SOCIAL PRECRIPTION MODELS IN LEICESTER AGEING TOGETHER

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IMH Research Support and Consultancy Service

Contents

Executive Summary

Background to social prescribing within Leicester Ageing Together

Leicester Ageing Together (LAT) is a multi-partner programme addressing the needs of diverse communities in Leicester City. The city is proud to be one of the most multicultural cities in UK. Leicester also has areas of economic deprivation, and the intersection between poverty and language barriers can lead to social isolation and reduced access to services (including NHS). Social prescribing programmes within LAT aim to address social isolation and hence directly address loneliness and also improve access to social activities, other benefits and services.

Participants report benefits, but the overall outcomes lack statistical significance

We have conducted a mixed method evaluation of two LAT social prescribing services, using a realist approach. Interviews with beneficiaries indicated that they had received a good experience. Unfortunately we do not have sufficient data to make statistical claims about outcomes, particularly in comparing one service to the other. However the combined data of the two services is consistent with a positive effect of the services for wellbeing, social isolation and loneliness. This indicates that the service did not cause harm and that the effectiveness is consistent with systematic reviews of social prescribing, which also show little statistical evidence of effect. We may speculate, that if individuals are receiving different referrals and services according to their individual needs and preferences, that we would not expect to measure a consistent effectiveness outcome. Put another way, each individual may gain a different benefit (eg wellbeing, participation, alleviation of economic hardship) and these may occur across different timeframes. From this perspective, it may be more meaningful to investigate how well the service reaches vulnerable groups and how well services are tailored or adapted to individual's needs.

Our realist evaluation approach describes and tests the 'mechanisms' which may be learning points for similar services elsewhere

In realist evaluation, the mechanism of a programme is inextricably linked with the context. That is, the cause of outcomes can only be described within a detailed picture of relationships, resources, and social circumstances. Here we will describe the contexts of the two social prescribing services, and suggest the mechanisms that may be 'fired' within these contexts that bring about positive outcomes for individuals. This is important because if we can understand these mechanisms then we can suggest how we may replicate such mechanisms.

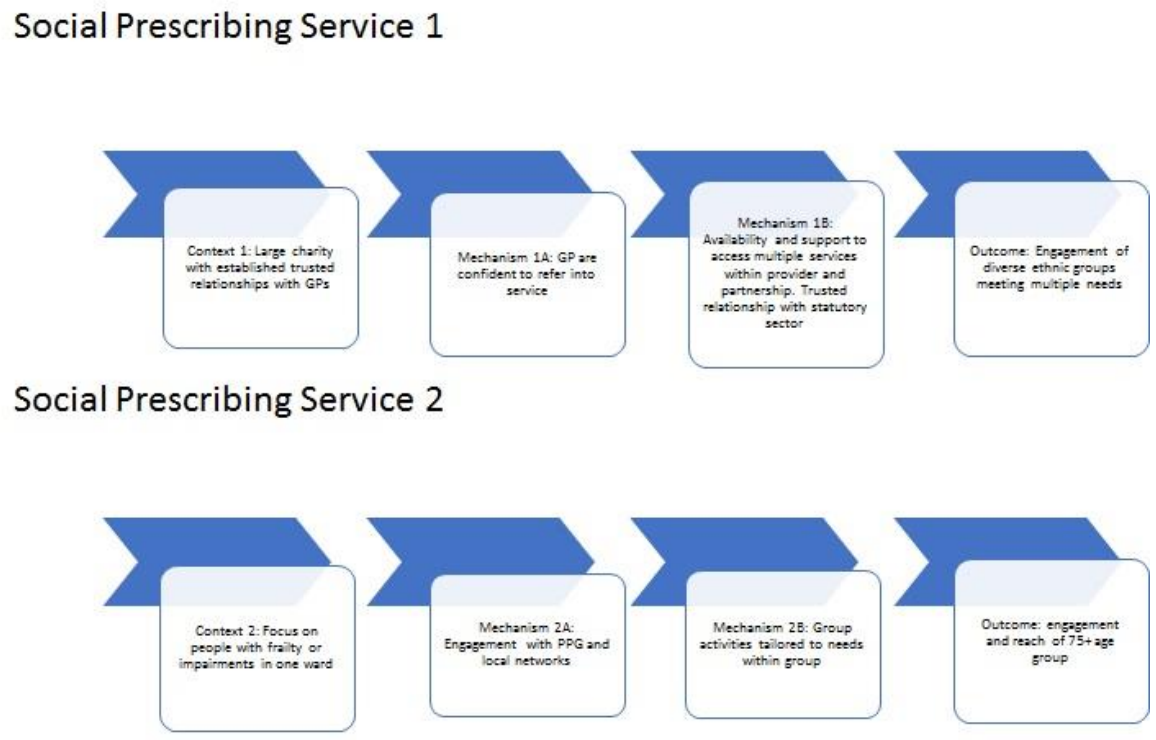
Service 1 Context and Mechanisms

For social prescribing service 1 (S1) the geographic context was all wards across Leicester City. This is a more diverse context than UK Ageing Better overall and possibly more diverse than any previous social prescribing evaluation; so this is a good test of implementing social prescribing in diverse ethnic communities. The organisational context is that the service provider is a large well-regarded charity with many established services across the city (some commissioned by Leicester CCG). Thus the first mechanism brought about by this context is confidence of GPs in the service, which means that it is more likely that the GP will write a referral to the service. A second mechanism is about availability and accessibility of services which may receive referrals from the social prescription advisor. Due to the multiple services provided by the charity for example befriending (also part of

LAT programme), it is likely there will be good support to access services. Beneficiaries may also receive support to access welfare benefits, housing or other statutory services (NHS and social care); and again credibility will be an aspect of this mechanism that enables the large established charity to gain rapid or efficient responses from statutory services (due to trusted relationship with professionals, as evidenced by many services commissioned by Leicester City CCG and neighbouring CCGs, and presence of this charity on the Dementia Programme Board.

Service 2 Context and Mechanisms

This service targeted one specific ward of Leicester and the service provider brings expertise with engaging the older age groups with frailty. The demographic of the ward is less diverse and not so deprived as other wards in Leicester. The data indicate that the service has been successful at reaching and providing a service to these older age groups (75-84 and especially 85 years and older), because the proportion of people in this age group is much higher than overall LAT and national Ageing Better. The organisational context is that the provider is a small local charity, which developed good relationship with the Patient Participation Group of the GP practice. This focused engagement enabled the service to engage people in the GP waiting room, and other people associated with the GP. The second mechanism of this service used a group approach where activities were developed within the service to suit the members of the group. This could be seen as an alternative model to the more frequently observed social prescription services which focus on referrals to other services rather than delivery themselves; which is well-adapted to this context, because the group of participants may be more frail and have mobility impairments. Thus the group activities may provide activities tailored to needs of members of the group.



Strengths and weaknesses

A weakness of the evaluation is lack of data of referrals of individuals to other services either within LAT, to other providers or to statutory services, due to data not being collected in this way. This

weakness has also been noted within evaluations of other social prescription services. A strength of our qualitative evaluation is that we have explored the interactions between multiple agencies in the community.

A notable strength of these two services is that they appear to have reached and engaged a group of particularly vulnerable people; an older group within the Ageing Better cohort (50 years of age and older) and a greater proportion of individuals of Black Asian and Minority Ethnic (BAME) background.

Main Report

1. Background

Leicester Ageing Together (LAT) is a partnership funded by the Ageing Better programme of The Big Lottery Fund to address social isolation and loneliness of people aged 50 years or older. We have evaluated two services within a network of 23 projects. The overall aim of LAT is to improve the well-being of older people in Leicester City who are at risk of social isolation and to support them to become more active in their local communities.

This report evaluates two social prescribing services in LAT. Using primarily qualitative methods, the evaluation aimed to compare services and explore the effective implementation of social prescribing within the local context.

2. Introduction

Two services within the LAT partnership are broadly defined as 'social prescribing' services that aim to reduce isolation and improve the wellbeing of older adults. While the LAT partnership aims to support isolated older residents across five wards in Leicester City (Evington, Thurncourt, Wycliffe, Belgrave and Spinney Hill), the two services being evaluated here have had different target areas. Service 1 covered all 21 wards of Leicester City Council, whereas service 2 focused on patients of one GP practice within one ward. The whole LAT programme has been designed to enable people to be supported by a network of diverse local services. Services are encouraged to refer beneficiaries to other services within the programme in order that individuals receive support tailored to their individual needs, characteristics and preferences. In this way the broader LAT programme offers a range of services which can be accessed via social prescribing and the approach of the programme is supportive of social prescribing.

The LAT Context

The LAT partnership is set within a unique social context, as Leicester is the third most ethnically diverse city outside London (Census 2011). In addition to English, eight other languages are commonly spoken by city residents including 16% of the population who speak Gujarati. One UK newspaper article describes the multicultural city as "the poster city for multicultural Britain, a place where the stunning number and size of the minorities – the 55 mosques, 18 Hindu temples, nine Sikh gurudwaras, two synagogues, two Buddhist centres and one Jain centre – are seen not as a recipe for conflict or a millstone around the city's neck, but a badge of honour." Continuing, the news article describes the impact of this diversity on the culture of the city; "The Hindu festival of

Diwali, the festival of Lights that takes place every October, has become the city's biggest party, and the biggest such celebration outside India. In Delhi and Bombay, Diwali is a Hindu affair; Muslims and others tend to stay at home. In Leicester, by contrast, all communities turn out for it." (The Independent, Peter Popham, Sunday 28 July 2013) Any social project implemented in the city should recognise the importance of this multicultural context, and evaluation should also be sensitive to language and culture, not only in methods but also outcomes. Loneliness and social isolation has negative physical and emotional outcomes. Those who are lonely are twice as likely to visit the GP and use other health care services (NHS Leicester City CCG 2016). Loneliness is a public health concern as 20% of the UK population report they feel lonely (DPH Annual Report 2016). Loneliness increases with age and those over 80 years have reported feeling lonelier then other demographic groups (NHS Leicester City CCG 2016). Social prescription that targets a specific group with activities can reduce the symptoms of loneliness for older people (Cattan et al. 2005).

Social Prescribing

The Next Steps on the NHS Five Year Forward View report (NHS England, 2017) endorsed social prescription as a creative way for healthcare to work with the voluntary sector for healthier communities. The predominant paradigm in health and social care is that social prescription can reduce the burden on primary care and emergency services (NHS 2014). Although there is evidence that non-clinical options to target specific groups can improve physical health and emotional wellbeing (Grant et al., 2000), some do call into question the cost benefits of social prescription to GP services (Bickerdike et al., 2017) when considering combined cost of routing and contact with primary care (Grant et al, 2000:419). Voluntary Action Leicestershire estimated that a social prescription service, run from one GP practice that used volunteers reduced the cost from fewer GP appointments, mirroring that of other evaluations of specific services (Dayson and Bashir,2014). Within Leicester, from published examples, Voluntary Action Leicestershire's model of social prescribing was such that GPs refer patients to a social prescription service run by a voluntary Patient Participant Group (PPG), who then work with the individual to locate services to improve wellbeing.

The Kings Fund defines social prescribing as the referral of patients by primary care services (GPs, Nurses and other Healthcare Professionals) to pathways that are outside their services, usually within the local community. The services available will be dependent on what is locally accessible, but these tend to be group activities such as crafting, art and social events. The main aim is for primary care to prescribe holistic care outside the NHS to improve the health and wellbeing of their patients.

> *'Social prescribing is a way of linking patients in primary care with sources of support in the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing' -* ***NHS England (2017)***
>
> *'a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, new skills, volunteering, mutual aid, befriending and self-help, as well as support with benefits, employment, housing, debt, legal advice or parenting problems'.* ***CentreForum Mental Health Commission (2014: 6)***

There is no one model of social prescription (Bickerdike 2017, Kimberlee 2013). There are key components of services, or actions taken by clinical staff that makes it social prescription. These include, prescriptions being made by a clinical staff to non-clinical services that are local to the patient, the patient works with a navigator or key individual over a longer period of time to identify the patients' needs. Additionally, non-medical solutions are decided in collaboration with the patient, but with emphasis on patients taking responsibility for their healthcare needs. The social prescription key worker tends to be a healthcare professional within primary care, or an employee of a third sector organisation. Kimberlee (2013) identifies three models of Social prescription termed: Social prescription light, Social prescription medium and Social prescription holistic. Social prescription light can be within different sectors either, primary care or the third sector and tends to focus on a single activity. Social prescription medium and social prescription holistic are within primary care and refer patients to different types of services. Kimberlee (2013) emphasises that a holistic model of social prescription will develop over time through services (usually GP practices and a third sector organisation) working together. They also have multiple referral routes in. Depending on the health needs of the patient, referrals can be made by different professions within health care, such as, GPs or physiotherapists.

There are multiple reasons for referrals to a social prescription service, but to be successful, Kimberly (2013) argues that it is essential that staff uncover what is going on underneath a referral and expect to manage the mental health needs of patients.

3. Objectives

The main objective of this evaluation is to explore the social prescribing projects within the LAT partnership in order to identify key elements of their models which are linked to effective outcomes and implementation. The aim was to identify what worked, why it worked and for whom it worked. From the Central Measurement Framework (CMF) data available loneliness, isolation and wellbeing outcome measures have also been analysed.

The evaluation aimed to:

- Describe the two social prescription projects, and the fidelity of the approach taken to other social prescribing models.
- Assess the effectiveness of the two services, including the context and mechanisms that are linked to positive outcomes.
- Explore the ease with which prescribers can connect older adults with services.
- Explore the extent to which prescribers can signpost to services outside their project programmes.
- Investigate to what extent the beneficiaries utilise the services that are prescribed.

4. Methodological approach

The LAT programme board specified the evaluation and discussions with the 'Evaluation and Learning' subgroup informed the methods. This research received ethical approval from the University of Nottingham Faculty of Medicine and Health Sciences Ethics Committee.

Realist evaluation

Realist evaluation is a theory-driven approach to evaluating social programmes. In this case our social programme is social prescribing; however this is set within a larger social programme of the LAT partnership. A realist evaluation framework was adopted to understand the contexts and mechanisms that underlie the outcomes associated with the two social prescribing services. Realist evaluation (Pawson and Tilley, 1997) aims to go beyond the traditional evaluation approach which focuses on outcomes, to analyse 'what works, for whom and under what circumstances'. A realist approach has been successfully applied to the evaluation of other social prescribing services (Arain, 2015; Bertotti et al, 2017) and has identified the important role of different stakeholders, such as GPs and local authorities, in overcoming the challenges in implementing effective social prescribing services. Box 1 summaries Pawson and Tilley's Realist evaluation of Context + Mechanism = Outcomes (Linsley et al., 2015).

Box 1

Building a realist theory involves a configuration of the following

- *Context*: The many pre-existing factors which influence whether and how an intervention or programme works. These include spatial and institutional settings, social norms and inter-relationships between people.
- *Mechanism*: Realist evaluation seeks to understand causal powers or mechanisms. These lead to patterns of behaviours and choices which influence the degree of success of a social intervention or programme.
- *Outcome*: If a specific pattern of outcomes is observed, this provides evidence to support the realist theory and also to support the success of the programme in practice.

Summarised from Pawson and Tilley, reprinted from Zubair et al. (2017)

For the development of theory within the evaluation, our starting point was the Theory of Change used to develop the whole LAT programme. We analysed documents of the LAT programme and the individual services. We also attended meetings with LAT staff, the LAT Board and the Learning and Evaluation subgroup to keep in touch with discussions of strategy within the programme and any developments that occurred. Newly published realist evaluation of social prescribing informed the iterative development of theory (Bertotti 2017).

Sampling and Data collection

In line with realist evaluation methods, we took a purposive sampling approach to gather information across a range of stakeholders to give an understanding of which aspects of the services worked, and why they might have worked. The following were invited to interview; project delivery staff, volunteers, beneficiaries as well as GPs, GP practice Managers and receptionists. We used both gatekeeping and snowball sampling techniques to recruit participants to the study.

The data collected via interviews was used to map the models of social prescription and approaches taken. Interviewees were invited to participate via email, in person or telephone. The research team recruited a Gujarati speaking peer researcher via the LAT programme, to conduct some of the telephone interviews in this evaluation as many of the LAT beneficiaries were of this demographic. Interviews were offered in, English, Urdu, Hindi, Mirpuri and Punjabi as a member of the research team spoke these languages. In total, 19 GP practices were identified as being within LAT wards and were all contacted up to three times to participate in the research project via email and telephone. In total, two agreed to participate and one agreed to circulate the information to GPs at the practice. In total, 2 GPs were interviewed and 3 practice manager Interviews were audio-recorded with the consent of the interviewee. They were arranged for a convenient time and place, including being conducted over the telephone where necessary. Data collection started in June and ended in September 2018.

Qualitative Sample

In total 26 people participated in semi-structured interviews. The sample included:

- Social prescription project leads and delivery staff (n=6)
- GP practice managers (n=3)
- GPs (n=2)
- GP receptionists (n=1)
- Volunteers (n=4)
- Members of Patient Participation Group (PPG) (n=2)
- Beneficiaries (n=8)

Demographics were collected for beneficiaries only as the small numbers of staff would have meant risking breaking anonymity. In total, 8 beneficiaries were interviewed. Two males and six females were interviewed, five with a white background and English speaking and three from the South Asian background, one speaking Gujarati and two speaking Hindi.

Qualitative Analysis

Interviews were transcribed verbatim and analysis was conducted in NVIVO 12 Pro data management software. Prior to data collection, both organisations that implement the social prescription models were invited to meet with the research team and comment on the original protocol and the description of their services. This helped inform the research process; however, these discussions and comments made are not included in the analysis. The descriptions of the models have been drawn from primary data collection. The researcher also made observation and notes as new information came to light which informed the research process. Often when attempting to recruit participants in the NHS primary care sector, they would share information over the telephone, but not have the time to take part in formal interviews. This too informed the research process. Thematic analysis was conducted by one researcher and then themes were considered within the realist evaluations theory of context and mechanism to explore outcomes. Themes were considered in the context of the objectives of the project.

In total there were 23 subthemes, these were ordered in 7 themes, which were then ordered into categories, 1) Models of Social Prescription, 2) Context, 3) Mechanisms, and 4) Outcomes.

Findings have been presented with careful consideration to the anonymity of participants, for this reason, limited quotes have been used and rich descriptions have been favoured.

Quantitative Data

Quantitative data relating to the demographics of the beneficiaries attending Service 1 and 2, their loneliness, isolation and well-being outcomes, were accessed from the CMF data. A total of 322 beneficiaries were involved with the social prescription services. Descriptive analysis was carried out using SPSS 19. Only beneficiaries who had completed both baseline and a follow-up for the outcome measures were included in the analysis. The number of beneficiaries included for the loneliness outcome analysis was 131, for the isolation outcome analysis 111 were included, and for the wellbeing outcome analysis 77 beneficiaries were included. Due to the very small sample size from Service 2 (n=5), a breakdown of the quantitative CMF data by service has not been conducted.

Quantitative Analysis

First percentages were run on demographic data for the beneficiaries attending the social prescription services, then the mean scores for the main outcome measures at baseline and follow-up were calculated. The results for those attending the social prescribing services are compared with the data for all LAT beneficiaries and all Ageing Better beneficiaries across the programme.

5. Findings

The themes presented in the Table 1 below show 23 subthemes that fitted within 7 overarching themes that were structured within the four categories: models of social prescribing in LAT, Context, Mechanism, Outcomes.

Model of Social Prescribing in LAT
Service 1 and Organisation 1 - Referral process in Service 1 - Delivering a service to patients - Connecting adults with other services & working with other organisations **Service 2 and Organisation 2** - Referral process in Service 2 - Delivering a service to beneficiaries - Connecting adults other services & working with other organisations
Context
Primary Care context - Pre-existing beliefs in Social Prescription - Existing beliefs and responses to loneliness beliefs on social prescribing - Primary care buy-in
Mechanism
Knowledge of the service - Different levels of knowledge

- Happenstance **Making it work** - Individual drivers - Working with primary care - Connecting with Beneficiaries - Person-centred focus
Outcomes
Beneficiary Experiences - Learning new skills - Support with a range of problems - Befriending - Increased confidence CMF data - Reach of the services - Beneficiary loneliness - Beneficiary isolation - Beneficiary well-being

Table 1. Themes and Sub-themes

5.1 Descriptions of Models of 'Social Prescription' in LAT

5.1.1 'Service 1' run by Organisation 1

Service 1 can be described as a mixed model version of what Kimberly (2013) defines as 'holistic social prescription' as the relationship with primary care has developed over time and there are multiple routes for beneficiaries to connect with the service. However, unlike Kimberly's description, this model does not exclusively work with primary care. This service is run throughout Leicester city and not exclusively in the wards that fall within the LAT programme.

Referral process in Service 1

Referrals to Service 1 come from GPs, Care Navigators, and the service is now piloting advertising with pharmacists. Beneficiaries and family members are able to self-refer. GP receptionists might identify that a patient is lonely then they will discuss with the doctor to consider making a referral, GPs will also refer to the Care Navigators who then will refer to the service. The reason the GP might refer to a Care Navigator could include isolation and loneliness, however, it could be for other reasons too, but the Care Navigator might identify that Service 1 could help the patient and refer on.

Service 1 takes a flexible approach to what they can do for beneficiaries when taking referrals from primary care, with no set criteria. They will not turn away a patient referred by primary care as a method of encouraging use of the service as it is believed GPs will not engage as well if restrictions

are set via a criteria. This method is to demonstrate they can help and solve challenging cases and provide support to primary care workers.

Delivering services

Service 1 has two part-time project workers, one of which is the 'key worker' who conducts all the initial face-to-face meetings with beneficiaries. Initial home visits aim to identify needs, ranging from homelessness and unsuitable accommodation, safeguarding issues, mental health and wellbeing including loneliness and isolation. The key worker can advocate for the beneficiary or contact different services on their behalf such as finding suitable accommodation, welfare benefits or assisting with communication to social care services. The number of visits made by the key worker will be dependent upon the needs of the beneficiary. Less complex cases might be referred on to the befriending service (a separate service run by the same organisation). The key worker takes a holistic individualised approach to understanding the needs of the beneficiary. The aim of the service is to look at beneficiaries who require additional needs. If needs are complex, such as unsuitable housing, or requiring certain benefits, these will be prioritised to solve first. If needs are about social participation, the key worker draws on specific knowledge of the area to discuss the different options and may refer beneficiaries to social activities within the community and to the befriending service.

Connecting adults with other services & working with other organisations

Following identification of issues and needs at the home visits, the key worker connects with Adult and Social Care, Adult Safeguarding Team, Information and Advice Welfare Department. They also discuss patient cases with the primary care workers and aim to feedback information and refer to other third sector organisations who provide different services.

Some services run by the organisation have a cost attached to them, such as the luncheon club; however, the befriending service is free of charge.

5.1.2 Service 2 run by Organisation 2

Service 2 is run by Organisation 2. This model is consistent with a category of 'social prescription-light' (as described by Kimberlee 2013); it is based around one specific activity, however, it sits on the periphery of primary care. There is one part-time key worker who connects with beneficiaries via attending the patient coffee morning and befriending service hosted by the Patient Participation Group (PPG) attached to one GP practice in one ward. The PPG established a befriending service which is run via the coffee morning they run next to the surgery.

Delivering services to beneficiaries

The aim of this service is to involve older beneficiaries in a programme of learning, either on an individual one-to-one basis or collaboratively with other older people within the same community. Programmes of learning should be broadly understood, activities have been art-based workshops over a period of time, social events, such as a special showing of a film and a fashion show. Activities are specific to beneficiaries' interests and are identified by the project worker through discussion with them. Activities take place within the local community, or transport has been provided for activities at other sites.

Referral process 2

This model has a more informal referral process from primary care. Service 2 is advertised at the GP surgery and locally, they work in partnership with the PPG Group. Beneficiaries have been directed to the service by a Patient Liaison role at the GP Practice. Reception staff might recommend the group to a patient, members of the PPG group might encourage beneficiaries and members of the community to attend their coffee morning and some of the members are beneficiaries of the programme. The events that are run within Service 2 are also open to the public. This model of social prescribing was established in response to Service 1 already working with the GP practice. It was believed to be confusing to have two services 'offering similar things'. This service was supported in the 'test and learn' model advocated in the LAT partnership and across the Ageing Better Programme at the time the service was initiated.

Connecting adults with other services & working with other organisations

The key worker will talk with beneficiaries and identify what older adults are interested in and who wants to engage in specific activities. They will develop a programme of learning, activity or an event. They will then work on a one to one basis to develop an activity that they might like to work on. This will be for around 6 sessions. This could be from a specific interest such as crafting, history of cinema, the events organised would be in collaboration with the older adult and the event would be open to the community. The service does not aim to prescribe to other services, however, if a need was identified they might communicate with the GP services or refer on to other LAT programmes. When beneficiaries participate in activities social groups are said to be formed and made stronger. Beneficiaries gain new interests and old interests are rekindled, and they might continue these activities after the session.

Some events open to the community have a nominal charge. The coffee morning ask for a donation of £1 to cover hot drinks and biscuits.

5.2 Context

5.2.1 Primary Care Context

Pre-existing beliefs in Social Prescription

Primary care workers had positive beliefs that social prescription interventions could reduce isolation and improve wellbeing of beneficiaries and subsequently reduce the cost in time and money to GP practices and Accident and Emergency departments. When a primary care worker had had a 'Support Worker' role in their team, whose role was to specifically look at non-medical solutions for adults, they had witnessed the immediate benefits of the role for beneficiaries such as being able to take someone who was socially isolated and dependent and introduce them in stages to being connected with others and be able to do activities independently and reducing dependency on primary care services. Therefore pre-existing beliefs around social prescription, in theory, would mean that organisations offering a social prescription service were operating in a context that would have supported their types of intervention.

> *"…her role was around the social prescribing thing, you know, around the not just signposting people on, to say oh like the Day Centre or visits to the local Community Centre, actually physically going with somebody …and gradually introducing them week by week and only maybe the first couple of times taking them, the third time maybe meeting them there… that*

building the confidence of people who are a bit worried and find it difficult, a bit socially awkward, find it difficult to break the ice and probably wouldn't do it if they had to go on their own. That was really, really successful." ***Primary care worker***

"…if patients were busy and not lonely, then of course that would take the strain off contacting community staff, if say someone had a district nurse going in for something, a dressing say, let us use that as an example, and you know, they are worrying about that, they might be contacting, you know, community staff, constantly, worrying about that, whereas if they were busy and had something else to focus on, that might take the pressure off them." ***Primary care worker***

It was, however believed that older adults could be reluctant to pay for services if they came with a cost. Some services offered and referred to by service 1 had a cost, as did some of the social events organised by service 2. Furthermore, services referred to by the care navigators also had cost to them and this was not brought up as a barrier to signposting.

"… might make them think twice. Even with small amounts of money, especially the older generation, they do not see the value if they have to pay out, to them a fair bit of money, but I do not know, I do not hear that all the time, I do not hear that a lot, but I know that can be a sticking point." ***Primary care worker***

Existing beliefs and response to loneliness

Primary care workers identified loneliness in patients by noting who had multiple GP appointments or contacted primary care services seemingly without a medical complaint. Others identified those patients as lonely who spoke with them at length about their personal life histories. Living alone due to bereavements or family members not living in the same area were believed to be factors behind loneliness. A GP noted that patients lived with extended family that could provide support for older adults. Others identified loneliness as a symptom of a mental health condition.

Responses to identifying loneliness appeared to be linked to the person's role. GPs mentioned referring to service 1 and other services run by organisation 1. They also mentioned Care Navigators and it seemed that there may have been lack of clarity between the latter and the social prescribing service. When reception staff identified a patient who appeared lonely, they would discuss it with GPs who could make a referral to service 1 or to the Care Navigator. However, they would not directly refer patients themselves. Those interviewed knew about the LAT programme and Services offered by Organisation 1.

Organisation 2 and Service 2, in reality, was operating in a different context to Organisation 1 due to their timing of implementation. Their model of social prescription could not take direct referrals from GPs as it was working on the periphery of primary care. Interview data indicates that the CCG had concluded that as Service 1 was already working with the organisation it would be too confusing to have two services offering similar things, further interviews demonstrated that the practice might not have engaged with the service, but there had been an individual working in a patient-facing role who would refer patients to the Service. Furthermore, the GP practice advertised the service and the Patient Participation Group also supported this. Regardless, of the background to this model, in reality, the interventions offered from each service were different with one focusing on providing community based social and learning activities, and the other dealing with difficult and complex

patient cases that primary care was struggling to resolve and delivering and providing befriending services. It is essential in this contextual comparison to bear in mind that the differentiating sizes and specific aims or the services and the reach of each.

Primary care buy-in

Services experienced challenges in getting GPs to endorse and use their services. The reasons given for why participants thought this was, was both organisational and individual. It was felt that GPs were working under pressures and within time constraints and therefore completing referral forms that needed to be printed off might be too time consuming. Operating with no formal referral mechanism was challenging to service 2 also. Staying on the agenda was important too when working in an environment where there were other services operating. It was also felt that GPs might not entirely understand the services that were offered. However, other primary care workers, who understood the role and experienced the positive impact of services, both appreciated and bought into what services could deliver. Even those with positive attitudes to the idea of social prescription would not use the service again if they had either had negative experiences, such as wanting patients to receive Organisation 1's befriending service, or received no feedback on how patients had been dealt with. It was also indicated that there had been some challenges getting the GP practice that organisation 2 engaged with to understand and endorse service 2, this might have been due to understanding but also scepticism about the service.

5.3 Mechanism

5.3.1 Knowledge of the service

Different levels of knowledge

Overall, those interviewed understood the services offered, including the purpose and reach of service 1 and 2. However, there was some confusion about the differences between the services. One GP in ward 1, where service 1 and 2 operated, did not understand what they could refer to the services for and wanted a criteria for each.

It was also believed that beneficiaries could refer themselves via calling the number of the services directly, which was indeed the case. Some of the descriptions of the service offered by Organisation 2 referenced other programmes that fell within the LAT programme or were within the local community unrelated to Organisation 2. City wide primary care workers had heard of LAT.

The different understandings could be a concern if the services they experience are inadequate or potentially could mean that not all the services are being utilized. Furthermore, because of the branding associated with one service, they might have referred for another service and conflated each with the other. However, understanding services as similar might have contributed to service 2 not being used in the GP practice. Service 2 was not used by Care Navigators because they did not know the referral process, however, Service 2's model was not intended to work with the wider city.

" It's about knowing what services are out there and prescribing them for patients, so that they can access these services." ***(Care Navigator)***

Happenstance

Whether primary care workers knew about the services depended on services 1 and 2 staying on the agenda or having regular contact with primary care for referrals. If primary care workers stopped using the service, or did not use them, it would result in fewer referrals and reduced working together. Service 1 and 2 attended meetings at practices and with primary care workers to explain and promote their services.

Service 2 advertised locally, via the PPG, the patient liaison role at the GP service and via the befriending service/coffee morning. It was therefore up to word of mouth and the viewing of advertisements if patients connected with the service, of which some had done.

5.3.2 Making it work

Individual drivers

Successful implementation relied on individuals working within primary care to endorse and use the service. For example, referrals to service 2 relied on who was in the patient liaison role to refer patients. Service 1 relied on referrals from the GPs or care navigators. Without instigators within this context meant that the service might not get mentioned or referrals would stop coming. This is why key workers in the service 1 and 2 were central to keeping their services on the agenda and pushing and opening doors, and finding solutions to challenges that occurred. This does however mean, without similar drivers, the services are at risk of not working.

Feedback for the services did not necessarily focus on what was provided, but how it was provided, for example, individual key workers were praised. The feedback focused on the individual impact they had had.

… I like the fact that when I knock on [xxx] door or the [Service xx] door, if I've had referred, you know, for instance if I say, "Go in, I think this patient needs a bottle of water". When they go in, they wouldn't just provide that bottle of water. If they find there are other needs, they would try to meet all of the needs and, if possible, liaise with other agencies to meet all the needs. If you understand? In some ways they are quite holistic in what they do. If I have referred for one particular thing, over the course of them working with patient [6], if they discover other things, they wouldn't say, "Oh, it's not our problem. That's not what you were referred to us for". As is common with some agencies or services. But they will try to holistically regard the whole situation and if it means coming back to you, they will come back to you. ***(Beneficiary)***

Working with primary care

Being able to connect with primary care, in particular the care navigators who reached the whole of the city was a vital way of connecting with patients in need of one-to-one complex support. Primary care workers assessed the effectiveness of the service by the feedback they received from key workers and if patients were able to connect with befrienders and received the service they were expecting. However, it was not seen as a solution in itself but as a route that could contribute to solve patients' problems.

> *"I think the [Service 1] Staff and when they go out, will probably doubly in a way, make sure that everything is in place and we can also often agree that at times you do perhaps advise*

or give that information, you know that they will help them on to claim Benefits, making sure that they have got that information regarding having social contact. **(Beneficiary)**

Connecting with Beneficiaries

Service 2 might have had a limited reach, because it was decided that they would not take referrals from GPs. They responded by working with the PPG, which has many contacts with staff and patients. Although a care navigator had heard of Service 2, they did not know the detail of the referral process, and thus had not utilised the service.

Some social prescription project delivery staff were aware that there were isolated people who did not even engage with GP practices and therefore these adults would have slipped through the cracks in receiving support from GP practices. However, accepting self-referrals from individuals and family members might have enabled connecting with those who would not have taken their issues to the GP surgery or whose issues would not have been picked up in an appointment.

Other interviews indicated that some isolated older adults might actively not engage with services because of denial and stigma of loneliness and mental health issues.

Person centred focus

Service 1 and 2 both placed a lot of attention on the needs of the individual in terms of their interests and general wellbeing. Beneficiary interviews show how this person-centred approach was a mechanism that was noticed and appreciated by beneficiaries. Emphasis was placed upon engaging the elderly community and making sure they felt comfortable and welcomed, due to this reason engagement levels were good and outcomes were mostly positive.

"Yeah, [it was tailored] towards my personality I think and the way I spent my time, yeah." ***(Beneficiary)***

"Needs were taken into account which was good because there were sometimes people with different needs. I'm not in a wheelchair or anything but in one group there was a lady in a wheelchair that I did notice that they were particularly good at making sure that she was okay." **(Beneficiary)**

5.4 Outcomes

5.4.1 Positive outcomes reported by beneficiaries

On the whole, both services were well received by the community and were felt to have made a big difference to their lives in a very positive way. At the same time, maintaining their interest at all times and making sure they are aware of who to turn to in times of need. In interviews with beneficiaries, specific positive outcomes were described for learning new skills, befriending, support with a range of problems and increased confidence.

Learning new skills

The main aim of Service 2 was to provide a variety of activities in order to educate and upskill older people. The interviews indicated that beneficiaries felt that the activities were mentally stimulating and kept them engaged, giving them something to do and look forward to in times of loneliness. It

was felt that the services offered them an opportunity to meet new people and also to learn from other peoples' experiences and skills.

> *"Participate in furthering some of their interests or sharing their interests with other people"* **(Beneficiary)**

> *"Yeah and it's a learning thing isn't it, so you are learning through other people's experiences I suppose."* **(Beneficiary)**

Support with a range of problems

Service 1 was particularly helpful in supporting the individual in times of need and would attempt to resolve any issues they had in the most efficient and effective way whether it be through signposting or one to one contact with other organisations. One keyworker would attempt to do so for all the individuals receiving the Service. Beneficiaries acknowledged this support and reported how they would take the advice provided by the staff, and how this benefited them.

> *''Jab meri koi problem hoti, meri [health supporter] woh aati thi….. [community centre] mujhe udhar bhejti hai jaane ke baad mujhe aacha laga… sab aapne log mere ko aacha lagta mein exercise karti hu … kahna peena logon ko milna hasna mein khelne mein….'' (Translated below in English)*

> *Whenever I would have a problem, my [health supporter] would come, she sent me to the [community centre] where I liked it as I saw other people so talking to them would keep my mind at ease and also I went to exercise in the gym, they would also provide food.* **(Beneficiary)**

Befriending

Befriending was also found to be very valuable to individuals as it gave them a chance to give something back to the community. For instance, caring for those who need physical support, this opportunity worked as a two-way process as it allowed the befriender to learn something new and also the recipient to receive some further assistance and support.

> *"I also enjoyed meeting the number of people over this period of time, I've got to know a lot more people in the locality and, you know, I tend to help them and [2]them around and support them so yeah, it's been a two way process really.* **(Beneficiary)**

> *"Oh yes it was great fun yes, and talking to other people and meeting people you know the events were fun … and you know because we are all of an age elderly"* **(Beneficiary)**

Increased Confidence

The keyworkers within both services were perceived to be very supportive and attentive to all needs of beneficiaries and would go the extra mile to make sure an individual could get the most out of the service in the best possible way. Efforts from the keyworkers were well appreciated by the community and the changes within the individuals were noted by others attending the group activities.

"I think she has been extremely good. One or two people that I know, I know that [the service staff] has brought them out quite a lot, you know, they were rather reclusive." ***(Beneficiary)***

"People that appeared quite sort of shy and reserved, now I feel that they are more inclined to offer their opinion because of the fact, you know, we have learnt that they do this, that and the other, so you are all, "what is your latest project?" that sort of thing. It has encouraged everyone else to ask what they are up to nowadays, so they have certainly gained something out of her attendance here without a doubt." ***(Beneficiary)***

5.4.2 Positive Outcomes from CMF data

Summary data were collected from LAT CMF data in order to compare the two social prescribing services with the overall programme data (including these two services). Data were also compared to data summarised at a national level for LAT programmes across England (programmes across England are still ongoing, so this data is a summary of data collected to date).

Reach of the service

The social prescribing services showed extensive reach into the target demographic groups for LAT, particularly in relation to the older age groups.

Most beneficiaries identified as female (69%), while 31% identified as male. These proportions are the same for the national gender demographics for the Ageing Better programme and very similar to the overall LAT programme (female=66%, male=34%) (see Figure 1).

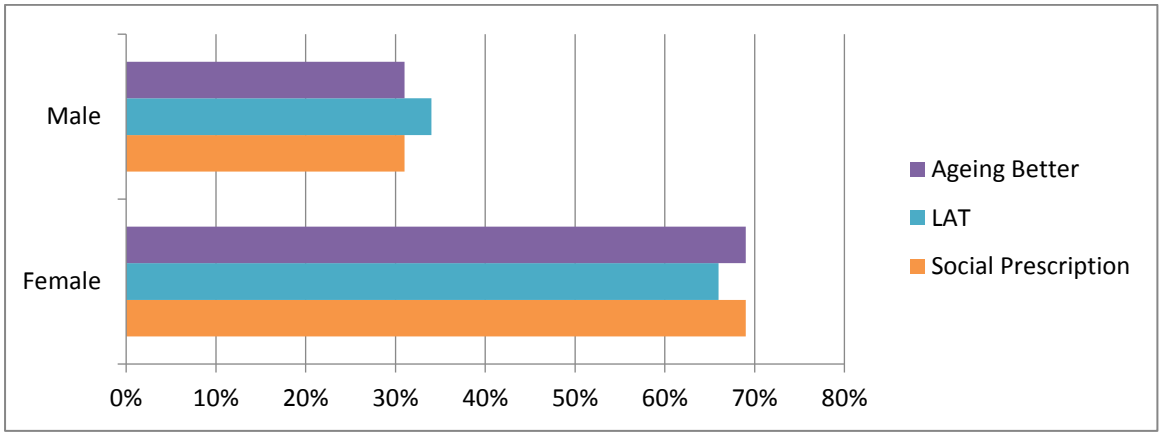


Figure 1. Gender of beneficiaries

In regards to ethnicity, there were a higher proportion of those using the social prescription services that identified as 'White' (62%), than the overall LAT programme (34%) (Figure 2). However, in comparison with the summary data for the national Ageing Better programmes, the social prescribing services have reached a greater diversity of ethnicities, as the national average was 76% White. Interestingly, the proportion of people who reported Black or Black-British was lower for social prescribing compared to either overall LAT or national Ageing Better Programme.

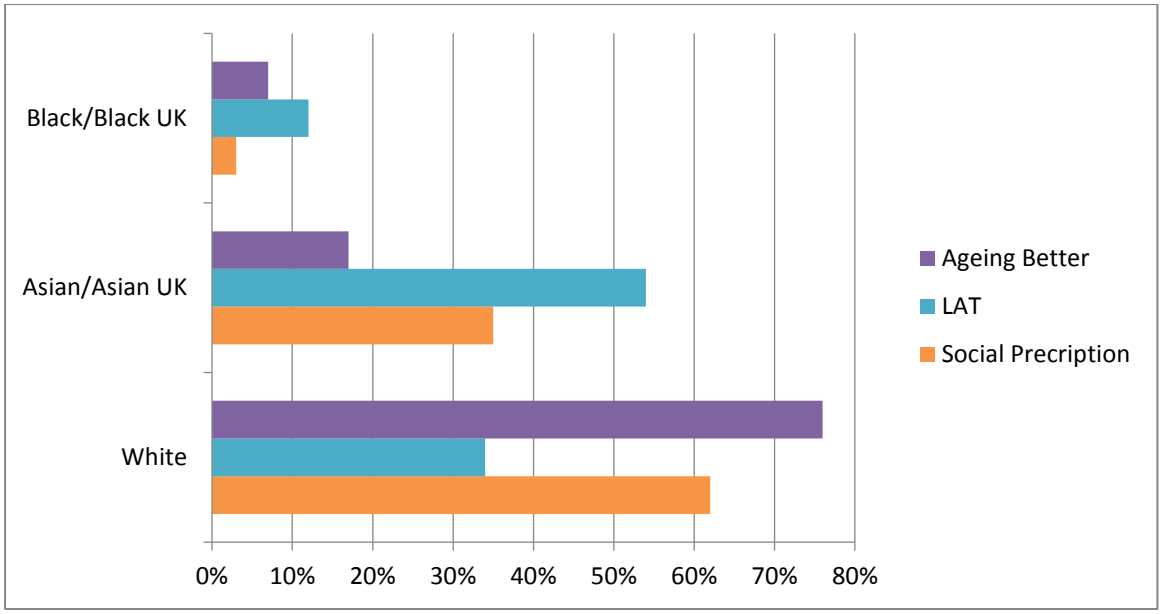


Figure 2. Ethnicity of beneficiaries

The age distribution indicates that the social prescribing service reached an older demographic in comparison to overall LAT programme, and the national Ageing Better programmes (Figure 3). The major difference can be seen in the 85 years of age and older category which was much higher (31%), as compared to the overall LAT programme (14%) and the average for all of the Ageing Better programmes (13%). There was proportionally less representation of age groups younger than 70 years of age.

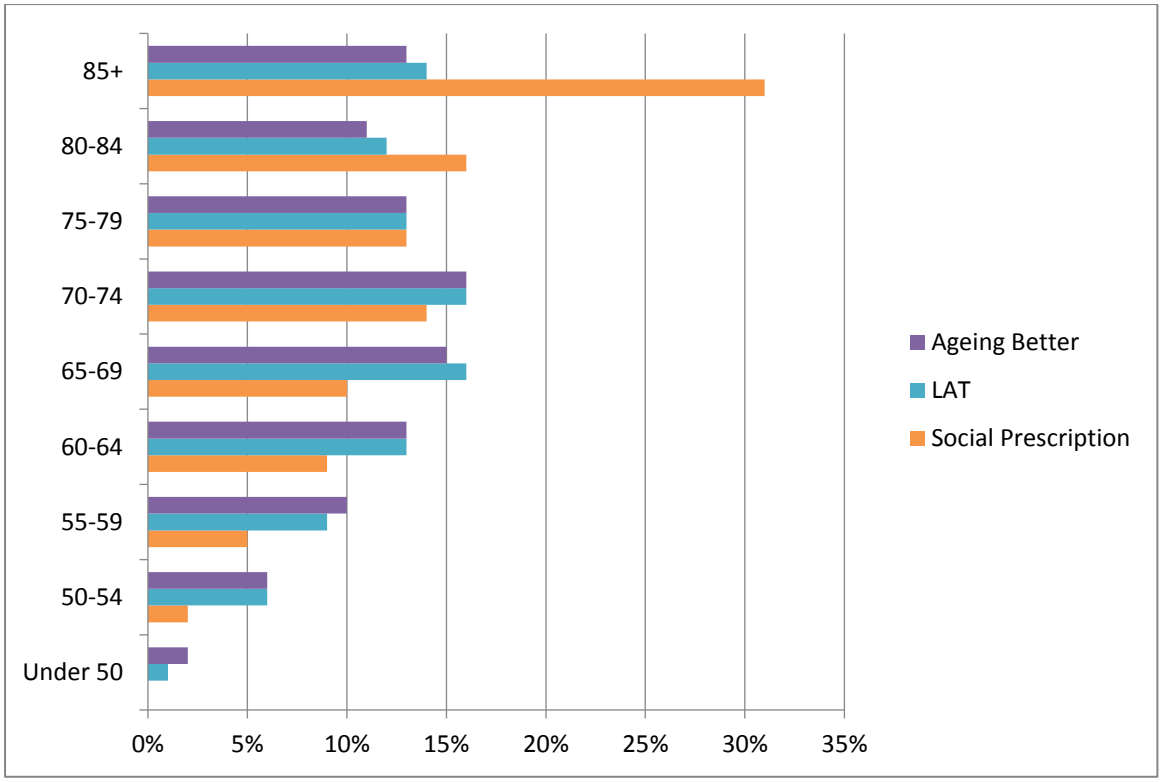


Figure 3. Age distribution

Beneficiary Loneliness

The mean loneliness scores at baseline for the beneficiaries of the social prescription services were considerably higher (4.2) when compared to LAT beneficiaries overall (3.4) and the national Ageing Better mean scores (3.3). This indicates that the social prescribing services were reaching people who were reported very high levels of loneliness (Table 2). These are descriptive data and we have not conducted statistical tests or shown standard deviation because of the large differences in nature of the samples (comparing one service in one city to data from the national programme).

The change in mean score from baseline to latest follow-up in Loneliness is fairly similar across all three groups: showing small reductions in mean loneliness scores for the social prescription service (0.5), the LAT programme (0.4) and the Ageing Better programmes in total (0.3).

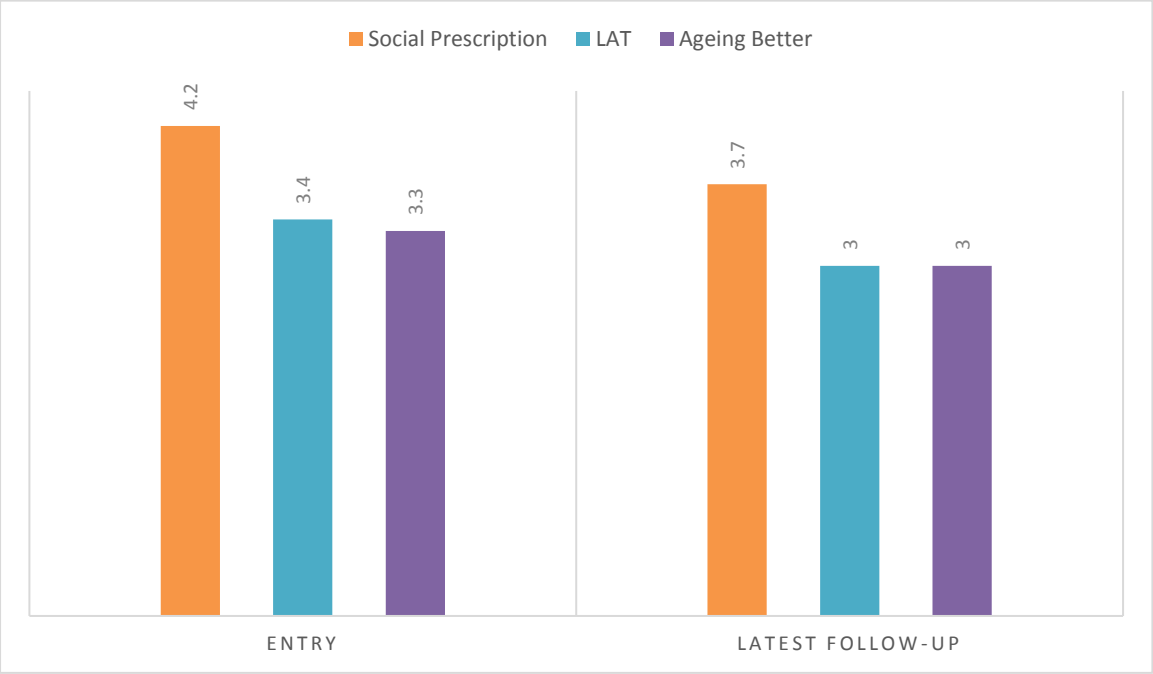


Table 2. Mean scores for the loneliness measure (Social Prescription, n = 131)

Beneficiary Isolation

These findings were echoed in the results for the isolation outcome measure, further supporting the finding that social prescription services were engaging with the most isolated individuals. Beneficiaries of the social prescription services had higher levels of isolation at baseline (6.8) than beneficiaries of LAT overall and the Ageing Better programmes (5.8 and 5.6, respectively) (Table 3).

The change in mean scores from baseline to latest follow-up were all similar across the three groups.

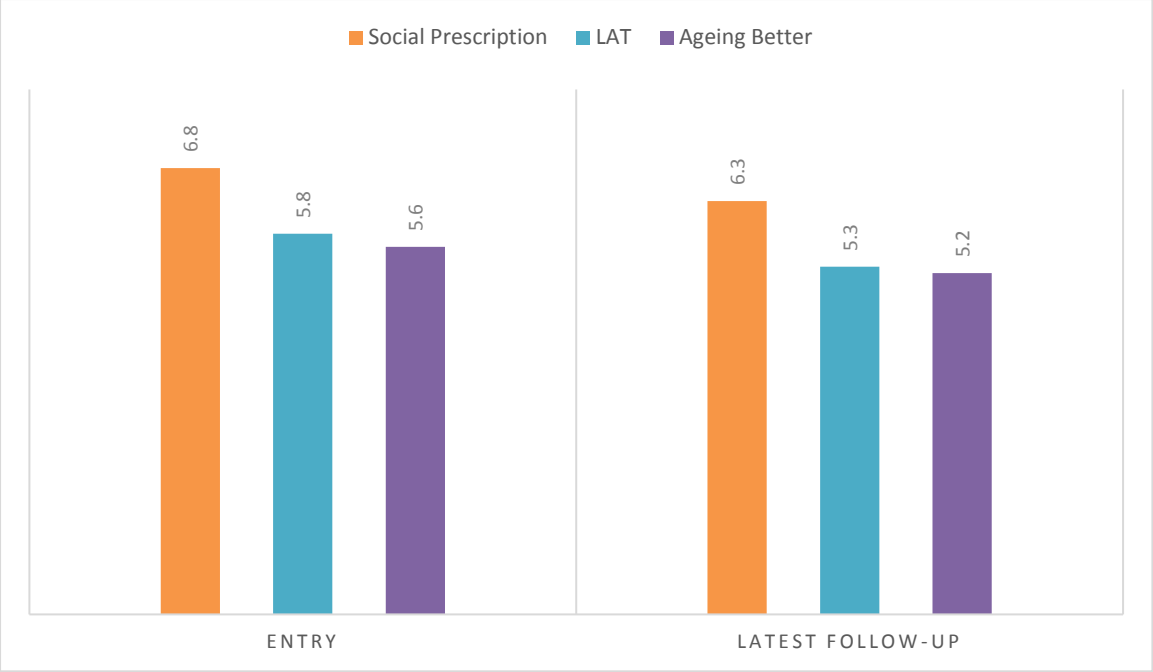


Table 3. Mean scores for the isolation measure (Social Prescription, n=111)

Beneficiary Wellbeing

As with the other two outcome measures, the mean well-being score at baseline for the social prescription services was lower than the mean scores at baseline for LAT and Ageing Better (18.8, 20.9, and 21.2 respectively). Thus indicating that the social prescription services were reaching those individuals with lower levels of well-being than other parts of the LAT programme, and the Ageing Better programme overall (Table 4). At follow-up, the increases in well-being were similar to those seen across the LAT and Ageing Better programmes.

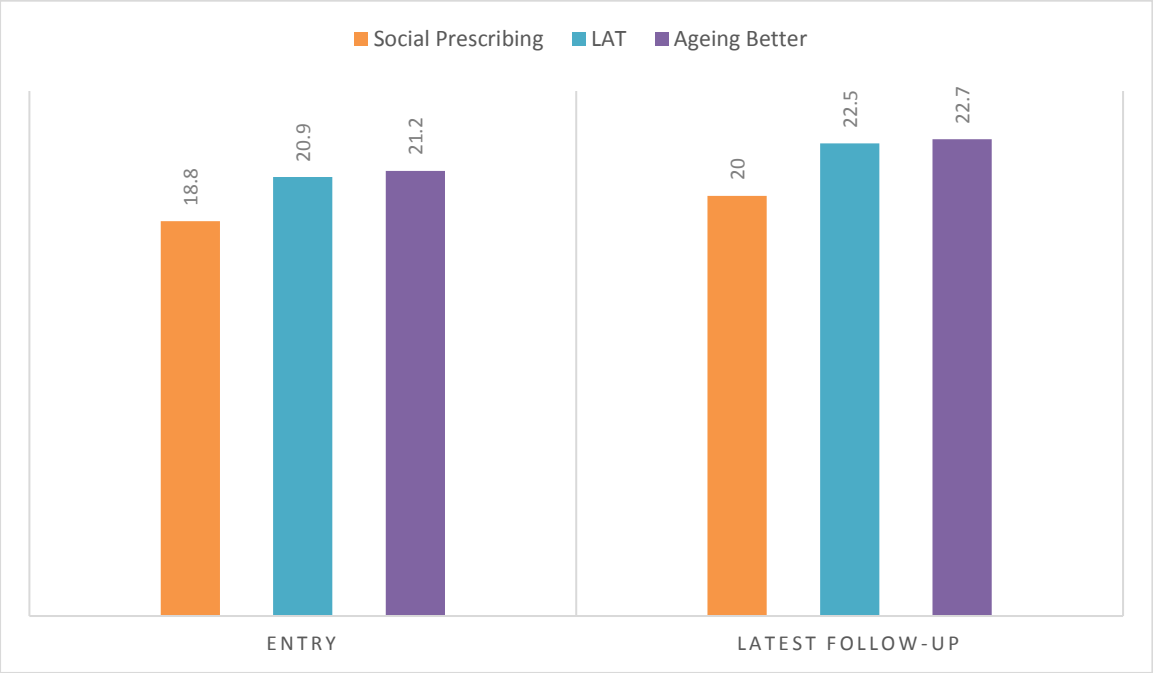


Table 6. Mean scores for the wellbeing measure (Social Prescription, n=77)

6. Discussion

The results emerging from this study have aimed to explore Loneliness Prescription and Social Prescribing projects within the Leicester Ageing Together (LAT) programme in order to identify key elements of their models which are linked to effective outcomes and implementation. Moreover, the aim of the study was to identify what worked, why it worked and for whom it worked, whilst also looking at the potential challenges faced in social prescribing.

Results from the present study suggest that Service 1 and Service 2 run very distinctly. Although Service 1 adopts some elements of the 'holistic social prescriptive model' (Kimberly, 2013; Bickerdike 2017,); it takes a much wider mode of implementation by focusing on areas outside of primary care. Therefore, the referral system within this service is not limited to the primary care sector but has links to the wider care system. Service 1 adopt a flexible approach in terms of the support they offer to patients when taking on referrals from primary care, with no set criteria. Therefore, Service 1 seem to be more able to assist and solve challenging cases and to provide as much support as possible to primary care workers.

Differences also lie in the service delivery between the two services, which is mostly dependent upon staffing levels. The former Service has a 'key worker' within the team who is responsible for all the signposting and matching older adults to the appropriate service such as Befriending. The latter service referred to as Service 2 have one part-time key worker who liaises with patients by attending the patient coffee morning/befriending services hosted by the Patient Participation Group (PPG) . Service 2 has more of a focus upon encouraging learning in older patients either on an individual one-to-one basis or collaboratively with other older people within the same community. The referral process from primary care is also therefore very much informal; with 'Key workers' being vital to making the service work efficiently and effectively (Moffatt et al, 2017).The two services also run in a different context due to their timing of implementation. From the present findings, it seems that as Service 1 was already working with the organisation it could become problematic to have two services offering similar things. Effective service delivery was to some extent dependent upon whether or not the organisation held positive pre-existing beliefs in Social Prescription. Within these services, primary care workers seemed to play an essential role in identifying loneliness in patients by looking at individual factors, however the responses to identifying loneliness were dependent upon the person's role within primary care. Referrals were either made to service 1 or through Care Navigators, It was shown in the study that if dissatisfaction was experienced from a particular service, it would prevent primary care workers from referring or utilising the service in the future. The effectiveness of the service was determined by the feedback received from key workers and whether or not patients were able to connect with befrienders and receive the service they were expecting. Nonetheless, it was not seen as a solution to solving patient's problems but as alternative route that could contribute to solving patients' problems.

It is also worth noting that services did experience challenges in getting GPs to endorse and use their services, this was due to both organisational and individual reasons. Without a formal referral

mechanism it could become a challenge for the Service, it was important to stay focused in such an environment where several services were operating. It also seemed that GPs might have had a lack of understanding about the services that were offered, which may suggest a need for providing more information to GPs in several mediums in order to improve engagement and the quality of the Service. Nonetheless, primary care workers who understood the role and experienced positive services appreciated and bought into what services could deliver. However, those who had negative experiences would not use the service again.

Although there was an understanding of the services offered including the purpose and reach of service 1 and 2, there seemed to be a lack of knowledge surrounding the differences between the services. This lack of knowledge could pose a problem if the services experienced were inadequate or could possibly mean that not all the services are being utilised, because of the branding associated with one service, they might have referred for another service and conflated each with the other. However, understanding services as similar might have contributed to some services being used more than others.

Primary care workers' awareness about the services was dependent upon the services' ability to stay focused upon the agenda or having regular contact with primary care through referrals. Less use of the services would eventually result in fewer referrals and less working together. The two services used GP practice meetings as a platform to explain their services. Service 2 was limited in reaching patients from not having direct referrals from GPs, and instead reacted by working with the PPG. Although care navigators were aware of Service 2, they were not aware of the referral process, which in turn prevented it from being utilised. The effectiveness of working with primary care in implementation with this model, was significantly reliant upon GP uptake, Service 1 on the other hand had multiple referral routes to recruit patients. On the whole, the two interventions offered from each service were different with one focusing on providing community based social and learning activities, and the other dealing with difficult and complex patient cases that primary care was struggling to resolve meanwhile delivering and providing befriending services at the same time.

The present study although shows promising results in terms of the effectiveness of the Social prescription services, it can be criticised for two major reasons which have had an impact upon the sample size. First of all in terms of the sample size, GPs did not form a great number of this due to their limited availability. Hence, there was very limited insight into GPs views on social prescription and isolation and loneliness in Leicester in older people. In particular, there was less insight provided from GP services in different wards of Leicester. Future research may wish to use incentives as a way of encouraging participation within GP services.

Furthermore, despite many recruitment efforts there was also limited number of interviews conducted from the Black Asian and Minority Ethnic (BAME) community, which was a target group of LAT services. Thus, there isn't a true representation of the sample population within which the services work. It would be useful to conduct wider advertisement of the research project and perhaps implement the use of incentives in order to gain a greater sample size. To add, it might be useful to conduct future research by conducting face to face interviews rather than telephone, as face to face interviews can hold the potential of capturing more information than telephone interviews (Vogl,2013).

Final remarks

In sum , these findings suggest that the social prescription services are reaching people that are lonelier, more isolated and have worse wellbeing than LAT or the Ageing Better programme are as a whole. Individuals who have utilised such services have had positive experiences and believe it has given them something to look forward to in their life especially at this age when due to health problems, one may not be able to have a physically active lifestyle. These results seem very positive as the aim of the social prescription services and all the Ageing Better programmes is to try and reach those who are the most lonely and isolated and to help them improve their health and wellbeing. It is also promising that the change in mean scores from baseline to latest follow-up are similar for the social prescription services, LAT and Ageing Better as this suggests that those who are lonelier and more isolated can benefit just as much from the projects/services. To add, the services can be made more effective if widely advertised on social media platforms, this would also help address the issue of a lack of clarity surrounding the differences in the services and therefore possibly increase patient engagement.

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Appendix

Table 1. De Jong Gierveld Loneliness Scale and scoring

Statements	Yes	More or Less	No
I experience a general sense of emptiness	1	1	0
There are plenty of people I can rely on when I have problems	0	1	1
There are many people I can trust completely	0	1	1
I miss having people around me	1	1	0
There are enough people I feel close to	0	1	1
I often feel rejected	1	1	0

Table 2. UCLA Loneliness Scale and scoring

Statements	Hardly ever	Some of the time	Often
How often do you feel that you lack companionship?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3

Table 3. SWEMWBS Scale and scoring

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Table 4. Raw score to metric score conversion table for SWEMWBS

Raw Score	Metric Score
7	7.00
8	9.51
9	11.25
10	12.40
11	13.33
12	14.08
13	14.75
14	15.32
15	15.84
16	16.36
17	16.88
18	17.43
19	17.98
20	18.59
21	19.25
22	19.98
23	20.73
24	21.54
25	22.35
26	23.21
27	24.11
28	25.03
29	26.02
30	27.03
31	28.13
32	29.31
33	30.70
34	32.55
35	35.00