Mrs B was an active member of her community, engaging with many friends and activities until suffering a stroke. She lost her physical and mental confidence after the stroke, with her condition worsening after some falls and deterioration of vision. In conversation with her Connector, Jackie, Mrs B set goals that she wanted to achieve as a part of the programme, and then worked actively to improve her health. Within a short period of time, Mrs B was attending activities again and feeling that her speech and movement had greatly improved. She then began to pursue her goal to help establish other groups to bring in other individuals with similar health issues who experienced stroke and now feel socially and mentally isolated from others.

Seeing how active Mrs B was and how much she enjoyed her new active role in the community, her Connector Jackie decided to connect her with a local master's student from the University of Kent who studies the effects of strokes on the brain. They agreed to meet to see if they would get on and be able to help each other – Mrs B would share her experiences with the student, and the student would accompany Mrs B to various places to increase her confidence to travel and widen her engagement. Through this collaboration, Mrs B managed to not only go to local towns in Swale on her own, but also to London by train and even got on a boat from Queenborough Harbour to see her granddaughter in Essex. This synergy of lived-in experience and academic research is just one of the examples of what is possible when social prescribing model is applied to address health issues and when individuals connect with each other through social prescribing.

While Connected Communities partnered with the University of Essex during the proposal phase, many social prescribing programmes do not have the opportunity to establish links with academic institutions right from the start. Some programmes are only able to connect with the academic researchers at the point of evaluation, which is often left until the programme delivery. This unfortunate timing is often due to a lack of mechanisms to facilitate engagement between public spheres such as local authorities, VCSE, and academic researchers. Social prescribing will be a more sustainable paradigm if academic researchers were part of programme design from the very start. Discussions around the programme design, data collection, analysis and impact evaluation determine how the programme will be delivered and to what extent the programme is likely to achieve and be able to evidence its goals.

Community Spaces

One of the spaces that seems to be underutilised in the social prescribing are libraries. There are numerous studies on the impact of museums, art and leisure centres, and gardening via social prescribing, and very few in relation to libraries. Libraries provide spaces for community groups to gather and as well as safe and restful spaces for individuals. Libraries have the resources to host reading clubs, which can help with alleviating mental health struggles linked to depression and anxiety as well as provide the opportunities for individuals to connect with each other through a reading activity. Reading is beneficial for many cognitive functions, and as such could be a valuable tool to utilise in social prescribing. The librarians could be trained to signpost people to social prescribing initiatives, thus expanding referral pathways. The library spaces and their staff have been underutilised in our programme and it seems similarly in other social prescribing initiatives.

Outcomes and Benefits

Despite the numerous challenges described above, Connected Communities partners observed profound benefits from participating in the partnership. We highlight some of these here: [85,105,106]

- Greater cooperation and connectivity among local authority departments;
- Improved collaboration with the VCSE and other local organisations who work outside of the field of public health (for example *La Poste* in France);
- Greater understanding of the different health and social care systems across partners and across the Channel;
- Greater understanding of funding procedures and requirements within European funding bodies;
- Greater understanding of partner's own local authority regulations in regard to implementing public health initiatives such as social prescribing;
- Generation of outputs and materials by multi-partner effort across regions and in two languages;
- Better information about what social prescribing is and how individuals, communities, sectors, and local authorities can benefit from it;
- An increase in awareness of loneliness and isolation and how to address them among ageing populations;
- The sharing of experiences with other service providers and organisations that work in the field.

Overall, Connected Communities provided partners with an opportunity to better connect with the internal and external stakeholders who work in the field of social prescribing, and this connection has enabled the partners to become more responsive to the local needs in their locality.

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