

What works in social prescribing?

Published in January 2019



Social prescribing is becoming increasingly prominent in health and social care policy and practice as it supports a range of strategic agendas including improving population health and independence, illness prevention and demand management, patient-centred care, integration of health and social care, and loneliness prevention.

Here we share insights into the key ingredients necessary for successful social prescribing services based on our review of the literature¹. The review also explores potential barriers to the widespread adoption of social prescribing services.

Please get in touch with our Head of Research, [Dr Stephen Boxford](#), for more detail or to continue the conversation.

1 About social prescribing

1.1 What is social prescribing?

1.1.1 Defining the social prescribing approach

NHS England broadly defines social prescribing² as:

“a means of enabling GPs and other frontline healthcare professionals to refer to ‘services’ in their community instead of offering medicalised solutions.”

[\(NHS England 2018\)](#).

In other words, social prescribing offers primary care professionals an alternative referral pathway for patients presenting with social, emotional or practical needs which do not necessarily need to be met solely through clinical intervention. This approach views people’s health and wellbeing as determined by a range of social, environmental and economic factors and so seeks to treat individuals in a more holistic way ([Social Prescribing Network 2016](#)).

¹ If you would like details on the methodology used for the literature review, or a full bibliography, please get in touch with the Cordis Bright research team: info@cordisbright.co.uk

² Social prescribing is sometimes referred to as a community referral ([King's Fund 2017](#)),

There is a wide and varied range of 'activities' offered on social prescription. The availability of these different 'activities' varies in different primary care settings depending on availability. For instance, 'activities' can range from sports and leisure activities that focus on improving healthy living or reducing social isolation, or be more focused on education and developing skills ([Steadman et al. 2017](#)).

Examples types of social prescribing intervention ([University of York: Centre for Reviews and Dissemination 2015](#))

- Community education groups
- Arts, creativity, learning and exercise on referral
- Self-help groups
- Computerised Cognitive Behavioural Therapy (CBT)
- Bibliotherapy/reading of self-help books
- Volunteering
- Time banks
- Supported education and employment
- Adult Learning
- Knit and natter clubs
- Fishing clubs
- Gym-based activities
- Guided-based activities
- Guided/health walks
- Green Gym/gardening clubs
- Cycling
- Swimming and aqua-therapy
- Team sports
- Exercise and dance classes
- Physical activity
- Learning new skills
- Befriending

1.1.2 Models of social prescribing

There are many different models of social prescribing being used. For example, some social prescribing services may focus on self-help interventions or some may focus specifically on particular health issues such as weight management or mental health.

In the last five years, one core model has emerged: the majority of social prescribing services are centred around a link worker (or community connector) who works with individuals to access local support which is normally provided by voluntary and community sector (VCS) organisations ([HM Government 2018](#)). The link worker works co-productively with the patient to come up with personalised solutions to their needs ([Kimberlee 2013](#); [Social Prescribing Network 2016](#)). This process aims to improve patient

activation³ by supporting them to take greater control over their own health conditions ([King's Fund 2017](#)). This is sometimes referred to as a connector scheme by the NHS and the Government. The only prescriptive part of this model is the existence of a link worker and the reliance on the voluntary/third sector to provide a social prescribing intervention.

In this core model, individuals can be signposted by primary healthcare professionals to a link worker or they can self-refer to a connector scheme run in the community. Similarly, social prescribing services can be run by a specific general practice, Clinical Commissioning Group (CCG) or the local authority meaning that the link worker can be physically based in a general practice or in the community. It is this core model of social prescribing via a link worker that forms the focus of this review.

1.1.3 Is there a target group?

There is no specific target group for social prescribing, with different services targeting different groups of need. However, most people accessing social prescribing services do tend to fall into specific categories of need, e.g. those with mild to moderate mental health conditions; long term conditions (LTCs) such as diabetes; vulnerable groups; people who are socially isolated or people who frequently attend primary or secondary care ([Kings Fund 2017](#); [NHS England](#)).

1.2 The current policy context

By 2023 Government will support local health and care systems to implement social prescribing connector schemes across the whole country, aiming to provide universal access via GP practices ([HM Government 2018](#)). This drive towards social prescribing has emerged due to a number of policy developments.

In the last two decades there has been a push towards improving individuals' health, independence and access to local services from academics, think tanks, the NHS, and central and local government. For example, in the 2006 White paper '*Our health our care our say*', social prescribing was highlighted as a vehicle for achieving these aims ([King's Fund 2017](#)). More recently in 2014, the [NHS Five Year Forward View](#) argued that healthcare services need to focus more on prevention and wellbeing, patient-centred care, and better integration of services, and emphasised the role of the third sector in delivering these aims. A social prescribing model encapsulates these principles, helping to cement its importance and relevance in the health and social care agenda.

Even more recently, the [General Practice Forward View 2016](#) has highlighted social prescribing as a mechanism not only for better integrating primary care services with the voluntary sector but also for potentially reducing the ever-growing pressures on GP services by linking up GP services with the third sector. In fact, social prescribing was singled out as one of the 10 high impact actions that should be taken to manage demand in primary care ([NHS England](#)).

³ "Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions." ([NHS England 2018](#))

Social prescribing also relates to the public health agenda. With its focus on holistic care, social prescribing views individuals' health and wellbeing as being a result of much more than good health care. It instead views health as being influenced by different social factors such as work, poverty, social isolation, education and so forth. This social determinant approach was evidenced in the 2010 [Marmot review](#) and has gained momentum over the last decade. For example, the recent strategy on combating loneliness shows how far things have come. Loneliness would not have been previously viewed as a health or wellbeing issue, yet social prescribing has been singled out as one of the key ways in which loneliness can be tackled ([HM Government 2018](#))

Social prescribing is therefore becoming increasingly popular in national policy and is steadily being reflected in policy implementation. In fact, 50% of CCGs are now investing in social prescribing programmes and one in five GPs now regularly refer patients to a social prescribing programme ([NHS England](#)). Moreover, 23 areas in England are set to receive funding from the Department of Health and Social Care's *Health and Wellbeing Fund* to specifically invest in social prescribing and a national clinical champion for social prescribing has been appointed by the NHS to share lessons from successful projects ([Department of Health & Social Care 2018](#)).

1.3 Why social prescribing?

There is increasing evidence that tackling the root causes of ill health such as social, economic, environmental and lifestyle factors is just as important as providing individuals with good health care ([Health Foundation 2017](#); [Institute of Health Equity 2010](#)). On top of this, it is estimated that 20% of patients visit their GP for a social problem, placing increasing pressures on GP services ([Steadman et al 2017](#)). For instance, patients may present with low mood or anxiety but the root cause of this may be a social issue such as debt or loneliness. The social prescribing model offers a way to address these root causes of ill health and pressures on health systems.

Evaluations of specific social prescribing interventions identified as part of this review have highlighted a number of positive outcomes⁴ for individuals and for healthcare systems associated with social prescribing including:

- Improved quality of life.
- Improved emotional wellbeing.
- Improved mental health.
- Increased patient activation.
- High satisfaction levels from patients and healthcare professionals.
- A possible reduction in the use of NHS services and related cost savings.

⁴ These positive outcomes will be explored in more detail throughout this review where they are fully referenced.

- Stronger links between healthcare services and voluntary and community providers.

However, robust and systematic evidence of the effectiveness of social prescribing is still thin on the ground. Most studies present positive outcomes relating to specific individual interventions rather than the core social prescribing model. This makes it difficult to generalise about the impact of social prescribing. Each intervention is different, therefore it is hard to make comparisons (e.g. in some interventions the link worker may work out of a GP surgery and in others they may be based in a community setting). Furthermore, much of the evidence available is qualitative, relies on self-reported data and is drawn from studies that are small in scale. A more robust approach to evaluating social prescribing is needed. This will be discussed in more detail in section 3.2.5 .

2 Key ingredients for effective social prescribing services

2.1 Overview

The evidence regarding the elements of practice that make for effective social prescribing is limited. This evidence identified by our review is primarily drawn from evaluations from specific social prescribing interventions and the Social Prescribing Network. To date there has been no national guidance on social prescribing set by the National Institute of Health and Care Excellence (NICE). There is some mention of a Social Prescribing Assessment Tool within the guidance for older people's independence and mental wellbeing but it does not mention anything about best practice ([NICE 2015](#)). There is an increasing amount of guidance being set by commissioners in the NHS and local government. However, there is still no joined-up approach to social prescribing and most pieces of research point to the need for more evaluations to be carried out to expand the evidence base.

In this section we explore the 'key ingredients' outlined by the Social Prescribing Network, as they offer the principal source of consensus around what a good social prescribing service should look like. Where possible, we have provided further evidence for each key ingredient and we have also refined the key ingredients accordingly. However, aside from the Social Prescribing Network's survey findings, the evidence underpinning each 'key ingredient' is limited. The key ingredients should therefore be viewed as a useful starting point for future social prescribing services rather than prescriptive guidelines for social prescribing.

The key ingredients of social prescribing:

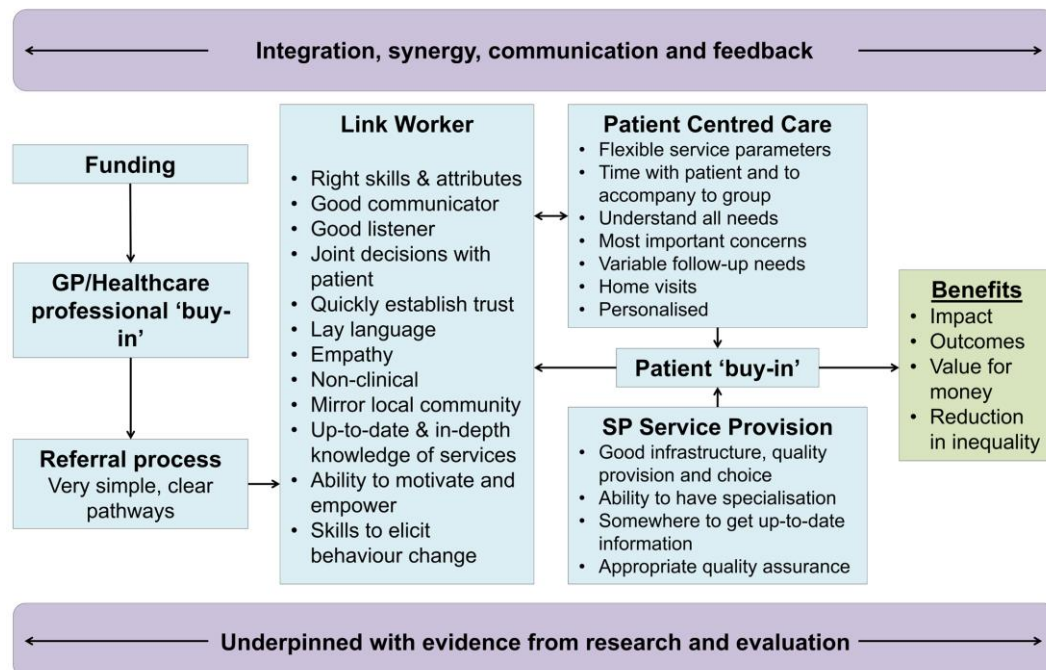
- Funding
- Buy-in of healthcare professionals
- Referral process
- Link worker
- Patient-centred care
- Collaborative working between different sectors
- Communication and integration between different sectors

2.2 Key ingredients from the Social Prescribing Network

The Social Prescribing Network was established in 2016 to support social prescribing at a local and national level by sharing knowledge and best practice. Figure 1 summarises what the Network understands to be the 'key ingredients' for a successful social prescribing service and shows how they link together. These 'ingredients' have been taken from the [report](#) of the Annual Social Prescribing Network Conference where

delegates were asked to fill in a survey prior to the event on what they thought to be the key ingredients of a social prescribing model (51 delegates responded). Delegates included representatives from the third sector, general practice, nursing, patients, CCGs, local authorities, housing associations, professional bodies and academics ([Social Prescribing Network 2016](#)). These 'key ingredients' are discussed in more detail below alongside supporting evidence from existing literature.

Figure 1: Key ingredients of a social prescribing service



Source: [Social Prescribing Network 2016](#)

2.2.1 Funding Models

The first key ingredient highlighted by the Social Prescribing Network is that funding models need to allow for social prescribing services to be tailored to the local context, whilst creating a return on investment for key stakeholders. The Network argues that this is more likely to encourage commissioners to continue funding the service ([Social Prescribing Network 2016](#)).

This view is supported by an evaluation of a social prescribing service in City and Hackney. ([Health Foundation 2014](#)). It also emphasised the importance of securing long term funding from commissioners so that the service has time to develop which, the report notes, is particularly important for complex interventions.

In terms of models of funding, there are two common forms: a GP practice-based model and a CCG/local authority-based model ([University of Westminster 2017](#)). Both have different strengths and weaknesses. In a general practice-based model, the practice controls the budget to facilitate a redesign of services to feature a social prescribing aspect. This means that the service is small in scale but tailored to the local community context. These kinds of services have most commonly been funded by the Big Lottery Fund or other charitable funds ([Social Prescribing Network 2016](#)). Alternatively, in a whole

system CCG/local authority-based model, a social prescribing service is commissioned at the CCG/local authority level rather than the service being an intrinsic part of a specific GP practice. This means the service is potentially less tailored to the local context ([Social Prescribing Network 2016](#)).

[Kimberlee \(2016\)](#) makes the case for the second model, arguing that sharing the cost of social prescribing between the NHS and the local authority improves return on investment. Kimberlee highlights that the financial risks associated with running a social prescribing programme are reduced when the costs of the programme do not sit with one organisation. Therefore, by distributing costs between different commissioners, the business case is strengthened for social prescribing services to be considered as a widespread service option. A strong business case also encourages buy-in from referring healthcare professionals and non-NHS organisations, which in turn increases the likelihood of long-term social prescribing programmes becoming embedded in the community.

Studies also highlight the importance of the funding model considering the partner organisations in the social prescription pathway. For example, the [City and Hackney CCG SHINE project](#) found that it was challenging to involve the voluntary and community sector (VCS) after the initial consultation in the social prescribing pathway because there was little direct funding to support the VCS organisations. This reduced their sense of belonging to the social prescribing pathway, which in turn affected working relationships ([Health Foundation 2014](#)). The Newham community prescribing scheme introduced a 'payment by results' system which, although presents challenges in administration, in this instance made joined-up working more successful. It has the potential to make VCS organisations more accountable, sustainable and facilitate better monitoring of the intervention ([Health Foundation 2014](#)). However, further research into the best funding model is required.

2.2.2 Buy-in of referring healthcare professionals

The second key ingredient is that time needs to be taken to educate healthcare professionals on the different aspects of social prescribing. This is important as to many it will still be a relatively new concept. This will hopefully help to manage demand and regulate the flow of referrals to local and community services ([Social Prescribing Network 2016](#)).

Buy-in from healthcare professionals is also an important factor to ensure continuation of funding and multi-agency working. See Section 2.2.1 and 2.2.4.

2.2.3 Referral process

The third key ingredient is that there needs to be clear and simple referral pathways because there are a number of different actors and organisations involved in the referral process (i.e. referral to a link worker, referral from a link worker to a local service, referral from a link worker back to a GP for crisis support) ([Social Prescribing Network 2016](#)).

This view was supported in a number of evaluations, with many highlighting the importance of central referral processes ([Bickerdike et al 2017](#); [ERS Research and Consultancy 2013](#)). For example, in the Newcastle Social Prescribing Project where GPs were provided with a specific social prescribing referral form, they reported in evaluation

interviews that the form was successful because it was specific to social prescribing and straightforward to use ([ERS Research and Consultancy 2013](#)).

The Social Prescribing network also highlight that all stakeholders need to agree upon the referral pathway to better establish multi-agency working but also so that GPs are able to follow a patient's journey to ensure their needs have been met. For instance, link workers should regularly ensure that participating practices know about the social prescribing service, and that it is accessible to practice staff and GPs through the referral process ([Bragg and Leck 2017](#)). One possible option is to build upon existing referral pathways used in primary care ([Pescheny et al. 2018](#)).

2.2.4 Good link worker (community connector)

The fourth key ingredient is in relation to the link worker. The network argued that the role of a skilled link worker in a social prescribing service is instrumental to its success as they must be able to: engage with referring professionals, engage with patients and engage with the local, community and social enterprise sector. They must therefore have a diverse set of skills ([Social Prescribing Network 2016](#)).

Many evaluations have supported the view that the link worker plays an important role in social prescribing, as they are responsible for taking referrals and then linking the patient to relevant services ([Langford et al 2013](#); [Bragg and Leck 2017](#)). For example, according to [Bragg and Leck \(2017\)](#) the most successful social prescribing services are those with link workers who have good local knowledge, as this helps to forge effective relationships between primary care and the VCS. In the early stages of a social prescribing programme, link workers are particularly vital for championing the benefits of the scheme to encourage buy-in from health professionals ([Community Action Southwark 2015](#)).

Link workers are also important as they have more time to spend with patients than the typical 10-minute GP appointment. This means patients are given time to talk in detail about their condition and any lifestyle factors which may be impacting negatively on their health ([Community Action Southwark 2015](#)). This holistic process means link workers are able to empower and motivate individuals to take control of their own health ([University of Westminster 2017](#)). The Shine project also reported that the ability to have hour long appointments meant that link workers were able to accurately assess their patients' needs ([Health Foundation 2014](#)).

The effectiveness of the role of link worker is further evidenced by a large social prescribing pilot in Rotherham where, three to four months after they had starting working with a link worker, 83% out of 280 patients felt they had made progress in one of the following areas: feeling positive, lifestyle, looking after yourself, managing symptoms, work, money, and family and friend relationships ([Community Action Southwark 2015](#); [Dayson and Bashir 2014](#)). Furthermore, an evidence review based upon link worker intervention found that on average there was a 28% reduction in demand for GP services

following a referral from a link worker (7 studies) and a 24% fall in A&E admissions (5 studies)⁵ ([University of Westminster 2017](#)).

2.2.5 Patient centred care

The fifth key ingredient is around Patient-centred care which is viewed as a key component of social prescribing. The network argues that it is important that there is a co-productive relationship between the patient and their link worker so that the patient's needs are met. Patients should be empowered to take control of their own health and wellbeing through a person-centred approach ([Social Prescribing Network 2016](#)).

In the wider health and social care landscape, there is evidence which points to the importance of taking a patient centred, personalised and co-productive approach to individuals' care as a method of improving self-efficacy and reducing demand on health and social care services ([NHS 2014](#)). There is also evidence that a patient centred approach is vital to social prescribing. For instance, an interim evaluation report of the Rotherham social prescribing pilot found that:

"People feel that they have more control over their health and they learn different techniques as ways of helping to develop the things that are important to them...proper breathing, learning how to deal with stress, learning how to relax, how to balance, how to move...."

(A link worker quoted in Dayson et al. 2013)

Other evaluations also highlight how important it was to the success of the project to provide personal and flexible support for patients facilitated through one-to-one contact ([Dayson and Bennett 2016](#)). For instance, a social prescribing service in Rotherham targeted at those with long term conditions concluded from interviews with GPs that patients experienced reductions in social isolation and loneliness, and in family and carer breakdown when they provided person centred services ([Dayson and Moss 2017](#)). The evaluation of the Brighton and Hove social prescribing pilot found that 62% of patients surveyed felt they were able to take the next step in their care due to the supportive and personalised relationship the link worker had fostered with them ([Farenden et al. 2015](#)).

2.2.6 Collaborative working between different sectors

The sixth key ingredient is that due to the fact that a social prescribing requires input from primary care professionals, a link worker and the voluntary services; then collaborative working between different sectors is vital. VCS and social enterprise organisations therefore need to be involved as early on as possible in the design of the service to establish collaborative working from the get go ([Social Prescribing Network 2016](#)).

Evidence has shown that for a social prescribing programme to be a success, collaborative working in the design, implementation and delivery stage is key. [Pescheny et al. \(2018\)](#) argue that applying a phased roll-out to implementation can facilitate success because it allows time for relationships between GP surgeries, link workers and the VCS

⁵ These studies sought to determine the effect of social prescribing on demand by comparing rates of use before and after referral, rather than between a control and an intervention group. This does not completely isolate the effect of the intervention as it fails to eliminate the impact of what would have occurred anyway over time.

organisations to develop and for all stakeholders to build a shared understanding of what the programme is aiming to offer and what is expected of each stakeholder.

Collaborative working is key to social prescribing. This is because social prescribing services need to adapt to the local context: the profile of the patient cohort and patient needs will differ between different local areas. Social prescribing services also need to adapt to reflect the VCS services available in the local area. Stakeholders can work together to balance these factors to ensure that there is a shared understanding between clinical and non-clinical staff, commissioners, service users, the link workers and other stakeholders of the scope of the social prescribing service ([Age UK; Pescheny et al. 2018](#))

[Pescheny et al. \(2018\)](#) suggest that general practices need to be 'link worker ready' to ensure successful implementation and delivery of the social prescribing programme, which means link workers need to be treated as a member of the primary care staff team. They suggest the following ways to achieve this:

- Understand the scope of the social prescribing programme and the link worker's role and skills.
- Provide a room for the link worker, which is accessible for patients and allows meetings without interruptions.
- Provide an induction including available staff facilities, safety procedures, computer login details, and telephone access.
- Invite the link worker to relevant meetings.
- Clarify how and when the link worker can contact the GP directly.
- Provide a lead staff member who can answer queries related to surgery systems and communications.
- Provide a secure space for link workers to keep their files, working material, and confident records in the general practice.

2.2.7 Communication and integration between different sectors

The seventh key ingredient is that effective communication and feedback loops need to be established between different sectors as it ensures transparency ([Social Prescribing Network 2016](#)). This includes:

- Commissioners being clear about the service they are commissioning, and relaying to all stakeholders the parameters of the service so everyone is clear on expectations.
- Healthcare referrers knowing if a patient has received the support they need. Read codes therefore should be added to the data management system for basic tracking of referrals.
- It is difficult to link electronic patient records to records of non-medical services patients have accessed in the community. However, software has been developed by companies for this purpose and should be further explored.

- The link worker should act as the communication hub between organisations to communicate with healthcare referrers and develop knowledge of the local service landscape.

A number of evaluations support the need for effective communication between different stakeholders ([Dayson and Bennett 2016](#); [Bragg and Leck 2017](#); [ERS Research and Consultancy 2013](#); [Bikerdike et al 2017](#); [Farenden et al 2015](#); [Health Foundation 2015](#)).

For example, in the evaluation of the Rotherham Carers Resilience service, which aimed to support the carers of people with dementia through a social prescribing service, the success of the pilot was attributed to the close working relationships between different stakeholders. For example, in the early stages of the programme there were issues in terms of clarity of roles and responsibilities but these were quickly resolved through open communication and a flexible response to delivery. Meetings between the project partners were held every two months to ensure that feedback could be incorporated in a process of continuous improvement. One stakeholder reported the importance of close working relationships saying:

"I think settling-in time, and roles and responsibilities and partnership working has now gelled. People know what their roles are now and we've worked through that really well. [We've] had some frank discussions about [what] our speciality is from and [what theirs] is, and I think that's now working a lot better...everybody's talking, communicating and we're working very much together as a team"

Stakeholder, Carers Resilience. ([Dayson and Bennett 2016](#))

3 Overcoming barriers to social prescribing

3.1 Overview

In this section we summarise the potential barriers to social prescribing programmes identified in our review of the literature. We also provide some guidance on how future evaluation studies might better capture whether social prescribing services are achieving their intended outcomes, as currently a lack of evidence is proving to be a real obstacle to the adoption of social prescribing.

3.2 Potential barriers

3.2.1 Establishing definitions

There is no uniform definition of social prescribing, which may not be an issue for patients as long as they receive the intended service and gain benefit from it. However, a common definition and a shared language might overcome barriers to engaging key stakeholders and commissioners, whose support is needed for funding and national take-up ([Social Prescribing Network 2016](#)). It would also be useful for evaluators and commissioners because comparison of different programme outcomes is very difficult without clarity of concept ([Social Prescribing Network 2016](#); [Healthy London Partnership 2017](#); [Polley et al 2017](#)). As mentioned in section 3.2.4, this standardisation may be achieved through guidance from national bodies.

3.2.2 Identifying a target cohort

The majority of social prescribing programmes have tended to target specific cohorts of the population, as mentioned in section 1.1.3. The Healthy London Partnership recommends that, whilst social prescribing services have the potential to benefit a whole range of people, catering for the general population through a social prescribing service may cause barriers when attempting to set-up or scale-up a programme as it may cause confusion around who is eligible to be referred into the programme or discourage buy-in from health care professionals. Therefore, it may be better to target specific groups of need within the population. Local areas can identify their target population by using existing knowledge of the local area such as their Strategic Needs Assessment, Sustainable Transformation Plans (STPs), other planning processes and through risk stratification ([Healthy London Partnership 2017](#)).

The Healthy London Partnership report that there is not yet consensus over which groups to target through social prescribing but commissioners and providers could target those who are most in need; vulnerable or are frequent users of healthcare services to help alleviate pressure in the system. They suggest the following groups that could be targeted:

- Those who have one or more long term conditions.
- Those at specific activation levels on the Patient Activation Measure (PAM) scale or similar.
- Those who use >£x of medication per week.

- Those who attend >x number of clinical contacts per month.
- Those presenting with a social problem/social isolation, or presenting frequently to primary care with a range of diffuse issues.
- Those presenting with mild to moderate mental health conditions.
- Those known to have health conditions, but don't currently use health services.
- Those who live alone.
- Those at risk of developing or worsening health conditions (e.g. pre-diabetic).

3.2.3 Low programme uptake and adherence

Low uptake and adherence have been reported in a number of evaluations as a problem. Reasons for this have been cited as: long waiting times for assessment; transport problems; literacy; concerns about confidentiality and disclosure in VCS organisations; and the availability, accessibility and appropriateness of the services that participants were referred to ([Public Health Wales Observatory 2017](#)). These barriers to uptake have been observed through qualitative reporting and have not been explored quantitatively.

3.2.4 Regulation and standards

As mentioned previously, there is no national guidance for social prescribing services and yet there is increasing support for these services from national bodies ([King's Fund 2017](#)). It has been argued that set standards for social prescribing would help reduce barriers to commissioning; as it currently stands, commissioners may be wary about commissioning a social prescribing service because it is unregulated. The implementation of professional standards is one other possible solution to quality assurance as this avoids rigid regulation, which could affect innovation in the sector ([Social Prescribing Network 2016](#)).

3.2.5 Lack of evidence

According to [Polley et al. \(2017\)](#) the most effective role for a national body at this point would be to direct the evolution of social prescribing services so as to ensure that any models and services being scaled-up and replicated are models which "work". There is therefore a need for the quality of evidence to be improved and for the benefits presented in evaluation findings to be consistent. This will allow for clear comparison between different social prescribing services. This could be achieved by encouraging further evaluation of existing services and helping to develop a common evaluation framework to properly assess impact and draw clear comparisons of effectiveness ([Polley et al. 2017](#)).

To date, most evaluations have been small in scale and limited by poor design. For instance, a systematic review found that social prescribing evaluations have been flawed by a lack of comparative controls, short follow-up durations, a lack of standardised and validated measuring tools, missing data and failure to consider potential confounding factors ([Bickerdike et al. 2017](#)). Furthermore, most of the evaluation evidence relates to individual interventions rather than the core social prescribing model, and a lot of the evidence available is qualitative and relies on self-reported outcomes. It is also difficult to measure the impact of complex interventions. ([King's Fund 2017](#))

A rapid appraisal of the effectiveness of social prescribing argues that if we are to improve existing knowledge of social prescribing services then studies need to be comparative by design and seek to address specific questions such as when outcomes should be achieved, who is it intended for, how well does it work, what effects does it have and how much does it cost ([University of York: Centre for Reviews and Dissemination 2015](#))?

Below are some recommendations for improving the evidence base⁶.

Recommendations for improving the evidence base:

- Evaluation studies should assess the effectiveness of the social prescribing model rather than the specific intervention ([King's Fund 2017](#)).
- A set of standardised measures and validated tools should be used to measure outcomes so that comparison between different social prescribing programmes is possible.
- Evaluations which seek to use a control group such as in an RCT would improve the quality of evidence available.
- A mix of qualitative and quantitative methods should be used to measure perceptions and feasibility of social prescribing but also impact.
- Evaluations of existing social prescribing programmes should be conducted to ensure that they are improving outcomes of patients and are good value for money.
- The goals and ambitions of social prescribing should be better defined and translated into specific and measurable objectives ([Goodwin et al 2012](#)). This is something that could be achieved through a logic model tool which ensures a close connection or relationship between **activities** undertaken, **outputs** produced, **impact** achieved and the **outcomes** delivered.

3.2.6 The business case for social prescribing

A lack of clarity around cost presents a barrier to social prescribing as it makes building a strong business case difficult. For example, approaches to measuring the cost effectiveness of social prescribing has varied with some researchers concentrating on short term costs (which tend to be higher due to the initial cost of the intervention) and others investigating longer term costs through a return on investment methodology (ROI) which has shown positive cost savings. Evidence is thus mixed due to a lack of standardised measuring tools being used and lack of clarity around where money is intended to be saved in the system. For example, are programmes looking to make cost savings for the CCG, local authority, the overall health and social care system or wider society?

⁶ Recommendations without a named reference are based on recurring issues identified through our review and our expertise in evaluations of complex programmes and interventions.

Our review identified the main difficulties when trying to measure the cost-effectiveness of social prescribing to be the variable case-mix, complexity of patient problems and the diversity of social prescribing models, all of which make it hard to quantify the costs of social prescribing in a consistent and standardised way. Below are some recommendations to consider when investigating the cost of social prescribing programmes which may help the business case.

Recommendations for measuring cost effectiveness⁷:

- The varied case-mix and diversity of different models poses challenges for monetisation. Therefore, a set of the same, standard tools is needed to measure outcomes to ensure equivalence in assigning value to various social prescribing approaches ([Social Prescribing Network 2016](#); [Bickerdike et al 2017](#)).
- Health services should use proper read codes for social prescribing to make sure that social prescribing activity in GP services is captured in order for social prescribing to be properly validated and monetised within the NHS. This will also make cost comparisons between different services easier ([Social Prescribing Network 2016](#)).
- Whilst commissioners prefer unit cost data when calculating the cost of an intervention, this is not appropriate for social prescribing where there is a variable case-mix. Therefore, it may be beneficial to compare cost-efficiency ratios with therapies such as 'Improving Access to Psychological Therapies' (IAPT) which are broadly commissioned across CCGs ([Social Prescribing Network 2016](#)).
- Both the short-term and long-term costs of social prescribing should be considered when deciding whether it is good value for money or not.
- Before deciding whether a programme is economically viable, clarity should be established regarding where costs are anticipated to be saved in the health and social care system or wider society.

3.3 Conclusions

This review has highlighted the potential of social prescribing services to combat the root social causes of ill health and so alleviate pressure and demand on primary and secondary healthcare services. Other potential benefits for patients and services include:

- Improved quality of life.
- Improved emotional wellbeing.
- Improved mental health.

⁷ Recommendations without a named reference are based on recurring issues identified through our review and our expertise in evaluations of complex programmes and interventions.

- Increased patient activation.
- High satisfaction levels from patients and healthcare professionals.
- A possible reduction in the use of NHS services and related cost savings.
- Stronger links between healthcare services and voluntary and community providers.

However, as discussed throughout the review, robust evidence remains weak with the majority of evaluations being small in scale and poorly designed. Commissioners need to consider this before adopting widespread social prescribing programmes. Moreover, before there is a wholesale move across to this core model of social prescribing a greater evidence base is needed which addresses patient satisfaction, patient outcomes and potential cost savings.