



**UNIVERSITY
OF HULL**

An evaluation of Connect Well and Social Prescribing in Hull: Final evaluation report January 2019 – December 2020.



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Introduction and background to the evaluation

This report details the findings of a two-year evaluation undertaken by researchers at the University of Hull into the social prescribing provision delivered by Connect Well Hull.

Background information

Social prescribing is a relatively new form of service provision, which seeks to link individuals, often via GP referral, to community-based agencies and groups (examples of which are given in Table 8). It seeks both to address individual need, in respect of issues such as isolation and loneliness; anxiety and depression; physical health and wellbeing; employment, and to respond to enduring challenges within primary care. These challenges include:

- Significant workloads for GPs, as well as recruitment and retention difficulties
- Increasing levels of patient need, associated with an ageing population, in which long-term conditions and multiple morbidities are prevalent
- Short consultation times with patients (typically approximately 10 minutes per appointment)
- High levels of presentation of non-medical or social problems at GP appointments, in addition to physical health issues.

(Hobbs et al, 2016; NHS England 2016; Husk et al 2019; Owen et al 2019).

It is recognised that both patients and GPs may lack awareness of the network of local support available for social issues, and that social prescribing may therefore represent an important bridge between GPs (and other referrers) and community-based agencies and groups (the VCS), enabling patients to access appropriate support, and wider determinants of health to be addressed (Popay et al 2007a, 2007b; Bertotti et al 2018; Skivington et al. 2018).

There is no single accepted definition of social prescribing, which has been variously defined and implemented, with diversity among schemes (e.g. Carnes et al 2017, Hamilton-West et al 2019). NHS England/NHS Improvement (2020) defines social prescribing simply as enabling 'all local agencies to refer people to a link worker'. This reflects the centrality of the 'link worker' role (referred to as Wellbeing Coordinator within Connect Well), within UK policy. This is a multi-faceted role which includes; providing time to focus on what matters to individuals, and to develop a support plan; connecting individuals to community groups and agencies for support; collaborating with local partners to support the sustainability and accessibility of community groups, and support the development of new groups, to fill gaps in availability (NHS England/NHS Improvement 2020).

Recent policy positions social prescribing as a core element in addressing patient need and challenges in primary care, as well as the social problem of loneliness, which is increasingly recognised as a significant issue in respect of health, mortality and quality of life (Holt-Lunstad et al 2016; NHS England 2016, 2019; HM Government 2018). The potential of social prescribing to contribute to addressing these needs was identified within the NHS Long Term Plan (2019) which announced a significant investment in social prescribing. While much of the policy focus of social prescribing has been in the context of primary care, the

Local Government Association (2016) has also highlighted the role of councils in respect of social prescribing.

Connect Well Hull

Connect Well is a joint initiative, provided both by Hull and East Riding Citizen's Advice (CAB) and the North Bank Forum. The service provides both Welfare Advice and Social Prescribing:

- 1) Welfare Advice is delivered by Welfare Advisors (WAs) who provide advice and support in respect of issues such as welfare benefits, housing and debt. This is a well-established service, which was considered to have a strong evidence base for its effectiveness, consequently no evaluation of this element of the service was commissioned.
- 2) Social prescribing: in this element of the service Wellbeing Coordinators (WBCs) work with clients to address matters such as isolation and loneliness, anxiety, physical wellbeing, and to link clients to sources of community support. This element of the service represented a new approach, and was the subject of this evaluation.

Although our evaluation focused on social prescribing, there was evidence of considerable need for advice in respect of finances, welfare benefits and debt, from clients, WBCs and referrers. Some clients received support from both WAs and WBCs, who sometimes made referrals internally between the two elements of the service.

During the period of the evaluation social prescribing was delivered by a small team (four at the time of writing) of WBCs, who were based in GP practices (and who have also been based in a small number of community services such as Age UK and the Hessle Road Network). WBCs had varied professional backgrounds prior to working with Connect Well; previous roles included working to support individuals with a range of needs, both within the VCS and NHS. Referrals were taken from a range of sources, which included GPs, social work/social care, other agencies (including the police, fire service, the VCS), in addition to self-referral. The social prescribing service was jointly funded by Hull Clinical Commissioning Group (CCG) and Hull City Council.

The evaluation

An evaluation of the effectiveness and impact of Connect Well social prescribing was commissioned by Hull CCG and Hull City Council. The aims were to use quantitative and qualitative methods to explore and evaluate the extent to which the stated outcomes in the Service Specification document for the Hull Social Prescribing Service (Connect Well) were delivered. These outcomes were identified as:

- 1) Improve the health and wellbeing of service users; including health, independence and ability to self-manage their care needs
- 2) Improve service user's self-reported wellbeing
- 3) Improve service user's ability to self-manage their condition
- 4) Provide timely access to social prescribing support and generalist welfare advice
- 5) Contribute to a reduction in primary care attendances for non-medical reasons, particularly for people with long-term conditions, complex conditions and frailty.

Further, the evaluation sought to identify key processes and relationships which could facilitate the delivery of the above outcomes, as well as making appropriate recommendations.

The evaluation took place from January 2019 – December 2020; an interim report detailing early findings was submitted to the funders in July 2019. This interim report highlighted:

- The newness of the social prescribing service and the unfamiliarity among potential referrers and members of the public, with a consequent need identified for ongoing publicity
- The challenges for WBCs in becoming embedded in primary care
- The potential isolation of WBCs who lack a consistent work base
- A need for more practitioner-initiated referral (rather than a reliance on signposting and self-referral), to enable those in greatest need to access social prescribing support.

The evaluation period; 2019-2020

The evaluation took place across a two-year period, which afforded the opportunity to collect rich, in-depth information about social prescribing in Hull, and to explore developments during this period.

The evaluation period was characterised by considerable change and flux. Staffing was initially very stable, but during the evaluation it underwent some changes, as WBCs moved on to new roles. There were also some changes to the places in which WBCs were based. These were relatively routine changes, which would be expected over time. However, there were also two key unanticipated changes that affected the service and required it to adapt, with further adaptations likely to be required in the future. First was the introduction of link workers into the newly formed Primary Care Networks (PCNs). Second, was the COVID-19 pandemic with associated periods of lockdown and social distancing.

PCN based link workers

At the beginning of the evaluation period, Connect Well was the only formal source of social prescribing in Hull (although there will have been some informal referral or signposting of individuals to agencies by GPs, other practitioners and agencies, which did not involve WBC support). However, during the evaluation PCNs were formed, and, in accordance with NHS policy, all were required to provide social prescribing via practice-based link workers. The arrangements for the management of link workers has varied across the different PCNs; some are managed by the North Bank Forum, some directly by the PCNs. Some GP practices now host both link workers and WBCs, however there are key differences between WBCs and link workers; link workers can only take referrals from within primary care (including self-referral), while WBCs have a broader referral base, also link workers have access to practice systems such as SystmOne.

The evaluation did not include exploration of the link worker role, and we did not collect information on how these workers are being deployed within the PCNs (in which there may be local differences), or the impact on Connect Well. Understanding the nature of this change, the role of the link workers, and how these might complement the service provided

by Connect Well, has been hampered by the COVID-19 pandemic, which has required changed delivery both by Connect Well and GP practices (including link workers).

COVID-19

The COVID-19 pandemic has required substantial changes in delivery both by Connect Well and GP practices (including link workers), which will be further explored in the main body of the report. These include:

- A move to home-based working for staff
- Reduced referrals, as well as changes to the kinds of support offered, especially early in lockdown
- An unavoidable move away from face to face working for much of this period, with client work instead taking place by phone
- A reduction in the range and quantity of services to which clients can be referred, as many have been unable to offer face to face support.

COVID-19 has also had widescale impacts, which are likely to continue beyond the pandemic; these include the increased prevalence of isolation and loneliness, and mental health needs. Additionally, issues associated with poverty, debt and work instability have been highlighted, which may lead to requirements for both welfare advice and social prescribing support. Social prescribing has therefore been identified as having a potential role to play in the long-term recovery from COVID (British Red Cross 2020). In Hull, the pandemic has highlighted significant issues in respect of food poverty, and anticipated needs for telephone befriending and emotional support during the recovery phase, and a consequent need to ensure that the VCS has the resources and capacity to deliver these (Forum, 2020).

It is clear then that this evaluation has taken place at a period of intense pressure and demand, both for Connect Well social prescribing, and for the wider community it seeks to support. Our understanding of how this will affect the local need for, and provision of, social prescribing in Hull is, inevitably, incomplete. Changes impacting on the service and the local community will continue to evolve beyond this evaluation period. However, the evaluation findings at this stage offer some evidence of good practice and recommendations for future delivery and practice.

The scope of this report.

In this report we consider social prescribing activity within Connect Well, including the practices and relationships of WBCs. However, we also reflect on the practices and perceptions of other practitioners (such as potential referrers) which impact on Connect Well and on individuals' social prescribing journeys.

Revised Evaluation methodology

The evaluation employed both quantitative and qualitative methodologies.

There were some changes to the methodology originally proposed; this original methodology is detailed in Appendix One.

Quantitative methods

The quantitative element of the project sought to evaluate social and economic benefits of Connect Well social prescribing. The following elements were to be achieved based on the condition that the research team were able to access key relevant data in an appropriate form. There were a number of difficulties in accessing the data required, which impacted on the proposed analysis, and which are detailed in the report.

- 1) Referrals-in to Connect Well Social Prescribing. How many GP practices engaged with the project and how many referrals-in (i.e. by GPs and Adult Social Care to WBCs, as well as self-referrals) were received overall and by practice. We agreed to look at age, gender and ethnicity if data format permitted.
- 2) Referrals-out refers to onward referrals of service-users to Voluntary and Community Sector (VCS) services. This included the number of onward referrals overall during the lifetime of the project, as well as the range of service up-take (where service-users are referred/signposted). This will illustrate the range and type of services accessed and areas of high and low demand. Data on whether clients attended were not available, so this provides a measure of potential rather than measurable uptake of services
- 3) In order to evaluate the impact on demand for primary care attendance for non-medical reasons, we proposed to look at data on the use of GP services by patients referred to the social prescribing service over the lifetime of the project, to establish the extent to which, if any, attendance rates have reduced over time.
- 4) We also proposed to conduct a pragmatic economic cost analysis using attendance data from GP practices; it would be possible to evaluate the impact on the demand on primary care resources using a cohort of patients where we have 12 months pre and post referral data. With these data it would be possible to estimate the economic impact by estimating the cost to commissioners per patient in relation to use of social prescribing against GP services.

Data collection

Data were provided by Connect Well via Hull CCG. To achieve aims 1) and 2) above we requested individual level data that included, i) referrer (or sign-poster) details, ii) registered GP, iii) reason for referral/signposting/attending and iv) VCS service referred to, as well as demographic data such as v) age, vi) gender, vii) ethnicity and viii) disability if possible. To achieve aims 3) and 4) above we requested data that allowed us to link i) to viii) with GP practice data (specifically, consultation frequency).

There were some challenges with processing the data available to us which we describe further below, along with the actions that we have taken to manage data limitations and as a caveat to the extent to which findings are reliable. This is not a comprehensive list, there were other limitations with the way data were presented that did not impact on our analysis; we present these alongside results to aid interpretation and weighting of findings.

Analysis

Aims 1 and 2.

There have been challenges with data collection which prohibit the extent of the analysis we are able to offer. We commend Connect Well on the improvement in data collected in year 3. However, there remain a number of challenges that compromise the scope of our analyses.

“Referral”

Many service users were signposted or advised to attend the service rather than formal referrals being made. Unless otherwise stated, when we use the word referral here we mean both people formally referred and those that were advised or signposted to the service.

Limited data (pre-May 2019)

Prior to May 2019 the data we were provided with were restricted to referral ID, “submission date”, referrer detail, registered GP, disabilities, ethnicity, gender, accessibility and communication needs and reason for referral.

Incomplete data

There were omissions in the early data collected. For example, neither registered GP nor “where did you hear about the service” were recorded until 16/5/2018. Gender was recorded on 6 occasions over the six month period 12/9/17 and 12/3/18. From 16/5/18, for the rest of 2018, 235 service users were recorded as “submitted” to the social prescribing service and there were fewer missing data but gaps remained. For example, gender was reported in 56% (n=132) of cases and “where did you hear” in 66% (n=155). Some data was entered by way of free text and establishing categories or themes was not possible because not all text could be coded. For example, “where did you hear”, sometimes included personal names that did not inform about role or place, only the category ‘GP’ generated more than 1% (n=4) of responses at 11% (n=19).

Variations in the data collected

Where a drop-down menu was provided for data entry the available options have evolved considerably over the three years of service delivery. Therefore, the trends we report are likely to be, in part, due to the changes in *data collection* rather than changes in service user characteristics. For example, “previous client returning” did not become a category of “referrer details” until the last quarter of year 2 (April 2019). As a result of this some of the analysis we offer focuses on year 3 only.

Data error

We were only able to pick up errors in data such as date seen when they obviously fell out with the parameters of the spreadsheets we received. For example, dates wrong by over a year, non-existent postcodes. We have put these down to typographical errors and where possible have included the cases in the analysis. They accounted for less than 3% of the data. We had no means of identifying error across other reported elements but assume these to be similarly accurate.

Linking data sets (data from May 2019 onward)

It is regrettable that we have found no automated or semi-automated means of linking many of the data provided. To do so would have required manual matching of cases across different data sheets.

This limits the usefulness of our analysis. We have been able to combine some data, but to combine all data would require a line by line manual combination of sheets. Therefore, whilst we are able to offer descriptive statistics on each of these elements, we are not able to cross tabulate data to offer meaningful suggestions on VCS provision or need according to GP, reason for referral/attending or any demographic factors.

Incongruities in numbers reported (data from May 2019 onward)

We were provided with monthly excel spreadsheets, within which there were three sheets relevant to our use. However, in each of these there were different parameters for reporting and/or parameters of reporting changed during the evaluation period. Logically, fewer people were seen than referred. Consequently, the number of people referred on the “activity template” were greater than those on the “cases” template (year 3 data only). We were unable to account for the difference in reported referrals between sheets. From occasional narrative data included on templates, it seems likely that this is due to service users being transferred internally from the welfare service to the social prescribing service. However, the data did not make it possible to establish this except when it was explicitly stated (as it was in April and May 2020 only). A further incongruity was that of referrals occurring through the “advice line” (reported only in June 2020). Another problem was that when a client had previously attended, often, and understandably, their data was not re-recorded. Unfortunately, as there was only client ID data for 16 months, in these cases the data were functionally not available.

Aim 3

Data was not collected at source in a way that would enable linking client data with GP systems to allow us to retrieve data regarding GP attendance rates (before and after receiving social prescribing support). Instead a member of the CCG ran a SystemOne audit of Read codes relating to social prescribing for the period 14th June 2018 to 14th June 2019.

Aim 4

There are too few data to calculate or estimate economic impact.

Qualitative methods

Participant Groups. Social prescribing is a complex intervention involving multiple stakeholders; therefore, it is important to collect data on the perspectives and outcomes for different groups (Aughterson et al, 2020).

In-depth interviews and focus groups were undertaken with the following:

- Key stakeholders: these included managers with responsibilities for social prescribing
- Referrers: this group included practitioners, such as GPs and social workers, who could refer or signpost individuals for social prescribing support. Those who had referred/signposted, as well as those who had not done so, were included, as both could provide important perspectives and insights

- Wellbeing Coordinators: all WBCs working in the service were invited to participate in the evaluation. Longstanding team members were invited to take part in interviews at two timepoints during the evaluation, in recognition of the evolving nature of the service and their roles, and the changes imposed by COVID-19
- Clients; individuals who had received WBC support were interviewed about their experiences of WBC support, of accessing VCS support, and any outcomes experienced
- Service providers; these included community organisations and groups (referred to collectively in this report as the VCS) to which clients of Connect Well could be referred or signposted.

In addition to the above groups, we originally intended to interview carers and family members of clients (with clients' permission) to explore whether and how they had benefitted from the service, and their perceptions of the benefits and outcomes for their relative. However, no client interviewed had a relative able or willing to participate. In some instances, this may have reflected the isolation of clients, who did not always appear to have a relative, friend or partner closely involved in their support. This is perhaps unsurprising, given that isolation is a factor underpinning many referrals for social prescribing support.

There were challenges in recruiting the following participants:

General practitioners. Following successful levels of recruitment to focus group and interviews (facilitated by the CCG) in year 1 of the evaluation, we were unable to recruit further GPs during the second year. This was an important time, as in addition to the evolution of Connect Well, link workers had been introduced to the PCNs and COVID-19 was affecting practice. To facilitate GP participation an online survey was designed, and a link to this was sent to GPs by the CCG on a regular basis. The survey included questions about GP use and experiences of Connect Well social prescribing; perceived patient benefits; access to and experiences of link worker delivered social prescribing; the impact of COVID-19 on practice, and the extent to which 'social problems' were presented at this time; experiences of social prescribing during the pandemic.

Clients. In common with other studies (Carnes et al 2017; Bertotti et al 2018, Pescheny et al 2018) a number of difficulties were encountered in recruiting people who had received social prescribing support. These included:

- Connect Well did not have permission to contact many of their past clients, once cases had been closed, and this did not change across the evaluation period
- Clients were often lost to follow up, and could not be contacted
- Individuals indicated to the WBCs that they did not want to participate, or did not reply when contacted by the researchers, having initially expressed interest in participating in the evaluation
- WBCs often work with clients for a relatively short amount of time, and can have relatively few face-to-face meetings. Therefore, they often needed to provide information about the evaluation at clients' first appointments, before they had much experience of the service and any outcomes

- WBCs were asked to exclude anyone who was experiencing significant levels of distress or who they believed would not have the capacity to consent to participating in the evaluation. As a result, some clients were not invited to take part.

The researchers liaised regularly with Connect Well and introduced amended ways of working to identify participants. The main recruitment method involved WBCs giving a flier to clients which provided brief information about the evaluation; clients could either contact the researchers themselves, or the WBCs could share their contact details with the researchers on their behalf. During the evaluation the researchers received contact details for 13 clients; of these only 5 participated in an interview, the majority of those who did not participate could not be contacted by the researchers (for example, did not answer the phone or respond to email). The researchers also developed an online survey for clients, which enabled people to share their experiences of the service without having to meet with a researcher. Although those who do not have access to digital devices or Wi-Fi were excluded from this means of participation, this methodology had potential to capture the views of those who are socially anxious or who did not have time to meet with a researcher.

The GP and client surveys were introduced in July 2020, in the period following the first wave of the UK COVID pandemic, and were open until the end of November 2020.

Data collection

Prior to data collection, all participants were provided with information about the evaluation and asked to give verbal and written consent.

Initial interviews and focus groups were conducted face to face with all participant groups; with the exception of one client who was interviewed by phone at their request. Following the COVID-19 restrictions, data collection was undertaken by phone or using online platforms.

All interviews were audio recorded, then transcribed. Following transcription, all data was anonymised. Participants' permissions were sought for the use of anonymised quotes in reports; where quotes have been used, these have been amended where necessary to reduce the likelihood of individual participants being identified.

Data analysis

All qualitative data was analysed by two researchers using a thematic framework identified by the researchers on the basis of the early data collected and through reviewing the existing literature on social prescribing. The analytic framework consisted of the following five themes which reflect the client journey through social prescribing; outcomes and impacts; good practice in delivering social prescribing:

- Getting in: gaining access to social prescribing
- Getting support: how wellbeing coordinators support clients
- Getting on: accessing support in the community
- Perceived benefits and outcomes of social prescribing
- Working to deliver social prescribing.

Further sub-themes were identified for each of the themes above.

Research Ethics

At the outset of the evaluation approvals for the study were obtained from The University of Hull Faculty of Health Sciences Ethics Committee and via the Hull City Council Research Governance process.

Quantitative Findings

In this section we use the term 'referral' to apply to all those for whom an initial contact is made with Connect Well or VCS services. This includes referrals made by practitioners, as well as self-referrals by potential clients, some of which will occur following signposting by practitioners or WBCs (in the case of onward referral to the VCS).

Referrals in

In year one 576 people were referred and in year two 914 were referred. There were data for year 3 only on which of these referrals led to attendance at the service. In year 3 there were 709 people referred and 511 "cases". People transferred from the welfare service to the social prescribing service were not always noted as referrals. This accounted for 56 people seen between April and June 2020. From conversations with the service providers we believe this is due to COVID, and the service taking a pro-active approach to contacting people on the CAB 'vulnerable list'. The referral data suggests that of the 709 people referred in year 3, 198/709 (28%) did not attend/were not contactable.

Aim 1: Referrals-in to Connect Well Social Prescribing. How many GP practices engaged with the project and how many referrals-in (i.e. by GPs and Adult Social Care to WBCs) were received overall and by practice. We agreed to look at age, gender and ethnicity if data format permitted

Table 1 indicates the numbers of people referred to the service and the referral source across all three years of the service. Across the three year period there were a total of 2199 people referred. In year one n=576, year two n=914 and in year three n=709. Figure 1 and subsequent figures show the percentages of referrals, in order to make comparisons across each year, because the number of services users was affected by start-up (year 1) and by Covid-19 (year 3).

Whilst data in year 3 was much more detailed, the potential for error increased due to data entry spreadsheets that allowed easy user-editing of drop-down menus. For example, there were 65 categories of "social services" and 106 categories of "health professional". Many of these are the same but written slightly differently. For example, "locality team, social worker, east locality" and "locality team, social worker, east locality team". Equally, "self-referral – digital" was entered four times, the only variation being punctuation. We therefore present according to broad themes.

Table 1: Service Users by Source years 1 to 3

Source	Year 1 referrals n (%)	Year 2 referrals n (%)	Year 3 referrals n (%)	Total referrals years 1 to 3 n (%)
Self-referral	179 (31)	282 (31)	192 (27)	653 (28)
Social Services	85 (15)	254 (28)	100 (14)	439 (20)
Health Professional	26 (4.5)	115 (13)	134 (18)	275 (12.5)
Returning Service User	-	97 (10.6)	149 (21)	246 (11.2)
Not recorded/unknown	204 (35.4)	-	-	204 (6.8)
Charity/Community/Voluntary organisation	35 (6.1)	35 (3.8)	42 (6)	112 (5)
GP	3 (0.5)	56 (6.1)	34 (4.8)	93 (4.2)
Friend/Family/Carer	19 (3.3)	25 (3)	25 (3.57)	69 (3.1)
CAB/Connect Well	18 (3.1)	21 (2.7)	6 (0.85)	45 (2)
Statutory	7 (1.2)	23 (2.5)	25 (3.5)	55 (2.5)
Other	-	6 (0.6)	2 (0.28)	8 (0.4)
Total	576	914	709	2199

The two main sources of recorded referrals across all 3 years were self-referral and social services. Despite the primary aim of social prescribing being to relieve GPs of repeat appointments, relatively few referrals were from GPs and, as will be seen shortly, most GP referrals were from a small number of practices (this latter point is also consistent with research findings from other areas of the UK; for example, Bertotti et al 2018).

The most significant changes in referral source over the three year period were:

- No missing data in years 2 and 3 compared with year 1 (missing data in year 1 was 35.4%, n=204)
- Returning service users in year 3 who accounted for 21% of all referrals (n=149) compared with zero in year one and 10.6% (n=97) in year two
- The rise in referrals from social services from years one (15%, n=85) to year two (35%, n=230) and subsequent drop in year three (14%, n=100).

Few recorded referrals were made directly from GPs; in year one 0.5% (n=3), in year two 6.1% (n=56) and in year three 4.2% (n=34). Not all referring GPs were recorded; where they were these are presented in Table 2.

Figure I: Referral Source by year

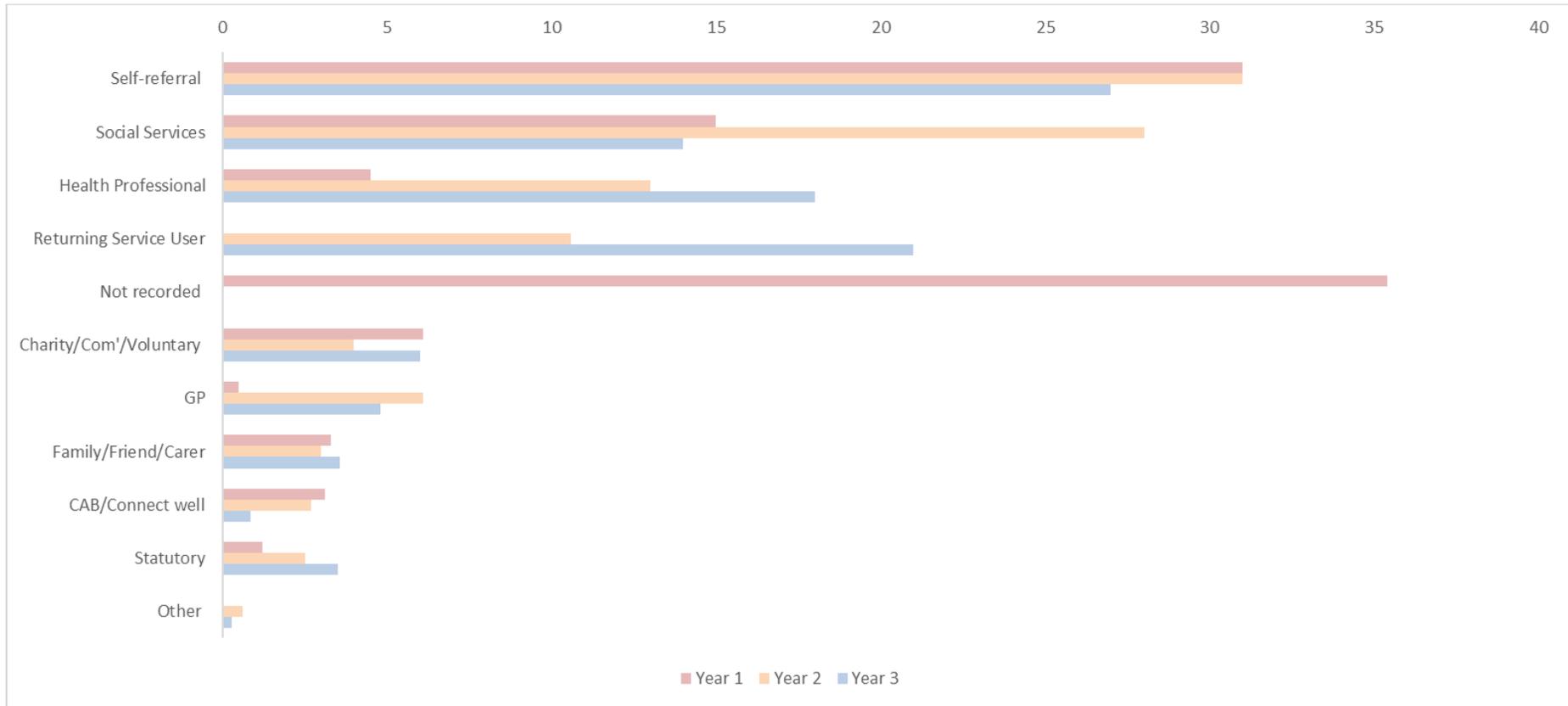


Table 2: Referrals from GPs

GP practice	Year 1 referrals n (%)	Year 2 referrals n (%)	Year 3 referrals n (%)	Total referrals years 1 to 3 n (%)
Southcoates		13 (29.5)	4 (12.5)	17 (21.5)
Burnbrae/Haxby		10 (22)	6 (18.8)	16 (20)
Marfleet Lane		2 (4.5)	2 (6.2)	4 (5)
The Quays	1 (33.3)	3 (6.8)		4 (5)
Kingswood			4 (12.5)	4 (5)
Calvert			4 (12.5)	4 (5)
Springhead		1 (2.3)	2 (6.2)	3 (3.8)
Newland			3 (9.4)	3 (3.8)
Faith House	1 (33.3)	2 (4.5)		3 (3.8)
Sutton Manor			3 (9.4)	3 (3.8)
Avenues		2 (4.5)		2 (2.5)
New Hall		2 (4.5)		2 (2.5)
Orchard		2 (4.5)		2 (2.5)
Kingston		1 (2.3)		1 (1.3)
CHCP Newington	1 (33.3)			1 (1.3)
Riverside		1 (2.3)		1 (1.3)
Wolseley		1 (2.3)		1 (1.3)
Hastings		1 (2.3)		1 (1.3)
Laurbel		1 (2.3)		1 (1.3)
Wilberforce		1 (2.3)		1 (1.3)
Field view			1 (3.1)	1 (1.3)
Bransholme HC			1 (3.1)	1 (1.3)
East Hull		1 (2.3)		1 (1.3)
St Andrews			1 (3.1)	1 (1.3)
Total recorded	3	44	32	79

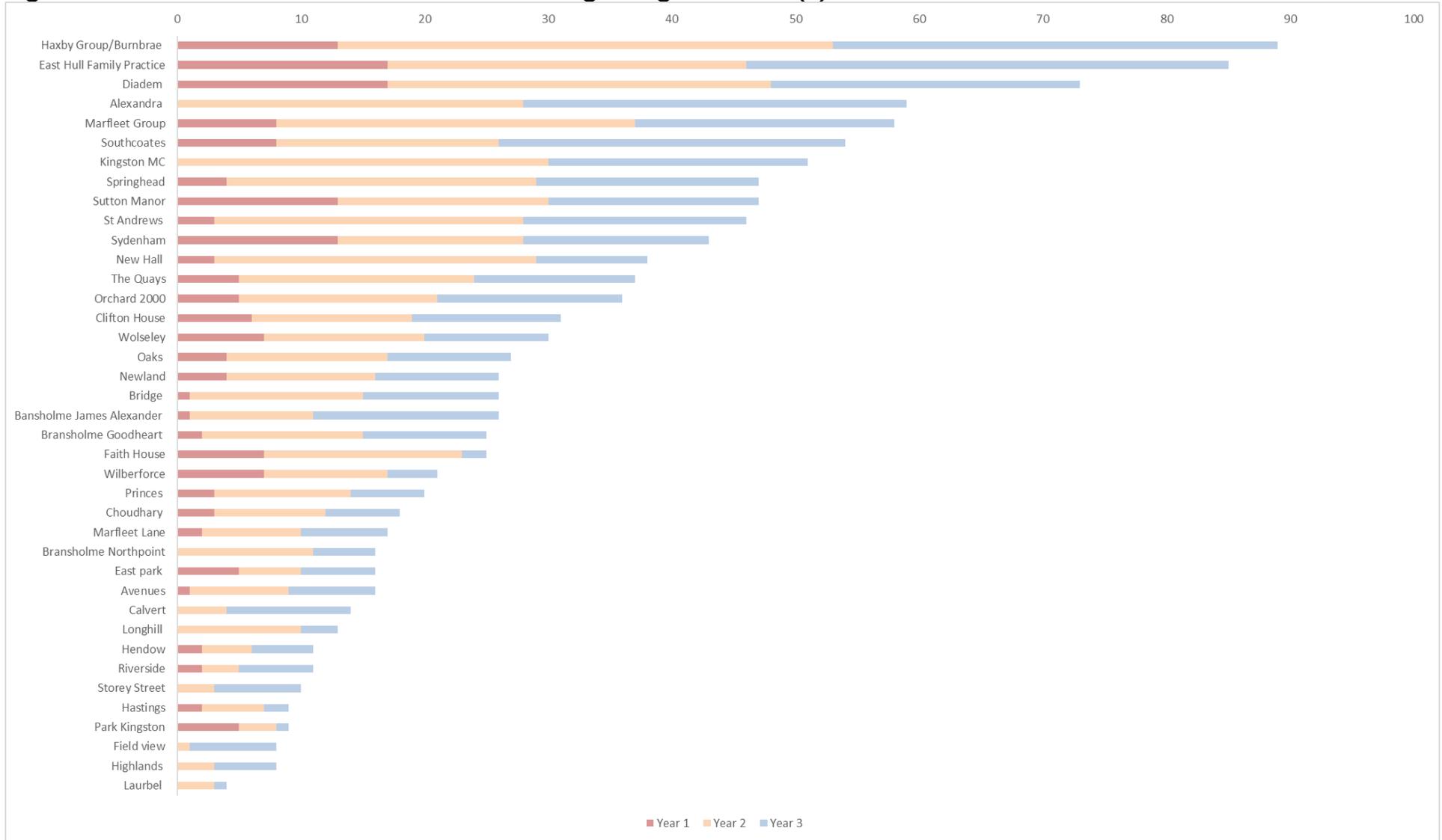
Southcoates 21.5% (n=17) and Burnbrae/Haxby 20% (n=16) were the practices who referred to social prescribing the most. There were no real changes in trend over the three years other than the number of practices referring increasing considerably after the first year, suggesting an increased knowledge of the service across GP practices after year one.

Table 3 and Figure 2 present the registered GP/practice for all service users referred. Again, data were entered free text, with GPs and practices being represented with a wide range of different texts (e.g. sometimes the individual GP and other times the practices, sometimes a broad term such as “Bransholme” where there are several practices). We have tried to cluster/theme these to the best of our knowledge and by checking surgery web sites. However, it is possible that some practices are presented in more than one category. In year 3, unlike other years, when a previous client returned many of their details were not recorded (including Registered GP).

Table 3: Registered GP for referred service users

Registered GP practice	Year 1 n (%)	Year 2 n (%)	Year 3 n (%)	Total years 1 to 3 n (%)
Not recorded/don't know/not registered	403 (70)	361 (39)	235 (33)	999 (45)
Haxby Group/Burnbrae	13 (2.3)	40 (4.3)	36 (5.1)	89 (4)
East Hull Family Practice/Morrill Street	17 (3)	29 (3.2)	39 (5.5)	85 (3.9)
Diadem	17 (3)	31 (3.4)	25 (3.5)	73 (3.3)
Alexandra	-	28 (3)	31 (4.4)	59 (2.7)
Marfleet Group	8 (1.4)	29 (3.2)	21 (2.9)	58 (2.6)
Southcoates	8 (1.4)	18 (2)	28 (3.9)	54 (2.5)
Kingston MC		30 (3.3)	21 (2.9)	51 (2.3)
Springhead	4 (0.7)	25 (2.7)	18 (2.5)	47 (2.1)
Sutton Manor	13 (2.3)	17 (1.9)	17 (2.4)	47 (2.1)
St Andrews	3 (0.5)	25 (2.7)	18 (2.5)	46 (2.1)
Sydenham	13 (2.3)	15 (1.6)	15 (2.1)	43 (1.9)
New Hall	3 (0.5)	26 (2.8)	9 (1.3)	38 (1.7)
The Quays	5 (0.9)	19 (2.1)	13 (1.8)	37 (1.7)
Orchard 2000	5 (0.9)	16 (1.8)	15 (2.1)	36 (1.6)
Clifton House	6 (1)	13 (1.4)	12 (1.7)	31 (1.4)
Wolseley	7 (1.2)	13 (1.4)	10 (1.4)	30 (1.4)
Oaks	4 (0.7)	13 (1.4)	10 (1.4)	27 (1.2)
Newland	4 (0.7)	12 (1.3)	10 (1.4)	26 (1.2)
Bridge	1 (0.2)	14 (1.5)	11 (1.6)	26 (1.2)
Bansholme James Alexander	1 (0.2)	10 (1.1)	15 (2.1)	26 (1.2)
Bransholme Goodheart	2 (0.3)	13 (1.4)	10 (1.4)	25 (1.1)
Faith House	7 (1.2)	16 (1.8)	2 (0.3)	25 (1.1)
Wilberforce	7 (1.2)	10 (1.1)	4 (0.6)	21 (0.9)
Princes	3 (0.5)	11 (1.2)	6 (0.8)	20 (0.9)
Choudhary	3 (0.5)	9 (1)	6 (0.8)	18 (0.8)
Marfleet Lane	2 (0.3)	8 (0.9)	7 (1)	17 (0.8)
Bransholme Northpoint		11 (1.2)	5 (0.7)	16 (0.7)
East park	5 (0.9)	5 (0.5)	6 (0.8)	16 (0.7)
Avenues	1 (0.2)	8 (0.9)	7 (1)	16 (0.7)
Calvert		4 (0.4)	10 (1.4)	14 (0.6)
Longhill		10 (1.1)	3 (0.4)	13 (0.6)
Hendow	2 (0.3)	4 (0.4)	5 (0.7)	11 (0.5)
Riverside	2 (0.3)	3 (0.3)	6 (0.8)	11 (0.5)
Storey Street		3 (0.3)	7 (1)	10 (0.5)
Hastings	2 (0.3)	5 (0.5)	2 (0.3)	9 (0.4)
Park Kingston	5 (0.9)	3 (0.3)	1 (0.1)	9 (0.4)
Field view		1 (0.1)	7 (1)	8 (0.4)
Highlands		3 (0.3)	5 (0.7)	8 (0.4)
Laurbel		3 (0.3)	1 (0.1)	4 (0.2)
Total	576	914	709	2199

Figure 2: Numbers of service user referred according to registered GP (n)

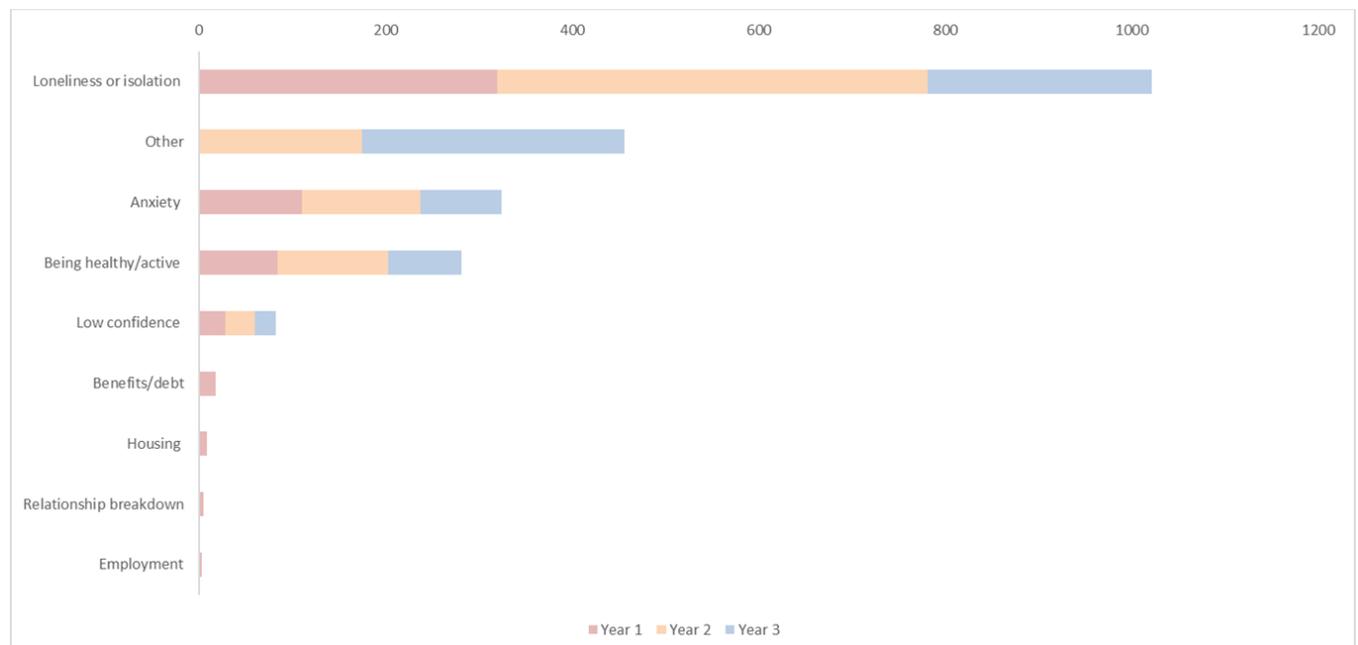


Data about reasons for referral across the 3 years are shown in Table 4 and Figure 3. Despite the large percentage of “other” reasons, it appeared that loneliness or isolation was by far the biggest reason for referral at 46% (n=1022), which, combined with anxiety and being healthy/active accounted for the majority of all referrals (75.5% across these three categories).

Table 4: Reasons for referral to the social prescribing service

Primary reason for referral	Year 1 Number	Year 2 number	Year 3 Number	Total n (%)
Loneliness or isolation	320	461	241	1022 (46)
Other	-	163	281	456 (21)
Anxiety	110	127	87	324 (14.7)
Being healthy/active	84	119	78	281 (12.8)
Low confidence	28	32	22	82 (3.7)
Benefits/debt	18	-	-	18 (0.8)
Housing	8	-	-	8 (0.4)
Relationship breakdown	5	-	-	5 ((0.2)
Employment	3	-	-	3 (0.1)
	576	914	709	2199

Figure 3: Reasons for referral for social prescribing



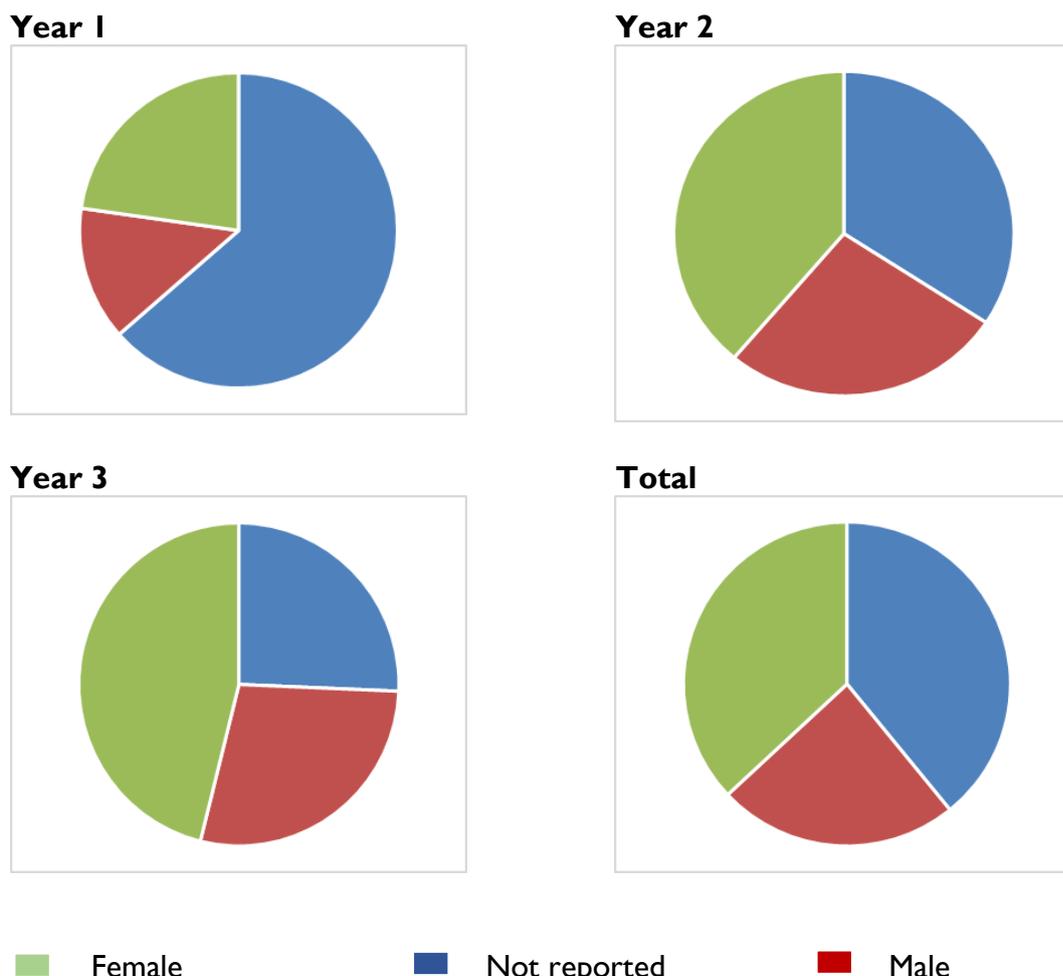
Gender

Table 5 and Figure 4 break down the referrals by gender according to year and in total. There were fewer missing data as the years progressed. Overall, where gender was recorded, 39% (n=525) of referrals were men and 61% were women. This disparity may reflect the gender inequality commonly found in utilisation of mental health services, although the extent of the missing data makes drawing conclusions difficult.

Table 5: Gender of referrals according to year

	Year 1	Year 2	Year 3	Total
Not reported/missing data	366	313	182	861
Male	79	246	200	525
Female	131	355	327	813
	576	914	709	2199

Figure 4: Gender according to year



Ethnicity

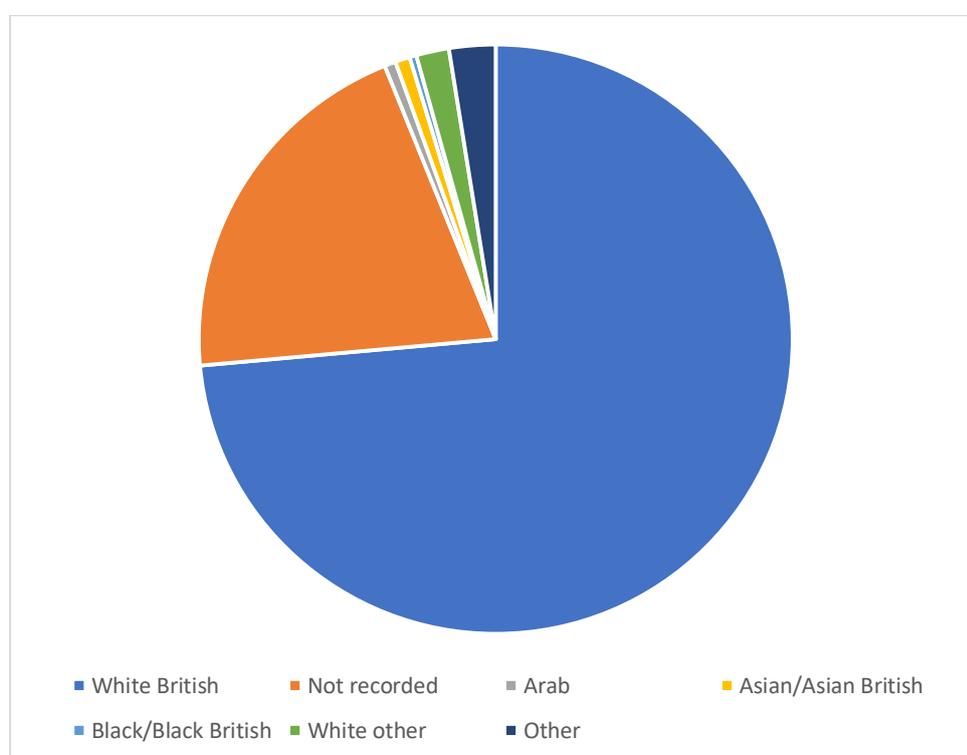
Data on ethnicity were not provided for year 1. Ethnicity of those referred for years 2 and 3, and the total for both years are illustrated in Table 6, and the total across both years, illustrated in Figure 5. Where ethnicity was recorded, the vast majority (74%, n=1194) of those referred were recorded as White British. Ethnicity data of those referred to the service broadly reflected that of the general population of Hull (89% White British, 4.1% other White, 1% Asian and 1.2% Black)¹.

¹ <https://www.ons.gov.uk/census>

Table 6: Ethnicity, years 2, 3 and total

Ethnicity	Year 2	Year 3	Total
White British	705	489	1194
Not recorded	143	187	330
Arab	8	2	10
Asian/Asian British	9	4	13
Black/Black British	4	2	6
White other	17	12	29
Other	28	13	41
Total	914	709	1623

Figure 5: Ethnicity all referrals years 1 and 2



Age

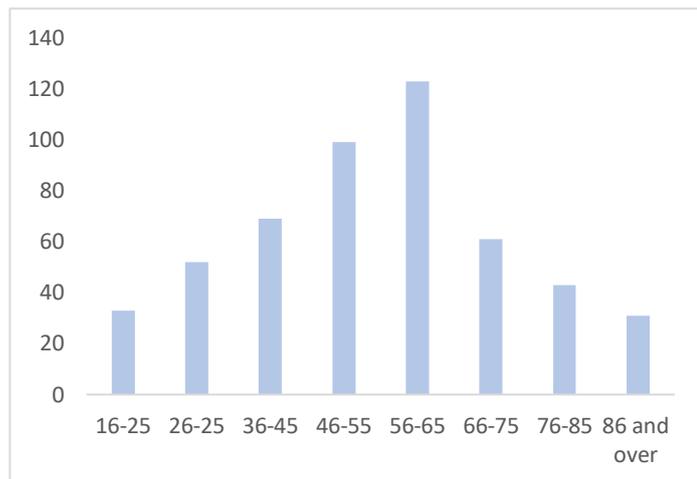
Year 1 and year 2 data on age was not complete. Age was recorded in year three for all 511 service users **seen**. Ages of service users in year three ranged from 16 to 101 years old. These data are illustrated in Table 7 and Figure 6. Although this distribution is similar to that of Hull as a population² there were proportionately more people in the over 76 age groups seen by the service. Compared to the age distribution of the population of Hull, social prescribing clients were more likely to be aged between 40 and 59. Older clients were seen in proportion to the population, while clients under 40 were under-represented.

² Observatory data 2019; http://109.228.11.121/IAS_Live/profiles/profile?profileId=1

Table 7: Ages of service users seen in year 3

Age	Number
Age 16-25	33
26-25	52
36-45	69
46-55	99
56-65	123
66-75	61
76-85	43
86 and over	31
	511

Figure 6: Ages of service users seen in year 3



Aim 2: Referrals-out. This refers to onward referrals of service-users to Voluntary Community Services (VCS). This includes the number of onward referrals overall over the lifetime of the project, as well as the range of services to which clients were directed (via referral or signposting). This will illustrate the range and type of services available and known to Connect Well, and areas of high and low demand. We do not have complete data relating to the community and voluntary services to which service users were referred or signposted for years one and two, and therefore present data based on year three in this section.

VCS referred to during year 3

This amounted to a total of 511 people who were made up of those referred, internal transfers from the welfare service and returning service users. Over this period of time a total of 979 referrals were made. The number of services any individual was referred to ranged from zero to 10 with the mean and median all being 2. Figure 7 shows the distribution of number of services.

Ideally, to understand need and gaps in provision, referrals would be related to gender, ethnicity, age and disability, but the problems linking data sets prevented this. We therefore present the range of services available in Table 8 and Figure 8, along with the numbers of referrals to each service. Of services where more than 2 people were referred, most offered social support (n=27) and Health support (n=19) with fewer offering Mental Health (MH) support (n=9), welfare advice (n=10) or educational opportunities (n=3).

Figure 7: number of VCS services each individual was referred to

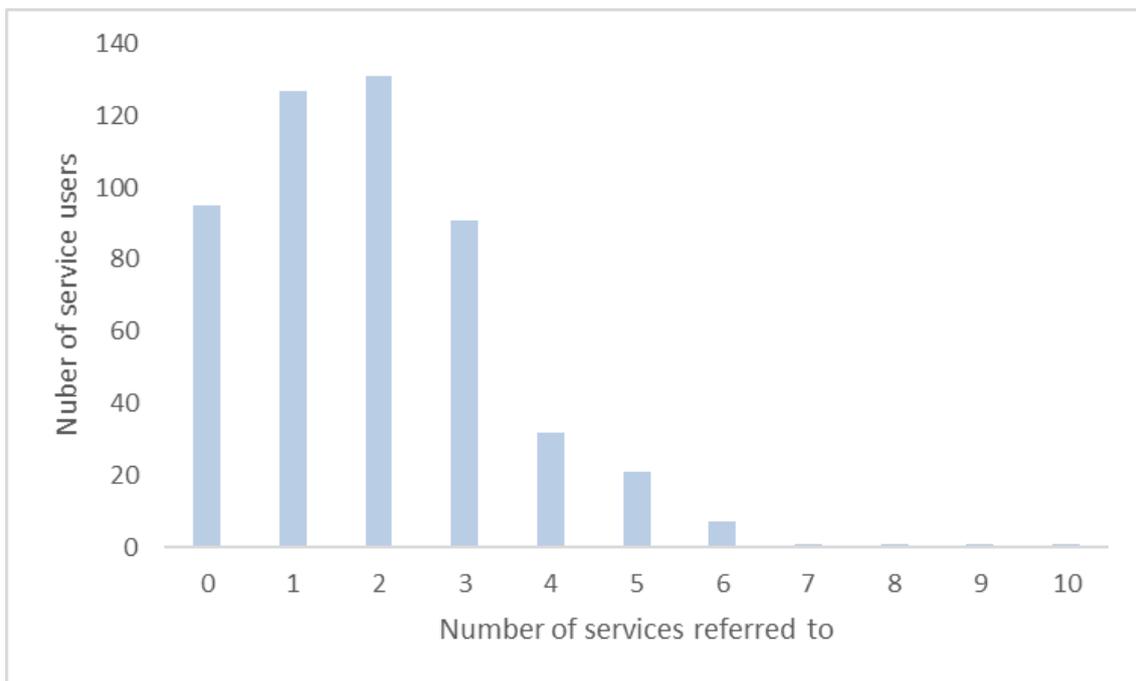


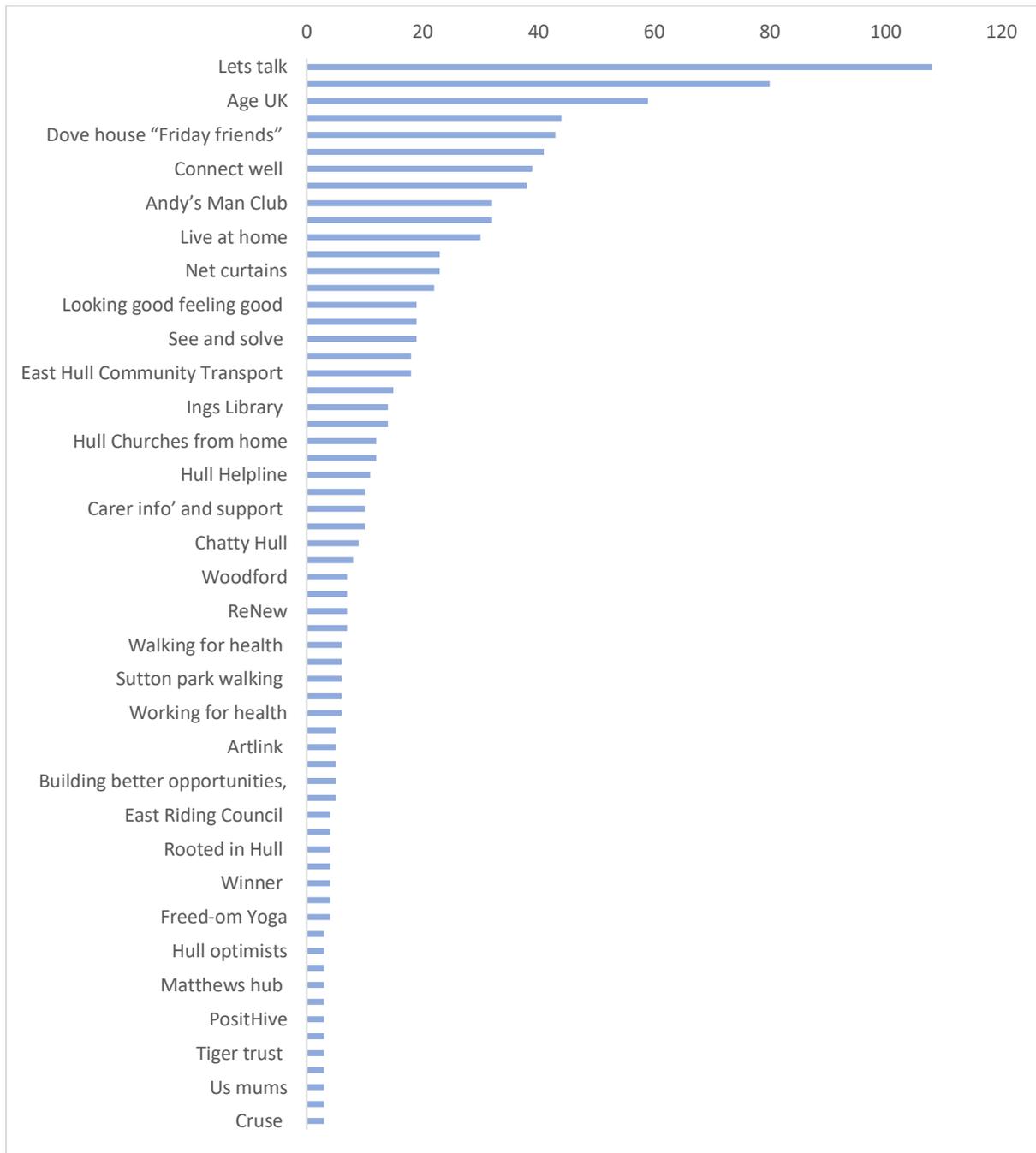
Table 8: Referrals to Community Voluntary Services

Service Name	Purpose/activity	Referrals n (%)	Health, fitness	Mental Health	Social and support	Education	Welfare
Let's Talk	Counselling	108 (11)		x			
Other	See below	80 (8.2)					
Age UK	Social activity clubs	59 (6)	x		x		
Jubilee Church Life College	Games, crafting and life skills	44 (4.5)			x		
Dove House "Friday Friends"	Befriending service	43 (4.4)			x		
Goodwin	Employment support	41 (4.2)					X
Connect Well	Welfare advice	39 (4)					x
Humber Recovery College	Wellbeing courses	38 (3.9)				x	
Andy's Man Club	MH and emotional support	32 (3.3)		x			
Hessle Road Network	Social activity groups	32 (3.3)			x		
Live at Home	Telephone befriending	30 (3.1)		x			
H&EY MIND	MH support/courses	23 (2.3)		x			
Net Curtains	Variety shows	23 (2.3)			x		
Freedom Centre	Social groups (over 55s, arts, gym, knitting)	22 (2.2)			x		
Looking Good Feeling Good	Exercising	19 (2)	x				
Men in Sheds	Model and craft making, music, metal work	19 (2)			x		
See and Solve	Equipment/adaptations at home	19 (2)					x
Lonsdale Community Centre	Social activity groups	18 (1.8)			x		
East Hull Community Transport	Transport/dial a ride	18 (1.8)					x
Endeavour Learning	Education and training	15 (1.5)				x	
Ings Library	Exercise and lunch clubs	14 (1.4)	x		x		
Back to Ours, the Living Room	Befriending/social group	14 (1.4)			x		
Hull Churches from Home	Telephone befriending	12 (1.2)			x		
Hull City Council	Housing support, care support,	12 (1.2)			x		x

Service Name	Purpose/activity	Referrals n (%)	Health, fitness	Mental Health	Social and support	Education	Welfare
	culture and leisure passes						
Hull Helpline	Emergency food, prescription pick up	11 (1.1)					x
Plug in Hull	Arts and crafts	10 (1)			x		
Carer Information and Support	Carer support	10 (1)			x		
Weight Wise	Weight loss	10 (1)	x				
Chatty Hull	Befriending	9 (0.9)			x		
Alf Marshall	Exercises	8 (0.8)	x				
Woodford	Leisure	7 (0.7)			x		
Endike Community Care	Social activities for people with dementia	7 (0.7)		x			
ReNew	Alcohol service	7 (0.7)	x				
Hull FC Inclusive and Disability Sports Hub	Sports	7 (0.7)			x		
Walking for Health	Walking	6 (0.6)	x				
Friendship Club	Social	6 (0.6)			x		
Sutton Park Walking	Walking group	6 (0.6)	x				
Empower	Learning about long term conditions	6 (0.6)				x	
Working for Health	Support for job seekers	6 (0.6)					x
St Andrews	Pilates	5 (0.5)	x				
Artlink	Workshops and craft	5 (0.5)			x		
Fit Mums	Walking	5 (0.5)	x				
Building Better Opportunities,	Employability support	5 (0.5)					x
Butterflies Memory Loss	Memory support group	5 (0.5)		x			
East Riding Council	Exercise	4 (0.4)	x				
Environmental Management Solutions EMS	Gardening, food	4 (0.4)	x		x		x

Service Name	Purpose/activity	Referrals n (%)	Health, fitness	Mental Health	Social and support	Education	Welfare
Rooted in Hull	Volunteering garden/allotment	4 (0.4)	x		x		
Shout	MH text support	4 (0.4)		x			
Winner	Women's centre support and social groups	4 (0.4)			x		
NHS Choices	Weight loss	4 (0.4)	x				
Freed-om Yoga	Yoga	4 (0.4)	x				
Community Voluntary Services	Volunteering opportunities	3 (0.3)			x		
Hull Optimists	Hydrotherapy	3 (0.3)	x				
Humbercare	Support worker	3 (0.3)					x
Matthews Hub	Advocacy	3 (0.3)			x		
Parkrun	Running	3 (0.3)	x				
PositHive	Arts and wellbeing	3 (0.3)			x		
Rainbow Garden	Gardening	3 (0.3)			x		
Tiger Trust	Football	3 (0.3)	x				
U3A	Social groups	3 (0.3)			x		
Us Mums	Fitness	3 (0.3)	x				
Alzheimer's Society	Memory café	3 (0.3)		x			
Cruse	Bereavement care	3 (0.3)		x			
Total		979	19	9	27	3	10

Figure 8: Numbers referred to VCS services



All services were specified. Where "other" appears in Table 8 this relates to services to which only one or two individuals were referred/signposted, illustrating the range and diversity of services to which clients were directed. These additional services are listed in Figure 9. Buddying was documented on 23 occasions.

Figure 9: Services included in the category “other” (presented alphabetically)

Ami yoga, Angels Volunteering, Armed Forces Club, Youth Club, autism plus, Beverley Road free swimming, Bilton Grange Community Association, Bingo In The Community, Book Club (Waterstones), Breakfast Veterans Club, Knit And Natter, CAHMS, children’s swimming, Children’s Centre (to volunteer), CAB, Community Advice Centre, DAP Emotional Abuse Service, Ethnic Minority Community Centre, Dyslexia Sparks, Electric Eels, Wheelchair Football, English My Way, Ennerdale swimming, Facebook OCD support, Family Information Service, First Ladies, Jobseekers, Stroke Club, Friends For English, Jubilee, Giroscope volunteering, Victim Support, health-share physio, Healthwatch, home library, House of Light (postnatal counselling), Hull for Heroes, Hull College, History Centre, Hull Vineyard (emergency food), Hull KR Heritage, homeless outreach, Kooth online support, Lemon Tree Children’s Centre, mental health response, Octagon Family Centre, Parkinson’s UK, Paul for Brain Recovery, Quakers support group, Ramblers Association, rapid response, stop smoking, recycling, Red Clover Women’s Group, Robin’s Ramblers, safeguarding, Samaritans, Singing for Health, Special Stars Music, Sports Academy, Sun-dragon Tai Chi, Take Control Employment, Timebank, Unitarian church, Vulcan sports, Warren MH young people, Wheeler Street children, WI, yoga.

In Table 9 and Figures 10, 11 and 12 we illustrate the areas within which service users live (we were provided with only the first three letters of their postcode for confidentiality reasons) and the areas of VCS provision. Both sets had missing data and the two could not be matched, so only group data can be shown. Most service users came from HU3, 5 and 9, while the VCS services most frequently used were located in HU1 and 3 (the city centre). There was a particularly noticeable disparity between the apparent level of need and number of agencies available within the HU9 postcode area. There was a dearth of service users from areas further away from the city centre, notably from the North of the city.

Table 9: Location of service users (n) and VCS (frequency of referral)

Post-code	Service Users	VCS
HU1	8	84
HU2	6	13
HU3	73	125
HU4	32	14
HU5	70	19
HU6	51	25
HU7	66	30
HU8	52	34
HU9	106	14
HU10	5	12
HU11	2	-
HU12	2	1
HU13	1	-
HU14	2	-
HU16	3	1
HU17	-	12
Total	479	384

Figure 10: Comparison of service user location (n) with VCS location (frequency)

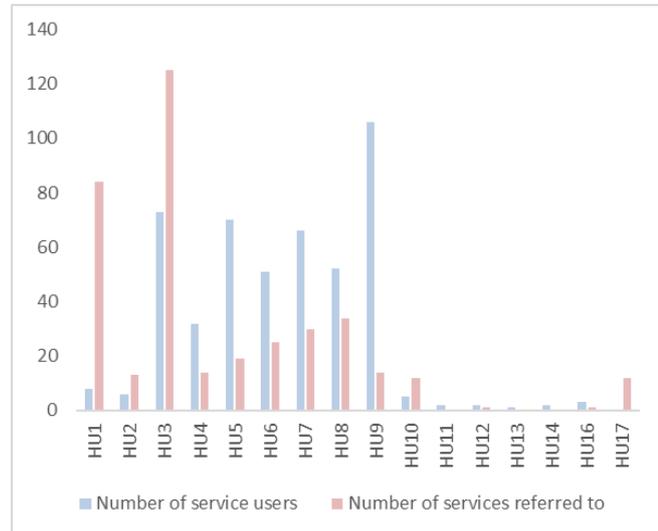


Figure 11: Location of service users (n)



Figure 12: Location of VCS (frequency)



Aim 3 & 4: As noted above, it was not possible to link social prescribing data sets to GP systems to allow us to retrieve data illustrating GP attendance rates. A SystemOne audit of Read codes relating to social prescribing for the period 14th June 2018 to 14th June 2019, run by a member of the CCG, only provided pre- and post-referral appointment data on eight service users, which was too few to analyse meaningfully.

Qualitative Findings

Participants

The number of participants taking part in interviews and focus groups are detailed in Table 10

Table 10- data collection activities with participant groups

Participant group	Individual participants*	Data collection activity
Key Stakeholders	2 KSHs – single interview 1 KSH – 3 interviews	5 individual interviews
Referrers	13 GPs – focus groups 1 GP – single interview 7 social care practitioners – single interviews 2 social care practitioners – joint interview 12 social care practitioners – focus group	4 focus groups 8 individual interviews 1 joint interview
Wellbeing Coordinators	2 WBCs – single interview 3 WBCs – 2 interviews each	8 individual interviews
Clients	5 clients – single interviews 2 clients - survey	5 interviews 2 surveys
Community Agencies and Groups	6 practitioners – individual interviews 2 practitioners – joint interview	6 individual interviews 1 joint interview
	Total participants: 57	Totals: 32 individual interviews 2 joint interviews 4 focus groups

* Some participants were interviewed more than once; this was where people had long term roles in respect of social prescribing and multiple interviews were necessary to understand how Connect Well and social prescribing had evolved over the two year evaluation period.

Participants shared rich data, which are presented within five key themes.

Theme One - Getting in: gaining access to Wellbeing Coordinator support

As social prescribing is a relatively new concept, it is critical that potential clients are aware of Connect Well, and can access social prescribing support from a WBC. This theme is concerned with the journey into social prescribing.

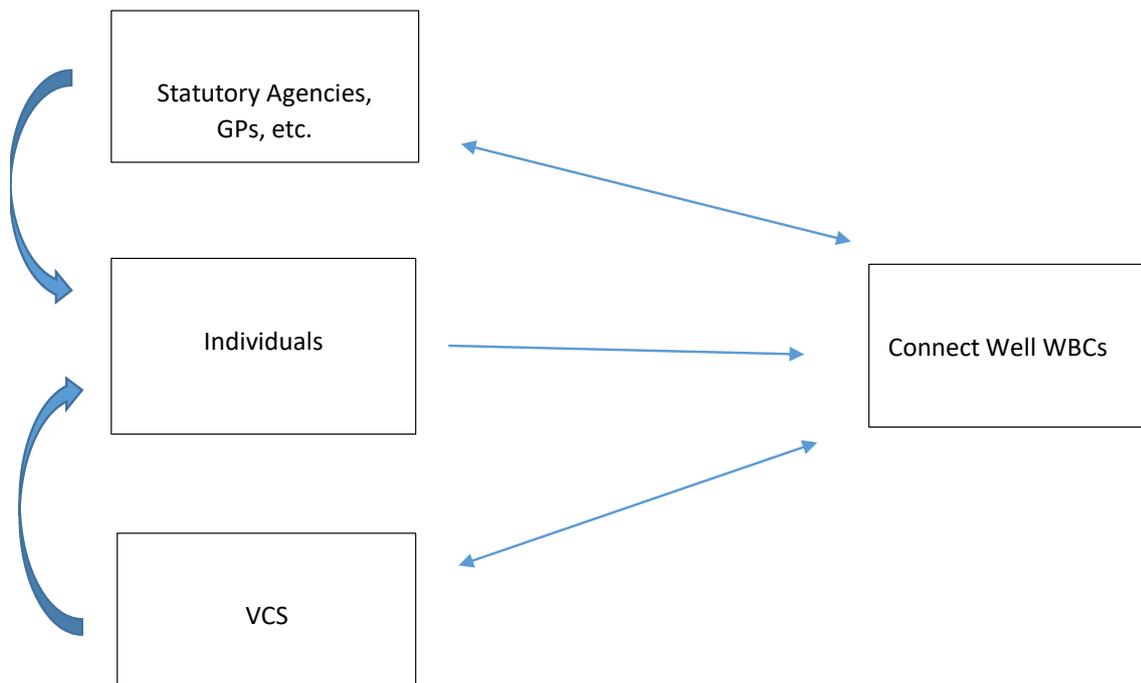
Sources of referral.

Connect Well has different entry routes and multiple sources of referral and signposting. Although social prescribing has a strong focus on primary care, within this evaluation there was evidence of referrals in to the service from a range of practitioners including GPs; social workers/social care; secondary health practitioners (including physiotherapists and occupational therapists); mental health teams; community police; the fire service. Such practitioners may make direct referrals, or they may signpost individuals. This signposting

activity may lead to self-referrals. Different professional groups may differ somewhat in their definitions of referral and signposting (and their definitions were not explored in depth in the evaluation); however, in this report referral broadly refers to a practitioner acting for a potential service user, for example, completing a referral form on their behalf; signposting involves a practitioner sharing information with an individual but relying on them to initiate contact with Connect Well (or other services). Self-referrals may also occur when individuals find out about Connect Well themselves, for example, through finding and responding to an information leaflet.

While the intended ‘end destination’ for social prescribing clients is the VCS, in which support is accessed from community agencies or groups, such agencies also referred in to Connect Well; furthermore, social prescribing clients were sometimes referred by WBCs to health or social care. Therefore, the routes in and out of Connect Well were complex and diverse, rather than linear; these are illustrated in Figure 13.

Figure 13 – Referral/signposting routes into and from Connect Well



Evaluation participants* had come into contact with Connect Well as detailed in Table 11

Table 11 – How participants had come into contact with Connect Well

GP/Doctor	3 clients; 1 was referred; 2 were signposted
Other Health Agency	1 client was referred
Welfare Advisor	1 client was referred
Leaflet at GP reception	1 client self-referred

*One client was not included in the table above as they were uncertain how the initial contact with Connect Well had been made.

Reasons for accessing social prescribing.

Unlike some social prescribing services which have been established to meet the needs of specific client groups, Connect Well has broad inclusion criteria, in which anyone over the age of 16 living in Hull, or who has a Hull GP, is eligible for social prescribing support. Thus, Connect Well is a highly inclusive service, which, in contrast to many services, does not require a formal diagnosis in order to access support.

Many reasons were given for referral or for seeking social prescribing support; these included mental health problems; depression and anxiety; isolation and loneliness; needs for social/group activities; relationship problems; weight loss/physical health; accessing employment. During the COVID-19 pandemic key reasons for people accessing the service were identified as mental health needs; social isolation; anxiety:

One of the things we've noticed was an increase in mental health referrals to the point where people with mental health issues were coming back to us because symptoms were exacerbated by COVID and people that never had mental health issues were coming to us because they were feeling anxious and depressed, so mental health was a massive thing (Wellbeing Coordinator).

It is apparent that those referred often have multiple needs and therefore WBCs may have to work with the person to identify a range of issues beyond those initially presented, and a range of supports and actions:

Even if they're presenting perhaps with a physical health issue there's often underlying anxiety and depression that have come alongside it, so...they might have a different reason down on their referral but when we sit down and have a chat there's other,...breakdown of relationship, bereavement, etcetera, etcetera...the wider picture is my mental health has changed at this time and I need some other things to do to improve it (Wellbeing Coordinator).

It was apparent that there is diversity among Connect Well clients in respect of their situations, circumstances and level of need, ranging from those whose needs can be addressed relatively easily, to those who were identified as having 'complex needs' and experiencing high levels of distress and need.

In addition to client focused reasons for seeking support, it was evident that access to social prescribing had a valuable role for practitioners when individuals did not meet the threshold or criteria for support from their service; when they did not know what resources were available to support the person; where they had limited time or the support they could offer was time-limited, and they perceived that the person required longer-term support. This GP perceived that while GPs can provide some social prescribing support, WBCs have more extensive knowledge of local resources:

Connect Well... these are the people who know everything and they are better in doing this than me and that's why I use them (GP).

The referral process.

Referrals for WBC support can be made online or by phone. Overall the process was perceived as quick and easy to use by most participants:

It's very user friendly. You don't think 'oh I've got that referral to do', it's just like 'oh yeah I can do that' (Social Care Practitioner).

Participants also noted that when they first spoke to the service, they were given clear information, and that the person they spoke to was friendly. For example, due to their experiences of anxiety, the following participant asked their partner to contact Connect Well on their behalf; they documented their perceptions of this initial contact and the reassurance this provided:

I almost felt like once my partner made that phone call, I was stood listening, I felt reassured, which is a big thing for me.....talked my partner through what would happen and the things I would require and who I would be seeing, where, what time, it was all pretty good, pretty fast and effective as well (Client).

Options to refer or signpost.

Practitioners and agencies can either formally refer or signpost individuals to Connect Well. For many potential referrers this decision was based on their perception of individuals' needs and preferences, and the perceived likelihood that, if signposted, they would initiate contact with Connect Well. For example, a practitioner who had referred a client, used their knowledge of the individual and their circumstances to conclude that:

If I'd have said to him 'oh you can call these, they'll be able to help you' he would never have done that (Social Worker).

Another noted that:

When I first started it was a lot of signposting and trying to empower them a bit to take.. but then you realise... you see them again – did you refer yourself? And it's like oh no, it slipped my mind. So I've learnt to do the referrals for them (VCS Practitioner).

However, some practitioners were keen to ensure that individuals were empowered, and did not wish to reduce their autonomy by acting on their behalf. Further, some believed that if individuals did not take the initiative to self-refer, they would not go on to engage with the service:

The kinds of issues we refer for I suppose are the type that.... if they don't want to take that step to contact the service it's unlikely they're gonna get much from it, they don't really have the motivation (GP).

Client interviews underscored the importance of practitioner referral into Connect Well. One client who had been referred in this way welcomed this, as they experienced difficulties using the phone and technology. Another, who had self-referred, noted that they would have preferred their GP to have referred them, because:

I weren't feeling very well within myself to be honest to make contact with people (Client).

This further highlights the risk that people may not feel able to initiate a self-referral, despite the potential benefits identified.

Barriers and facilitators to referral.

Participants identified a range of factors that affected the likelihood that they would refer or signpost individuals for social prescribing support.

Lack of familiarity. Social prescribing is a relatively new form of support (although some practitioners and agencies considered that they were already providing some level of social prescribing support themselves); this meant that people were not always familiar with what was on offer and the support that might be available. Further, some noted that they had contact with other agencies that were perceived as providing a similar service, with whom they already had a trusting professional relationship. Practitioners are frequently busy, and need to link into a wide range of services to support patients and clients. GPs highlighted that, as generalists, they direct patients to a wide range of services (within and outside of the NHS); in this context, remembering the diverse range of possibilities was challenging, and GPs felt that they needed frequent reminders that social prescribing was an option:

The great difficulty for any GP, particularly with a new service, is to remember at the time of consultation that that may be an appropriate service to use.....GPs need a lot of help to be reminded of a new service and to then use it appropriately (GP).

In contrast, social workers noted that they received a prompt on assessment forms and contact logs to check whether they had considered social prescribing when working with individuals:

You can't avoid it and if you don't click it you can't authorise the assessment, you can't complete (Social Worker).

Client and practitioner interest. Practitioners also identified that some people were reluctant to access social prescribing support:

I've had people in the past say oh no, there's no point, nobody can help me.... I've got a lady at the moment and everything we suggest she's got an excuse or a reason not to be there or not to go and she really does need social support but she won't accept anything (Social Worker)

However, when people understood what was available they sometimes appeared more interested:

I think when you say social prescribing people give you that look of 'well what?' but we explain it's about social wellbeing, being content with how you're spending your days, improving your routine, your emotional wellbeing, and I think once we've given that whole picture of what it is then they seem a lot more receptive (Social Worker).

While many practitioners recognised the value of social prescribing, some did not appear to perceive a need for this:

I've never really found a need for it personally (GP).

Time and timing. Practitioners are frequently busy, and may therefore lack the time to explore the need for social prescribing with individuals, as highlighted by this GP:

Probably as well it's easier to give prescriptions and say off you go, that's it, rather than taking some time and say look, I don't think there's anything medically we could do for you, these are the things

that we can do that might take a bit more of time and effort as well and you think we might have to sell that, it's not always possible in GP surgeries sometimes.

In addition, some practitioners considered that they did not always meet individuals at the most appropriate time:

We meet a lot of people where pain might be the barrier to engaging in social activity, so we have those conversations about 'once your pain is addressed then here is a really good service to help with those aspects', and then they take it away (Social Worker).

In such instances, providing information about social prescribing meant that individuals had the option of self-referring at a more appropriate time.

Lack of feedback. Practitioners highlighted the importance of feedback; where this was missing they lacked a positive reinforcement of the value and benefits to individuals of social prescribing. This is discussed in greater detail below.

Feedback.

Some practitioners identified that they would like more feedback from Connect Well. Such feedback could enable practitioners to better understand the potential benefits of social prescribing, and who benefits, and could provide a positive feedback loop to encourage further referral and signposting; for example, *'it would help us know that we're referring the right people'* (Social Worker). There was variation among practitioners in respect of their preferred level and detail of feedback; some felt that an overview of social prescribing activity would be helpful, providing general information about numbers seen and the kinds of agencies they were referred to, others appeared to want feedback about specific patients/clients. Practitioners' views and needs in respect of feedback also appeared to reflect their individual roles (and the extent to which they had ongoing contact with clients) and their professional cultures and expectations. For example, one GP observed that:

Obviously GPs, when they refer to hospitals and psychiatry services, we'd work on the basis of getting feedback and that then reminds you what the end result of your decision was and if you don't give a GP that feedback then you don't necessarily reinforce the value of the service or the learning from it.

However, a social worker noted that:

It would be nice to know...., but we don't get feedback from any service, it doesn't work like that and I think maybe the fact that it's a service we're not used to, that's why that would build trust, even if it's generalised figures, 'who've you seen?' 'what referrals have you made?'

While feedback had the potential to support practitioners and encourage referrals, it is important to recognise that creating the climate for enabling feedback is a joint activity between potential referrers and Connect Well. Detailed client or agency specific feedback can only realistically be provided where clients are referred rather than signposted for support; however, as already noted, an apparent preference for signposting has been identified among some:

Some GPs were saying that they haven't got any information back about referral, it was because... we have no way of knowing that they've come from that GP... we have no way of knowing other than...the service user telling us but even then we couldn't take that as a referral (Key Stakeholder).

The provision of feedback to referrers in primary or social care was also potentially hampered by social prescribers' lack of access to SystemOne and Liquid Logic.

Information and understanding.

Social prescribing is a relatively new form of provision; therefore, a considerable amount of work has been required to raise awareness of social prescribing and what the service provides. Connect Well reported carrying out publicity and promotion work to address this need. As a service with broad inclusion criteria and a scope which increasingly reaches beyond primary care, there has been a wide range of agencies and practitioners to inform and develop professional relationships with, as well as ensuring that members of the community are aware of the service.

Some participants felt that they had a good understanding of the service. However, data collected within the first year of the evaluation especially suggests that, despite the promotion activity, the service was not well understood by all potential referrers or users, and examples were given of inappropriate referrals being made, which may arise from poor understandings of the service (but which may also be attributed to a lack of other appropriate services):

A lot of people come to us but still they don't know exactly who we are and there's still a lot of misunderstanding, a lot of clients come to us, they think we are a counselling service, a mental health service or they think that we, we have a caseload, like social workers, we work one-on-one and then be with them long-term (Wellbeing Coordinator).

Further, if the service is not well understood, this may impact negatively on referrals.

Participants' comments highlighted the need for ongoing information provision and outreach, to ensure that as staff groups change (and busy practitioners forget about this source of support), they remain aware of the service, and receive regular reminders and updates about the service. For some people, the distinction between the welfare and social prescribing arms of Connect Well, and between Connect Well and Connect to Support, were not clear, and a source of confusion, further highlighting the need for frequent information provision and updating.

This all suggests a need for considerable ongoing activity (in addition to that already undertaken), to publicise and share information about the service; this will require both breadth of activity to achieve a broad level of awareness, as well as revisiting agencies to ensure depth of understanding and awareness. Connect Well is currently working with a marketing company to produce video-based information for the community and voluntary sector, and to raise their social media presence. This is intended both to increase awareness of Connect Well within the VCS sector and referrals into the service from this source.

Theme Two - Getting support: how Wellbeing Coordinators support clients

This theme focuses on what happens when individuals work with WBCs, and how Connect Well delivers social prescribing support.

Support from the Wellbeing Coordinator.

Given the broad referral criteria for Connect Well, WBCs encounter people with very different needs and in diverse circumstances. There appeared to be several important elements of initial social prescribing support:

Identifying clients' needs. WBCs reported that some people are very clear about what their needs are, however, others require support to identify and articulate issues and needs. This appears to require skilful questioning and listening from the WBCs. The complexity of needs of some clients has been noted, accordingly some WBCs spoke of the need to 'dig deep' or to 'unpick' the person's problems, and help them address problems:

We always do that real in-depth discussion on first contact ...of "well I've come to see about this but really the issue is this", so we always do that anyway, so there's always that deeper questioning and probing and finding out what people actually want and need (Key Stakeholder).

Such work could then enable the WBC and client to develop an action plan. This role includes identifying services which may meet clients' unique situations and circumstances, and some examples of thinking 'outside the box' were given in the WBC interviews.

Establishing an effective working relationship. Building working relationships with clients appears to be an important element in facilitating the work that is needed to effect change. This involves people feeling listened to; feeling understood and supported; ensuring people have enough time; WBCs demonstrating empathy. Participants gave examples of such support:

I've been fighting for many many years for someone to turn around and say 'I can see you're struggling but what I can see you struggling with is your people skills' and no-one's ever said that, they've never got to the root (Client).

[WBC] went above and beyond [the] job role to help me. Was clear and honest, did all [they] could to support my needs. WBC supported me throughout COVID while I was shielding, and I can't appreciate them enough. I trust WBC and felt comfortable talking to them about my worries and issues. My relationship with my family isn't the best so I was lucky to have someone to talk to (Client).

Working with clients to help motivate them to effect change was a further important element of the WBC role:

I'm glad [WBC] kicked me up the arse to be honest with you (laughs) because otherwise I wouldn't have... I've been meaning to go and I'd just not got around to it sort of thing (Client).

A small number of clients did not appear to perceive that they had developed a positive working relationship with the WBC; this was attributed to factors such as not being given enough time (with reference made to very brief initial contact); the WBC not asking sufficient questions to enable them to open up about the problems they were experiencing; not perceiving that the WBC was interested in or understood their situation:

I was hoping that I could go and talk to [WBC] about my problems and how I was feeling to be honest and I was a bit disappointed when [WBC] didn't ask enough questions so I wouldn't necessarily bring them up do you know what I mean? (Client).

Providing information. Clients and practitioners may be unaware of services, groups and resources which can provide ongoing support and opportunities. Therefore, a key element of the WBC role is to provide clients with information to support the next stages of their social prescribing journey. This requires them to be resourceful and knowledgeable about sources of support locally, as well as national agencies that can help individuals:

She just knew stuff, she was really knowledgeable, she was just plucking things out of her mind really and saying well we could try this or did you know about this? (Social Worker).

Just showed me what's actually about because I didn't know any of it existed and I've been through the system many times (Client).

Drawing on information collected at the point of referral could enable WBCs to anticipate potential issues and resources, enabling them to plan ahead for the client appointment (in addition to responding to issues raised during the appointment):

I need to sit down and do research for that person and make sure that when they come in to see me I've got something to give out to them. I don't like people going away empty-handed. I know... we'll not have everything and we do research, we post information out to our clients but I always like to have something positive to give out to them, something to look forward to, something just to give them a little bit of hope (Wellbeing Coordinator).

The duration of support.

Connect Well workers often described the service as providing short term support, often an initial appointment (lasting approximately one hour) with follow up sessions often conducted by phone: *Between one and four sessions is, is I would say the average, that includes follow-ups as well (Key Stakeholder).* However, there was also recognition that some people required longer term support, for example, to develop motivation, effect change, address multiple issues, and develop sufficient trust to enable discussion of deep-seated issues. Therefore, there was some flexibility to respond where longer term support was required. The service approach was outlined by one WBC as follows:

Our service is a very short intervention service, ideally we have an initial appointment, I address the issues, signpost and refer them where they want to be and after that we have a follow-up call and we close the case, that's an ideal case scenario and that happens a lot of times but so many other times that's not the reality, people have complex multiple issues, so we may see people more than once face to face and we may have contact with them multiple times, some people stay with us for months and months and have tens of different interaction with them through phone and face to face and so it depends, it's case by case (Wellbeing Coordinator).

One WBC reported working with one client for nine months, however:

[The] case was a one-off, I don't remember working with anyone else for that long, it's normally tops three months.

Some clients appeared satisfied with the duration of the support provided; however, some clients, as well as those who had supported them, reported that they would have preferred more support than had been available. There appeared to be a need among some people for longer term support to enable them to make the transition to new services, and to provide ongoing support that was perceived as missing more generally from within service provision,

highlighting needs and desires for longer term social prescribing support, and for longer term support from other services. One VCS agency highlighted the value of longer-term support for clients and also in providing an ongoing link for the agency if advice is needed or they have concerns:

So that if there's any problems you sort of have access to someone for some advice or help, if there's like a big problem..... because if we've had clients in the past....I've had social workers, so you can ring up the social worker and sort of pose a question you know like 'what should we do about this' or what you know, 'should we do anything about it?' but whatever the problem may be, like a little bit of help (VCS Practitioner).

Accessibility of the service.

Prior to COVID-19 the majority of initial visits occurred face to face, usually at a GP practice or community base, although follow up contact was frequently by phone. Home visits were available, and could be an important source of initial support for people defined as housebound or experiencing debilitating anxiety:

It would have been practically impossible [to attend an appointment] because I would have had to ask someone to take me (Client).

Some practitioners however were not aware of the availability of such visits, or believed they were offered infrequently, which had potential to impact on their readiness to refer. The provision of appointments in venues close to where clients lived or worked was important, as travel and transport were identified as difficulties for some. Further, the flexibility demonstrated by a WBC who made helpful efforts to meet a client in a place which was familiar to them and in which they therefore felt secure was noted as helpful:

The [client] I've been working with recently, she's got really bad anxiety..... they're understanding, they've made sure that she can go to a place that she's comfortable.....which is close to her home (Social Worker).

During the COVID pandemic, face to face meetings have not been possible (although a small number were offered where possible, between the first and second waves of the pandemic), and much client contact has been conducted by phone. While some WBCs noted the loss of face to face contact, others identified that phone calls had provided a positive means of contact for some clients:

My perception before, I didn't like phone appointments,...but it doesn't feel as negative as I had thought....I still seem to be able to build a rapport..... For some people I think, whereas they find it quite anxiety provoking or perhaps intimidating.....or just difficult to physically get somewhere, sit in a room with someone they haven't met before, I'm sure that that was probably the cause of a lot of our DNAs before (Wellbeing Coordinator).

To date, the service has not been able to offer meetings via online platforms, although this was regarded within Connect Well as a useful option. It appears that there is potential in the future to offer a range of options for client contact, including face-to-face, phone and online meetings, to best meet the needs and circumstances of individual clients. More choice in how initial appointments are conducted may enable more people to engage with the

service, reducing DNAs (Did Not Attend) and the work associated with these, and benefitting potential clients, although this is currently untested.

WBC support during COVID-19

At the beginning of the COVID-19 pandemic and the initial UK lockdown, Connect Well changed the ways it was working to support the response to the pandemic. All staff moved to working from home, and initially their role changed to contacting people on the CAB 'vulnerable list' and checking whether they had any immediate needs for food, shopping, and prescription collection. Where these needs were identified, they were referred to relevant agencies for immediate support using the Hull City Council corona virus response number. They also continued to provide social prescribing support, supporting people to identify needs and access support, albeit with a smaller range of referral and signposting options, due to the need for social distancing.

Theme Three - Getting on: accessing support in the community

Connect Well clients are referred or signposted to a diverse range of agencies and groups within the VCS sector, highlighting the importance of WBCs having extensive and up to date knowledge of the local (and often changing) community landscape. It is important that clients attend and engage with agencies and groups as part of the next steps towards gaining support and effecting change. Therefore, the support they had in respect of their early contact with agencies and groups was important; this included support in respect of referral and buddying.

Making the initial connection with agencies

Initial contact with agencies could either be made by clients themselves, or by the WBC on their behalf (often referred to respectively as signposting or referral). Which route was used depended both on agency policies and perspectives, and perceived client preferences or needs.

Some agencies preferred or required a formal referral, which was made by the WBC. However, one practitioner interviewed identified a strong preference for individuals to self-refer, and an expectation that in most circumstances they would do so. WBCs recognised that, while some individuals wanted to self-refer, and they felt confident that they would do so, others might not take this initiative; they preferred in such instances to make the first contact on their behalf. The importance of this was also reinforced by clients and their supporters:

WBC understood that he wouldn't do that. She said 'do you want to go?', 'Yes I do'. 'Leave it with me, I'll sort it, I'll give you a call tomorrow'. And she did. He had an appointment and he's been, so he's actually been to his appointment (Social Worker).

Further, a client who struggled to use the phone or the internet noted that it would have been their preference for their WBC to have made the initial agency contact on their behalf; in the absence of this support, they had not contacted the groups about which they had been informed.

Buddying

Taking the first step to attending a new agency or group could be daunting for some; clients variously noted that new groups and settings could be 'frightening', 'daunting', and that they could feel 'nervous' and 'apprehensive' about attending.

Although always available in principle, the offer and use of buddying, in which a WBC attended the first session alongside a client, appears to have increased in use during the course of the evaluation. This appears to have been welcomed by clients who had received buddying support, and other practitioners, who recognised the need for this form of support:

I couldn't do it on my own... I needed someone there beside me just to make that initial step over the threshold, familiarise me (Client).

The same client considered that without buddying support they would not have attended their initial appointment; *wouldn't have attended at all.... I wouldn't be sat here talking with you, 100%.*

During the COVID pandemic, buddying has not been used, due to the lack of face to face meetings, however, in some instances WBCs have made the first contact with an agency on an individual's behalf, to help them make the transition to new support arrangements.

While the value of buddying was evident, it was not a guarantee of long-term engagement. This support was usually offered on a one-off basis; in some instances, it was reported that this had not been sufficient to enable ongoing attendance for some, who did not return to a group after their initial supported visit:

I think where we lose people sometimes... I've buddied people and they went for one session and they didn't go again (Wellbeing Coordinator).

I kind of hoped somebody would go and take him [after the initial buddying visit]. Just sit with him, have a cup of tea. If he got to know people, you know felt a bit more comfortable in that environment, I really feel like he would have began to...access it in his own right (Social Worker).

This points to enduring difficulties for some in gaining the confidence to attend agencies and groups independently, and suggests that for some individuals there is a need either for Connect Well to be able to offer longer term support, with attendance gradually tapering off as the person gains confidence and becomes more settled, or for another agency to be able to provide such support. Without this, those who have the greatest need of engaging with agencies and groups risk being inadvertently excluded from this support. However, the resource implications of this are acknowledged, as well as challenges identified in research and evaluation of other social prescribing services in facilitating extended client support while not building dependence on the WBC (Woodall et al 2018, Wildman et al 2019a).

Barriers to attendance

In addition to the need for support to attend an initial session, other barriers to attending agencies and groups were identified. Such barriers included:

- Costs; some people were identified as unable to attend some activities or services due either to the costs of sessions or of the transport required. This highlighted the

need for WBCs to work to research options within individuals' budgets and/or within their locality.

- *Identification of the right support for the person.* One client perceived that they had not received sufficient time or questioning at the initial appointment to draw out the key issues that they were experiencing. They reported that the resources offered were not in line with their needs and preferences. Therefore, the quality of the initial contact with WBCs appeared important in enabling individuals to move on to support which was right for them.
- *Client ambivalence.* In some instances, it was evident that a number of options had been offered, but each one had been, in some way, 'wrong' for the client. This highlights the importance of WBCs being very resourceful in identifying potential supports, and supporting individuals to make initial (and potentially ongoing) contact. It also suggests that, in some instances, clients may not be ready to try something new, or to identify what they need. This further highlights the importance of the WBC role in exploring in depth client needs and wishes, and working to develop and support client motivation to change. Clients' wellbeing may also militate against them engaging with new sources of support: *a lot of the people that I see that don't move forward with things, it's definitely because of mental ill-health, low self-worth, low self-esteem, it's those things that, that are stopping them, that are the main barriers (WBC).* Motivational Interviewing and buddying (offered as a short or long-term support), may help overcome such barriers for some.
- *Illness.* Periods of ill-health or hospitalisation could sometimes interrupt individuals' journey to support, meaning that they did not engage with services, or required further WBC support to enable this.
- *Language barriers.* Although Connect Well can access interpreters, this support was reportedly not available in all VCS agencies, representing a barrier to accessing further support for some.
- *Waiting lists.* These were identified as being lengthy for some services (both within the statutory and VCS sectors), with the risk that people would disengage if they had a significant waiting time.
- *Transport.* The ability to travel to agencies and groups was identified as a key difficulty; this is further considered in the section on gaps in provision, below.

Gaps in provision

It has been widely acknowledged (e.g. Bickerdike et al., 2017, Woodall et al 2018) that the success of social prescribing is contingent upon a diverse, vibrant and adequately funded community and voluntary sector. The provision of the grant scheme to enable funding for new groups to meet identified need is a welcome and useful element of the social prescribing offer in Hull.

During the evaluation two key gaps in provision were identified; these related to transport, and support for people with mental health problems.

Travelling to groups was challenging for those who did not have their own transport or who could not afford public transport and taxis. This is pertinent as the quantitative data indicates that many services are located in the city centre. Most of those referred in were

from areas proximal to the city centre, rather than from areas further from the centre; this suggests that some are not able to benefit from services at a distance due to travel barriers.

Community transport provision was used frequently. However, it was noted that there was a significant gap in the availability of transport for people who required support to move from their house, and into the community venue, in addition to travel between these two points.

Throughout the evaluation the high level of referrals from people with mental health problems was noted. This was a group who often appeared to 'fall between the service cracks'; they could be both ineligible for NHS/clinical support, while needing more support than was readily available within the VCS, including the need for long term support. For example, in respect of people coming in from the crisis team a WBC observed that:

I have seen several people with suicidal thoughts, several people who had been in touch with the crisis team and have been discharged but still need the support and they just go around in circles within the community. They just get referred across from pillar to post when what they really need is clinical support.

A wider range of options for people who need help and support in respect of enduring mental health problems, such as agoraphobia and social anxiety appears an area of significant local need.

The post-COVID 'recovery phase' can be anticipated to increase the need for support from the VCS. At the time of the evaluation, needs for services to support re-integration of people who have become isolated; support for people with mental health problems; support with digital skills and to reduce digital exclusion were all identified as probable areas for need and development.

Moving onto support during COVID-19

A significant difficulty during the pandemic and lockdown has been the reduction in options for forward referral, as face to face provision has not been possible (or at times, highly restricted).

Our role is to help people to become more socially active and participate in group activities, go out more, engage with people, meet new people, make new friends but when COVID came and the restrictions from the Government... that was totally opposite what we were trying to do (Wellbeing Coordinator).

This has meant that WBCs have had fewer referral options, and have needed to connect people to online or telephone support, in lieu of group provision; in this context telephone befriending has been an important source of support at this time:

A lot of services came together and was doing a lot of befriending for people and if that wasn't happening then I think we'd have had a big problem in Hull (Wellbeing Coordinator).

Other services have begun to offer support or activities online; however, not all social prescribing clients are active online, further highlighting the need for resources to support the development of digital skills and confidence in the COVID recovery phase.

Theme Four - Perceived benefits of social prescribing

Information about the outcomes and benefits of social prescribing were sought as part of the evaluation. Information was given by clients themselves; other participant groups also identified benefits of social prescribing, both for clients, and for themselves within their professional roles. Therefore, this section includes information on benefits from multiple perspectives.

Benefits for clients

There are challenges in identifying the outcomes and impacts of social prescribing for clients. In this evaluation these included:

- The relatively low number of participants among Connect Well clients (some of whom had not accessed any services at the time of interview). Therefore, of necessity, the information below about benefits for clients is drawn from a very small number of interviews/survey responses.
- The interviews took place relatively early in the social prescribing process; therefore, participants were at an early stage in their engagement in social prescribing activities, and their long-term engagement, and any consequent benefits, were not evidenced at this stage.

Furthermore, it is difficult to establish whether impacts identified can be attributed (wholly or partially) to social prescribing, as other experiences and relationships may influence outcomes. However, the interviews and surveys did provide information and insights into some of the benefits reported by clients. These included:

Social benefits: Some reported that they had been able to meet other people and were socialising more:

It's helped me by thinking more about myself and getting to mix and that and not be frightened (Client).

One client described how joining a peer support group had enabled them to be:

Around like-minded people what are suffering and being able to talk, be free, knowing you're not being judged even if you cry.

However, they also highlighted the challenges of meeting new people and engaging in peer support. Their social encounters had, at the time of the interview been limited:

I've never had a conversation with anyone other than the people what work here yet. I can't bring myself to that level.

They also noted the challenges of witnessing others' distress in group settings:

It can be negative as well because you can take people's problems home with you which I also did. The one I've just spoke about. I even dreamt about it and it was a bit... I was thinking of it that much that I didn't go the following [week]. It almost triggered me a bit, I didn't know what to do with myself.

Gaining confidence. Some identified that they had gained confidence. One person, who did not wish to participate in the evaluation, contacted us anonymously to report their

satisfaction with the support they had received, noting that they had gained the confidence to try new opportunities.

Leaving home. For people who experienced isolation and social anxiety, leaving the security of their home represented an important step:

I'm getting out. I'm going out of the front door that's my biggest one. No matter where I am as long as I'm out the front door.

Gaining motivation. Motivation is an important element of engaging with change. One person indicated that their contact with the WBC had given them greater motivation:

[They've] given me a nudge alright... I'm grateful for it as well believe me, I'm very grateful for it.

Improved mental health. An important aim of social prescribing is to support greater emotional health and wellbeing. One participant noted the improvements they had experienced in respect of depression:

I've come on leaps and bounds about depression. I maybe get, well once a month now I feel down but by the time the night's over and I've listened to a bit of music, next day I'm sort of back up here again.

The numbers of clients experiencing significant or complex mental health problems has already been noted. This client, who had engaged with both WBC and VCS support, highlighted the enduring nature of these problems, such that the pace of change may be slow:

My thinking's not gone away, my worrying's not gone away, my shaking's not going away, my anxiety's not going away. My deep dark thoughts are not going away. My thoughts of ending it are not going away but...if I don't come out I won't be able to say, at least I tried, and that to me is a big thing.

WBCs identified the work they do to 'unpick' problems. This was not explicitly mentioned as a benefit by clients. However, one noted that this had not occurred (they did not feel they had been asked sufficient questions to draw out an account of their needs), suggesting that this would have been valued. Another noted that the WBC 'gave me a plan of the way to go as well, what to do first and when to do it'. This suggests that an important element of the WBC role, from which clients benefit, is support to identify and articulate needs, and to work out and plan how to address these.

Referrers, agencies and WBCs were all also asked about perceived outcomes for clients. In many instances they were not able to identify these. Their reasons included:

- Referrers did not always see people again after referring or signposting them to social prescribing.
- Agencies did not always know whether people had come to their service via Connect Well (this was likely to be an issue when people were signposted, rather than referred).
- WBCs reported that a proportion of clients are lost to follow-up, and that they do not always find out whether people engage in new groups and activities, and the impact of doing so.

However, members of all groups highlighted benefits similar to those reported by clients. Further they reported benefits that had not been identified; these included gaining a sense of purpose; feelings of pride at engaging with new opportunities; becoming a volunteer, which had the potential for positive outcomes both for the person volunteering, and for agencies.

Benefits for practitioners

Furthermore, there were potential benefits for practitioners. Social prescribing has been positioned as a solution to the level of need in, and demand for, primary care, and specifically for reducing the numbers of people attending frequently and for non-medical issues. GPs taking part in the study did not identify that any reduction in demand or patient attendance had necessarily occurred; however, as this GP observed, such changes may be hard to perceive:

I couldn't say that I've felt that impact. Now that can be for any number of reasons, but sometimes it can just be because, if that patient is no longer coming to see you as often, it's just somebody else who's coming to see you (GP).

This appears to reflect the high levels of demand within primary care, such that GPs may not be well positioned to notice the absence of specific individuals, but instead respond to those that present at the surgery; furthermore, other research has highlighted that some people may make greater use of primary care following social prescribing support (Woodall et al 2018, Husk et al 2020). It is notable that more referrals came from social services than from GPs, as identified in the quantitative data.

Other practitioner benefits were identified. These included having access to a service that is knowledgeable about the range of sources of support available for clients, and can provide support that may be outside of the scope of practitioners' professional roles (such as buddying); reducing their workload:

Social Worker 1: I think for me personally it does help with reducing our workload....we don't have that stress or responsibility of solving that right there and then. Social Worker 2:if we were trying to do that social prescribing bit all ourselves, we'd have to research, we'd be using the internet, printing off you know, information for people....so it would make more work for us.

Furthermore, a social worker noted that knowing their client had been able to access a wide range of groups and supports, enabled them to end their client work confident that new forms of support were in place. They considered that for their client:

It's changed her life, it really has [the support available]... gives her some purpose really and it's getting her away from them people who had taken advantage of her (Social Worker).

Theme Five - Working to deliver social prescribing

Within this theme, some important elements are highlighted which facilitate the delivery of social prescribing support.

Embedding in primary care

Throughout the evaluation period, the WBCs have been based in GP practices, and a smaller number of 'community bases'. Location in such bases is anticipated to enable WBCs to see clients in a suitable, familiar and accessible location, and to network with primary

care staff, enabling referral and support for clients. There have been changes over time, both in respect of the number of practices in which WBCs are based, and moves to different bases.

A consistent message throughout the evaluation has concerned the difficulties of becoming embedded in primary care. While working well in some, variation was highlighted among practices:

In this particular practice, I'm known and...I talk to the manager quite a lot and some of the staff so... they regularly know me now so I don't feel separate...And some other places you can feel a little bit out of the way, a little bit disconnected, and practices are very busy so everyone has their own job and it's not like you can just kind of stand around chatting, so that's all part of it but it seems to be working okay (Wellbeing Coordinator).

In such contexts:

... you can't see GPs, you can't see nurses, it's difficult then for them to recognise us as a resource (Wellbeing Coordinator).

Accordingly, both WBCs and GPs perceived that the WBCs were not always visible within practices, although WBCs worked to attend practice meetings and Protected Time for Learning to share information about the service.

There were a range of factors which appeared to impact on embedding in practices. The size and layout of health centres, in which several practices were co-located, or of large practices, meant that WBCs could be situated away from GPs, meaning that they were, in effect, physically isolated within the practice (although their co-location with other external agencies could enable useful exchange of knowledge and development of working relationships with other agencies):

I'm in one GP practice, sort of properly embedded and then I'm at one of the huge health centres, where there are multiple practices and I'm based in the community side of the building, so I don't really have access to the GP services in those parts of the buildings and that does present a challenge (Wellbeing Coordinator).

You do get a sense of community. Here for example obviously eventually with time you do get to know the receptionist, they know who you are, there's that link that relationship of trust and you do get to know faces and you see the same people all the... so I know the faces, I know who they are..... If I've got any struggles what-so-ever I'll go and ask them (Wellbeing Coordinator).

As a service not directly delivered by the health service (and situated within the VCS), Connect Well and primary care have different professional roles, cultures and expectations, and as a new service, social prescribing was unfamiliar to GPs. GPs and WBCs have different training, professional backgrounds, status and standing, and work within different practice models (the medical and the social). GPs interviewed early on in the evaluation recognised the importance of social prescribing becoming embedded, but did not always perceive that the service was visible to them. However, it is clear that the process of a new service becoming embedded requires investment by WBCs, their managers, and by GPs. This may be challenging, given the high workloads and lack of time identified for many GPs (Hobbs

2016, NHS England 2016, Owen et al 2019), as well as the differences in professional roles, status and hierarchies between GPs and WBCs.

Participants in other agencies, and other research (Tierney et al., 2020) have highlighted the difficulties of embedding in GP practices. This both highlights the difficulties of bringing external agencies into primary care, while also underscoring the importance of this being achieved, in order to facilitate the WBC role (and potentially the link worker role, although this was not tested in this evaluation) of bridging primary care and the VCS.

Developing relationships with other agencies

Due to the multiple pathways into social prescribing, and the range of agencies to which onward referrals were made, it was necessary for Connect Well and the WBCs to develop effective working relationships with a range of agencies, over and beyond primary care. There was recognition among WBCs, social care and the VCS of the importance of developing closer working relationships. Such relationships, and the knowledge that underpins them, could support referral into social prescribing, as well as directing clients to effective sources of community support. For example, one participant from the VCS noted that their contact with Connect Well appeared to have led to increasing numbers of people accessing their service:

The social prescribers have really been integral in that sense, I think, because they've all come and had a look, seen what it's about... some of them have come, had a look, seen what it's about and they'll always mention it to people and be like 'it's a really great place to go' (VCS Practitioner).

Although social prescribing is often perceived as a solution to some of the challenges within primary care, referrals from GPs to Connect Well have been lower than anticipated. Connect Well appear to have worked hard to develop new relationships and build awareness of the service. Recent such work includes work with Occupational Therapy, and developing a role with Hull for Heroes and the Veterans' Hub to provide support to veterans. They will also be involved in a pilot of an app for people living with COPD, in which it is envisaged that users will be directed to social prescribing support.

Support for Wellbeing Coordinators

WBCs are at the heart of the social prescribing process. This sub-theme recognises the complexity of their role, which includes client facing work, as well as networking and developing professional relationships with potential referrers and the extensive (and frequently changing) range of agencies and groups within the VCS. The breadth of their role was defined as:

There's the patient-focussed bit, patient-centric bit...it's that patient focussed empathy and listening, it's all of that but actually there is something as well around having honest conversations....Being able to have those, those sometimes difficult conversations and being open enough for patients to be able to say to you, I'm not going to do this,...it's about being able to find out what patients want and back that up with the knowledge and confidence.... [Having] a conversation with a GP and say you've not referred anyone to me, do you want to come and have a chat about what I do? A good social prescriber can have those conversations, a good social prescriber can sell social prescribing to anybody.... [They'll] have had conversations with

organisations....saying so what are you looking for, what do you want, who's it suitable for?....You wouldn't refer somebody to something that wasn't appropriate (Key Stakeholder).

In order to be able to fulfil these multiple roles, WBCs require good support.

Training has been provided to WBCs in diverse areas including safeguarding; suicide awareness; mental health awareness; motivational interviewing. Induction is available to new workers, which has included shadowing colleagues and visiting community agencies.

The initial WBC team had been very stable, and was described as close knit; however, through the evaluation period there were changes to the team when WBCs left, as would be expected to occur over time. The team meet regularly, face to face or online. They also use email and WhatsApp to keep in touch and share knowledge and resources:

We've got a big WhatsApp chat that we always put new services in.... you're always in a loop with, with what your colleagues know as well, as well as doing your own research.... So if one person finds out something new then by the end of the day we'll probably all know it (Wellbeing Coordinator).

However, despite these points of contact, it is also evident that the WBC role, which involves a considerable amount of remote working, can be an isolated one (in which they may be isolated both from other WBCs and from staff in their bases), especially when working in practices where they have not become embedded or developed working relationships, and where there are limited referrals:

Where I am... the only person that I really see is the receptionist ... Today I've only spoken to that person for about five minutes... other than that I've literally been on a room on my own all day (Wellbeing Coordinator).

The isolation of WBCs was raised as a concern in the interim report (July 2019) and the potential impact of isolation on workers' energy and motivation was noted (although none was reported by any participants). In this context, the plans to develop a local network for social prescribing workers from within and outside of Connect Well is welcome. It is envisaged that this will enable workers to meet, share ideas, information and knowledge, and support one another. The development of the network appears to have been delayed due to COVID-19, and therefore has not formed part of this evaluation; however, the plans have the potential to contribute to WBC support and reduce isolation, and therefore appear a welcome development.

Through the pandemic, the WBCs have worked from home; their familiarity with working away from a stable office base may have contributed to the transition to home working. This form of working was not identified as problematic for any WBCs, and Forum were considered to have put into place the necessary support for WBCs quickly.

Limitations

There are some limitations to the qualitative and quantitative data collected. These have prevented the research team from addressing all the original evaluation aims.

Limitations associated with the quantitative data have been highlighted above. There were also some limitations related to the qualitative data, presented below.

Data in respect of client perspectives

As already noted, there were substantial difficulties in recruiting social prescribing clients, despite making several changes to the recruitment methodology during the evaluation. Other researchers have reported similar difficulties (Carnes et al 2017, Bertotti et al 2018, Pescheny et al 2018); by definition, many of those accessing social prescribing are experiencing difficulties such as social anxiety, depression or mental health crises (including feeling suicidal) which are likely to make engaging in research difficult and unappealing. In this evaluation, the following additional challenges were encountered:

- Connect Well did not have permission to contact clients once their case was closed
- Clients were often lost to follow up, and could not be contacted. Others were not invited to take part, if judged by their WBC to be experiencing significant levels of distress or if they appeared to lack capacity to consent to participating.
- Individuals who were given information about the evaluation reported to the WBC that they did not wish to take part, or did not respond when contacted by the researchers.
- WBCs' work with clients is often short term and they may have few face-to face meetings.

As a consequence of these factors, WBCs usually had to inform participants about the evaluation at their first (and sometimes only) face to face meeting. This meant that clients were being asked to consider taking part in the evaluation before they had had much contact with Connect Well and knew little about the support on offer and whether or not they would benefit from this.

Participant recruitment involved WBCs giving a flier to clients which provided brief information about the evaluation; clients could either contact the researchers themselves, or the WBCs could share their contact details with the researchers on their behalf. During the evaluation period the researchers received contact details for 13 clients; of these only 5 participated in an interview, the majority of those who did not participate could not be contacted by the researchers (for example, did not answer the phone or respond to email); this further underscores the difficulties for Connect Well and WBCs in maintaining contact and carrying out follow up work with clients.

Longitudinal data from potential referrers

Overall, a substantial number of referrers participated in the evaluation. This included 21 social care practitioners (social workers, social care workers), and 13 GPs; this is a far higher number than in the initial proposal, and therefore is a strength of the evaluation. However, all GPs took part in the first year of the evaluation; despite continued attempts at recruitment and the development of an online survey, none took part during the second year of the evaluation. Given that there have been lower than anticipated referrals from

primary care, and that GPs initially highlighted the newness of both social prescribing and Connect Well as barriers to referring or signposting patients, it would have been helpful to track whether and how their views changed over time. The demands of the COVID pandemic during the second year of the evaluation may have affected GPs' readiness and ability to take part in research; however, this meant that their evolving attitudes to, and perceptions of, social prescribing; their experiences both of Connect Well and link worker provided social prescribing; their perceptions of need for social prescribing during COVID-19, and the post-pandemic recovery phase, could not be documented.

The quality of the evidence base for social prescribing has been criticised. Bickerdike et al (2017, p. 15) suggest that in part this reflects the fact that social prescribing schemes have 'emerged' rather than being systematically planned, with evaluation built in from the outset, an issue which has affected this evaluation. Preparatory work as a new service starts up has been advocated to ensure that services are 'evaluation ready', in that the required data are being collected and can be accessed (Hamilton-West et al 2019). Such work in advance of this evaluation, jointly undertaken by commissioners, Connect Well and the researchers, could have identified potential difficulties and solutions, ensuring the robustness of the data collection, increasing the value of the evaluation. The challenges encountered in this evaluation point to the need for pre-evaluation work to identify what data can feasibly be collected, and in what format, in order to facilitate analysis, and an agreed approach to client recruitment, ensuring that all clients (apart from those screened out due to concerns about vulnerability) are proactively informed about the evaluation, at a specified time, in order to promote greater levels of participation, and ensure that any future evaluation is grounded in the client perspective.

This evaluation was limited in the extent to which it could identify outcomes and impacts for clients, and those identified were at a relatively early stage. Work is also required to identify the long-term benefits of social prescribing, and the extent to which these are maintained (Bickerdike et al 2017).

Discussion and Recommendations

This evaluation has taken place across a period in which there have been many changes and developments to which Connect Well has adapted. These include lower levels of referral from primary care than anticipated; the introduction of PCN based link workers; the COVID-19 pandemic. Consequently, Connect Well has worked hard to develop new professional relationships, and new ways of working in response to the constraints of social distancing, to ensure that social prescribing continues to be delivered. Thus, it has been a period of adaptation within a climate of change and uncertainty; accordingly, this report does not represent the description of a service at its 'final destination' but captures a period in time, from which ongoing change and further adaptation is probable. Within this report, we acknowledge the work that has been undertaken to develop this new service, and to evolve in response to local need, changing policy and the unanticipated challenges of a global pandemic.

The potential benefits of social prescribing are many and varied and include benefits for social prescribing clients; referrers; the VCS; primary care and other services. This evaluation identified benefits from social prescribing as delivered by Connect Well. Clients appeared to have benefitted from the support they received from WBCs, which enabled them to explore issues, feel supported, gain motivation, access information, and make initial contact with VCS agencies. Few clients had engaged with agencies at the time they were interviewed, however, some benefits such as meeting others were identified. Further research with more participants, and with participants who had longer term engagement with agencies, may highlight additional benefits and outcomes. In addition to client focussed benefits, referrers benefitted from the opportunity to refer to a service which was perceived as being well-informed about diverse community-based sources of support, and the assurance that clients had support when their own work with them ended.

The evaluation also highlights important aspects of client need and social prescribing which can inform future service delivery by Connect Well and the practice of other professional groups. It also highlights areas of need in respect of the wider service landscape. It should be noted that all data collection with people from outside Connect Well were collected prior to March 2020 and therefore do not reflect any recent perceptions of change.

In common with other research, (e.g. Woodall et al 2018, Wildman et al 2019b), the evaluation has highlighted the centrality of the WBC role. Previous research, and our work during the evaluation, indicates that this is a complex role which includes information provision; skilled work with clients to identify and explore their needs and priorities and help them develop motivation to engage with the process of change; and helping link clients to new forms of support, in effect acting as a bridge between referrers and the VCS. In some instances, to find the right support or opportunities for clients demands that they explore a range of options and are innovative in identifying potential opportunities to best meet individual circumstances. The WBC role outlined above demands greater skills than those required simply to be a 'signposter' to support, although the depths of the role may not always be appreciated by those outside of the service.

The evaluation highlighted variation among clients accessing social prescribing. Some appear to require relatively low-level support, in which the WBC and the information they provide

act as a catalyst for largely self-initiated change; others appear to need considerably more support to articulate their needs, explore solutions and begin attending new groups and agencies, reflecting the complexity of need identified among many clients. This latter group appears to need more intensive and prolonged engagement with WBCs. This highlights a further variation, between social prescribing as a short-term form of support, and one that is more intense and requires longer term provision of support.

There was recognition that clients may need different levels of support and to engage with WBCs for differing amounts of time, and there was flexibility in the duration of the support offered, in line with clients' needs and circumstances. Nevertheless, there was a sense that the default model had (at least early on) been for short term provision, with flexibility to deviate from this. Connect Well appeared to offer relatively short-term support in contrast to other schemes. This relatively short-term model appears in contrast to the recognition within the service of the complexity of need of many clients, and the observation of some clients and referrers that they would have liked longer term support. This diversity in respect of client needs is not unique to Connect Well, and is evident in other research in which social prescribing schemes were often reported to support people with complex needs (Skivington et al 2018, Wildman et al 2019b) and in which this complexity is at odds with *social prescribing often being talked about in terms of referrals to dance classes or gardening groups* (Cole, Jones and Jopling 2020, p.38).

Clients came to social prescribing through diverse routes, and where referral or signposting occurred, this was initiated by practitioners from a range of different sectors and in diverse roles. During the evaluation period the majority of referrals which could be attributed to a specific group (rather than self-referrals which predominated), came from social services. This is in contrast to one of the key aims of social prescribing which is to address some of the problems of primary care, and to relieve GPs of patients attending repeatedly due to complex psychosocial problems and loneliness. While there is a need for social prescribing, the pathway from GP to the service did not often happen. In consequence, however much social prescribing has relieved GPs of unnecessary consultations, they would rarely be aware of this because they did not make the referral, (and therefore did not get feedback), and due to such patients being replaced by others requiring GP support. Therefore, there is a risk that GPs will undervalue the service despite its important contribution out of their sight. These findings highlight the importance of ongoing work to ensure that GPs recognise the value of the support available, and increase referrals, as well as signposts, to the service. Additionally, it highlights the value to practitioners (and their clients) from outside of primary care, and an ongoing need to maintain relationships with such agencies, ensuring that they continue to recognise the value of social prescribing support.

Given the complexity of need among a proportion of clients, support at all stages of the social prescribing journey was necessary to enable participation for some; we refer to this in this report as 'personal support'. Such support is required both at the point of gaining access to Connect Well and for onward progression to the VCS. While some clients are able and willing to initiate contact and self-refer, for others this is challenging and there is a consequent risk that, without personal support, they will be unable to access support from WBCs/the VCS. It appears that for some, active referral (on the part of GPs, social workers and WBCs) is an important element of the social prescribing journey, without which some

will be unable begin the process of engagement and change. This is in contrast to the view of some practitioners and agencies that to refer individuals is to disempower them, and that those who are unable to initiate contact independently lack the motivation to engage with support (whether from a WBC or the VCS). Instead, the findings suggest that for clients with high levels of need or anxiety and/or low self-confidence or self-efficacy, there appears to be a need for a process in which there is progression from practitioners initially acting on behalf of individuals, with a tapering of support over time, as clients begin to be better able to initiate and maintain their own change process. A greater emphasis on inward referral by practitioners would also promote better feedback about client progress which was highlighted as a need by some, and which previous research has identified as an important factor in providing positive feedback and reinforcement to referrers (Tierney et al 2020). However, it is acknowledged that referral will not lead to service take up by all.

An important element of personal support is buddying, and the growth of this form of support during the evaluation period is a positive development (and an element of social prescribing that has been highlighted as valuable in other research, for example, Husk et al 2020, Kellezi et al 2019). Clients interviewed who had received buddying support appear to have found this invaluable (a view reiterated by some other participants, such as referrers). One participant who had been given information only, had not made independent contact with the agencies recommended; this further highlights the needs of clients, who appeared to require guidance to overcome anxiety to enable them to make initial contact with agencies, and underscores the previous observation that social prescribing is a complex and intense role, providing more than signposting. While the increased use of buddying is a welcome development, for some a single supported visit did not appear sufficient, perhaps due to complex needs discussed above. There appears to be a need for some clients to be able to access longer term personal support and/or buddying from Connect Well, or for another source of support to provide people with longer term guidance enabling them to make the transition to new forms of support. As has been noted, there are resource implications of working to provide a more intensive form of support for some clients, and this also requires skilled work in order to minimise the risks of clients becoming dependent on WBCs. However, there is some evidence to suggest that higher levels of link worker contact are correlated with greater levels of uptake of community services (Mercer et al 2019).

Overall, the above findings highlight the importance of more support, which some participants referred to as 'hand holding', but which we think it is appropriate to call 'personal support', and which is needed for some during the beginning of the social prescribing journey. Writing of general practice Watt (2019, p.274) observed that *self-help and self-management are destinations, not starting points, for many, and are only achievable after time is taken to build knowledge, confidence, and agency*; arguably this also applies to the journey into and through social prescribing. One client highlighted the value of a WBC; *having that person by your side....having that person there, that person what's willing to push that pen for you or talk that talk or solve that problem or maybe help you if they can't solve it or try, that goes a long way*. As previously acknowledged, this then requires skilled WBC support to minimise the risk of dependency and ensure people gain the confidence and skills to take a greater role and initiative in managing their own ongoing change process and agency engagement. Signposting/referring and the provision of information about services are key

WBC roles; however, the evaluation findings suggest that WBCs can contribute a great deal more to clients through the provision of more in-depth work to explore issues and needs, articulated by one WBC as 'unpicking'. If this personal support role is not well understood by potential referrers, the service may not be used to best effect because it is underestimated and seen simply as a somewhat personalised alternative to a Google search for local resources. The term "Social Prescribing" draws an analogy with the work of pharmacists, with an emphasis on fulfilling 'prescriptions' originating with GPs by sourcing appropriate materials. As with pharmacists, WBCs' actual role is much more complex and developed than this and includes a lot of direct work with patients/clients.

In addition to highlighting the need for more intense and prolonged support for some, the evaluation has also highlighted a paucity of certain services (notwithstanding the richness and diversity within the VCS and among community groups). Although the most often mentioned reason for referral was loneliness, it seems likely that feeling socially isolated as a problem can be the tip of an iceberg of more complex problems that are not necessarily resolved by just prescribing a VCS involving social activity. Moreover, due to individual complexities, it may be challenging for WBCs to establish which VCS is appropriate for which client. Outside of social prescribing, there is something of a service gap for people who have complex but ordinary psychosocial problems, perhaps combined with common physical health issues. They fit neither in primary care services as currently configured, nor in specialist mental or physical health services. WBCs appeared to be picking up some of this complexity, which can include isolation, anxiety, depression, bereavement, stress due to the problems of others, life transitions, responses to chronic health problems and disease, and problems with sleep and maintaining a healthy daily routine including only moderate substance use, often exacerbated by physical health issues. Within such a complex, most 'problems' may not be sufficiently severe to warrant "caseness", or a diagnosis, and specialist referral, while neither primary care nor specialist physical/mental health services may be capable of managing the entire complexity. During the evaluation 'inappropriate referrals' to Connect Well for social prescribing support were noted. These may arise due to the service not being well understood, further highlighting the need for ongoing work to publicise Connect Well and develop understanding of the scope of the social prescribing offer. However, this also suggests that in some instances the services people really need may not exist. The findings suggest that support for people with mental health problems, who do not meet the thresholds for clinical support, but who need ongoing support which may not always be fully met within existing services, is a service gap. This may account for some inappropriate referrals. Local work to map and identify support gaps for people with mental health problems may be a valuable area of future work, which could include, but not be restricted to Connect Well.

The interim report noted concerns about the isolation of WBCs who work away from the main office, and rest of the team, and who are not well embedded in some bases. The plans to develop a wider cross-Hull network for WBCs and link workers (who may experience similar issues) appears a valuable development, with the potential for effective information sharing, WBC support and the development of a positive peer support network. While this plan has been stalled due to the COVID pandemic, it has potential to make a valuable contribution to WBC support; further, it may help to integrate and harmonise the work of

WBCs and link workers. The complexity of the social prescriber role highlights the importance of continued and sustained good support for WBCs.

Connect Well and social prescribing are both still relatively new (although some practitioners considered that they already provided some social prescribing). Consequently, members of the public and potential referrers are not always sure what social prescribing is, how to access this, and what Connect Well delivers. Furthermore, the social prescribing element of Connect Well had not always stepped out of the shadows of the well-established welfare advice project, and there was confusion among some participants about the two elements of the service, what social prescribing could provide, and indeed some confusion due to the similarity of the name with Connect to Support, (and due to the new link worker role). This newness and lack of familiarity highlights a need for ongoing publicity of the service, work to inform people about the scope of the support available, and to provide regular reminders and updates about social prescribing, how to access it, and the potential benefits. This publicity would be enhanced by clarity about the complexities of what WBCs actually do in practice, ensuring that the level of support available and the potential impacts are well understood. This has been a feature of Connect Well's work during this evaluation period, as they have worked to identify and explore the potential of developing professional relationships with a range of agencies and professional groups, and to explore potential new sources of referral, extending the possible reach of the service. The importance of ongoing work to maintain relationships with, and awareness among, agencies with whom links have already been made is also important, as the evaluation findings suggested that this information can be forgotten over time, and ongoing information sharing and engagement is needed to continue to promote the service and ensure continued referrals. The observation above that some practitioners already consider that they offer some social prescribing, raises a question about what practitioners perceive to be the nature and benefits of social prescribing, and where they occur. Such benefits may lie in the work undertaken by clients with WBCs, or in their engagement in and support from VCS services, agencies and groups (and in reality, both probably contribute benefits). If however, the benefits of social prescribing are understood to be delivered when clients reach the VCS, then the perceived role of WBCs (and other link workers) is reduced to effective signposting and information provision, without recognition of the complex role we have called 'personal support'

The COVID pandemic has brought unavoidable changes to the ways in which Connect Well works. While outside the scope of the evaluation, valuable telephone support appears to have been offered to individuals identified as 'vulnerable' during the early wave of the pandemic. The pandemic has also created challenges for WBCs, notably the reduced number of agencies and groups available. The response to the pandemic and requirements for social distancing have led to the realisation that telephone appointments can work well, and may be preferred by some clients. However, during the evaluation period it has not been possible so far to offer online appointments. These may also be valuable for some, and would offer the face to face contact that WBCs found helpful, and which is missing when offering support by phone. While the pre-COVID model of face to face work may be the ideal for many people, the pandemic has highlighted the potential to offer various options for contacting and interacting with clients. Telephone and video appointments may increase engagement amongst those who find face to face meetings difficult. This also emphasises the potential importance during the recovery phase of ensuring that there is support within the

community to enable people to develop digital skills and confidence in that domain. These are issues which we understand Connect Well to be committed to exploring and highlighting.

Service delivery recommendations

- 1) That consideration is given to the optimal model of delivery, and the anticipated time that clients can be supported for, while continuing to retain flexibility in this. There are resource implications in offering longer term support, however, this may promote greater long-term engagement and enable the anticipated outcomes of social prescribing to be delivered to those who would benefit from more prolonged support.
- 2) That the personal support role of WBCs is widely recognised and established as part of their work. Personal support can vary from being minimal to providing complex and extended support to a client. We further recommend that buddying continues to be offered to clients as required.
- 3) That all services involved in the social prescribing pathway reflect on the benefits and limitations of referral and signposting, and consider the place of more proactive referral for clients coming into Connect Well and moving on to community support.
- 4) That a more diverse range of appointment options are available, building on the learning from the pandemic, and the recognition within the service of the importance of including a digital option for client contact. This range of options may include face-to-face, telephone and online appointments, extending client choice.
- 5) Ongoing work is undertaken to continue to publicise the service, develop new professional relationships among potential referrers, and to continue to support existing relationships, ensuring the service is not overlooked or forgotten, new developments are communicated, and momentum is not lost.
- 6) Further work is undertaken to explore the potential for feedback to referrers, and the most helpful form such feedback could take. This recommendation recognises not only the potential need for the development of further feedback by Connect Well, but for practitioners to make more formal referrals, without which some feedback, especially feedback focusing on individual progress, will not be possible. We also acknowledge that different practitioners have different expectations of feedback, making this a challenging area for the service.
- 7) Ongoing work to continue to ensure that WBCs continue to be well supported and to minimise the risks of isolation. This may include the development of a social prescriber network for Hull, which appears to have potential to support this aim.
- 8) The broad referral criteria to Connect Well which does not require a formal diagnosis is welcome, as it enables the wider population of Hull to access social prescribing. However, the data suggests an under-representation younger people receiving support from the service; further work to explore the needs of this group and increase referrals would be valuable. More consistent data collection in respect of client demographics is also recommended. This would enable monitoring of any changes in clients referred to and supported by the service, and collection of more detailed data on gender which would help to identify whether men are under-represented (and the extent of this under-representation), allowing consideration of whether any actions are required to ensure more men benefit from the service.

- 9) The most significant levels of referral are for clients experiencing loneliness and isolation. These are well-recognised needs for social prescribing, and they highlight the importance of ongoing work to alleviate isolation and loneliness, and to ensure that there is a wide range of services and groups within the community to help bring people together and develop social connections. This is anticipated to be especially important during the recovery phase of COVID-19.
- 10) Consideration of the imbalance between the levels of referral from people living in the HU9 postcode, and the amount of services referred on to, may suggest that further service development in this area is required, and that consideration of such should be given.

Recommendations for future evaluations of social prescribing

- 1) That any future evaluation of social prescribing is preceded by a greater period of reflection and consultation on; the data to be collected; how this will be recorded (and the feasibility of recording and sharing this); how more social prescribing clients can be informed about the evaluation as a standard element of their contact with WBCs/link workers, including collecting agreement to contact clients after cases have been closed, for evaluation purposes. Many NHS services routinely collect patient consent regarding the anonymous use of their data for audit and research purposes and we recommend that Connect Well adopts this model in the future. This consultation process should include the service to be evaluated; the commissioners; and the research team, and will require time to explore the feasibility of different options for information sharing and client contact, and any potential information governance issues or restrictions.

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Appendix I – Evaluation methodology initially proposed

The evaluation methodology originally proposed is detailed below. As noted in the report, not all elements of this could be delivered.

This project aims to explore and evaluate the extent to which the outcomes in the service specification are achieved.

Data collection will comprise the following work-stream phases:

Work-stream 1. Quantitative analysis of social and economic benefits (strand led by JD and MR and with the support of health economist, Joyce Craig)

WS1a) Referrals-in to Social Prescribing Service. We will evaluate how many GP practices engaged with the project over the three years (July 2017 – July 2020). We will calculate how many referrals-in (i.e. by GPs and Adult Social Care to WBCs) were received overall and by practice. We will look at age, gender and ethnicity if data format permits. *

WS1b) Referrals-out refers to onward referrals of service-users to VCS services. We will calculate the number of onward referrals overall over the lifetime of the project as well as the range of service up-take (where service-users are referred to). This will illustrate the range and type of services being accessed and areas of high and low demand. *

WS1c) In order to evaluate the impact on demand for primary care attendance for non-medical reasons, we will look at data on the use of GP services by patients referred to the SP service over the lifetime of the project. We will use this data to calculate the extent to which, if any, attendance rates have reduced over time*

WS1d) We will conduct a pragmatic economic costs analysis. Using attendance data from GP practices we will evaluate the impact on the demand on primary care resources using a cohort of patients where we have 12 months pre and post referral data. The number of appointments before and after referral will be counted and changes compared. We will estimate the economic impact by estimating the cost to commissioners per patient in relation to use of social prescribing against GP services. In future, consideration of hospital episode statistics relating to in-patient admissions, Accident and Emergency attendances and outpatient appointments is recommended but is beyond the scope and funding for this evaluation.

I d) Where it is available, we will look at data on well-being outcome measures collected internally by different services to measure progress towards social outcomes (1-5 above)*

* All based provisionally and on condition that the research team have access to relevant key data in an appropriate format from North Bank Forum. The team will liaise closely with North Bank Forum, Hull Citizens Advice Bureau as well as NHS Hull Clinical Commissioning Group (SL, SB, PD) to ensure this.

2. Qualitative analysis of social and economic benefits (strand led by JB with RA support)

Over the course of the two-year evaluation we will conduct a range of in-depth interviews with key groups, drawing the on experiences of all those involved. This will provide detailed illustrations (including case studies and thematic analyses) of the types of outcomes and impact (both benefits and challenges) more widely as a result of social prescribing in the longer term from multiple perspectives:

WS2a) Interviews with key stakeholders (e.g, North Bank Forum, Citizens Advice Bureau).

WS2b) Interviews with referrers (e.g, GPs, social workers)

WS2c) Interviews with WBCs

WS2d) Interviews with service providers

WS2e) Interviews with service-users

WS2f) Focus groups with service-users

WS2g) Interviews with carers / relatives of service-users

	Year 1	Year 2	Total
Interviews with key stakeholders	2		2
Interviews with referrers	2	2	4
Interviews with WBCs	3	3	6
Interviews with service providers	3	3	6
Interviews with service users	4	4	8
Focus groups with service users	1	1	2
Interviews with carers / relatives	2	2	4
Total	17	15	32

WS2a) We will begin with in-depth interviews with key stakeholders to establish the wider background and context of the project and to help us identify key issues, areas of demand and appropriate contacts for further interview data gathering.

WS2b) Interviews with referrers will gather the views of this group on the extent to which (including how and why) the social prescribing service: improves the health, well-being and independence of services users; improves their ability to self-manage their care needs; provides timely access to social prescribing support and generalist welfare advice.

WS2c) Interviews with WBCs will gather the views of this group on the extent to which (including how and why) the social prescribing service: improves the health, well-being and independence of services users; improves their ability to self-manage their care needs; provides timely access to social prescribing support and generalist welfare advice.

WS2d) Interviews with service providers will gather the views of this group on the extent to which (including how and why) the social prescribing service: improves the health, well-being and independence of services users; improves their ability to self-manage their care needs; provides timely access to social prescribing support and generalist welfare advice.

WS2e) Interviews with service-users will draw upon their experiences of participating in Social prescribing services and their views on how their health, well-being and independence has been impacted as a result.

WS2f) Focus groups with service-users will draw upon their experiences of participating in Social prescribing services and their views on how their health, well-being and independence has been impacted as a result.

WS2g) Interviews with carers / relatives of service-users will gather the views of this group on the extent to which (including how and why) the social prescribing service: improves the health, well-being and independence of services users; improves their ability to self-manage their care needs; provides timely access to social prescribing support and generalist welfare advice.