



This is a ‘**platform**’ evidence summary commissioned by the National Academy for Social Prescribing (NASP) from their Academic Partnership (AP). The AP has a research track record in the review question or topic and were able to provide an expert commentary on the evidence base, together with an indication of the limitations of that evidence base. Their commentary represents the ‘platform’, from which they undertook further literature searches. They worked with an information specialist to design and conduct database and grey literature searches relevant to the review question or topic (see appendix 1 & 2). They screened references located from these searches against inclusion/exclusion criteria. Included studies were added to the commentary provided by their topic expert(s) to update, broaden, or otherwise add to the existing ‘platform’.

Measuring outcomes for individuals receiving support through social prescribing

Context

This evidence summary is one of a suite commissioned by the National Academy for Social Prescribing (NASP) from their Academic Partners in 2021 (<https://socialprescribingacademy.org.uk/academic-partners-collaborative/>). The topics included in this suite were identified through a robust prioritisation process with individuals representing the breadth of the social prescribing landscape. The summaries were produced by researchers from the NASP Academic Partnership; specific teams are listed on each document.

Four of these topics had significant work conducted previously by members of our group, and so we report that work then build out using new database searches and broader grey searches; to produce synthesised conclusions about what is known (we term these ‘platform’ reviews, see above). The remaining summaries are ‘fresh’ reviews of the evidence base as it stands.

The summaries are intended for a broad readership but have a policy and practice focus; bringing together what is known on specific areas relating to social prescribing and summarising the findings, limitations, and gaps in that field. Each summary contains a detailed bibliography, and we would encourage readers to follow these links for further, more detailed, reading on each topic.

Recommended Citation

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Question description

Based on previous work, we refined this prioritised topic into three core sub-categories:

- (i) What are the outcomes reported for individuals receiving support through social prescribing?
- (ii) What are the challenges associated with collecting outcomes for beneficiaries of social prescribing?
- (iii) What outcomes are collected from beneficiaries of social prescribing and how?

Methodological approach, plus additions for this summary

Platform element

The current evidence was summarised by the NASP Academic Partnership members most aligned with this topic. As with the other summary based on outcomes, the comprehensive and robust recent work by Polleyⁱ is used as a starting point so as to avoid unnecessary duplication of effort. Readers are directed to this work for initial reading.

Additional evidence element

The team above used their extensive work to develop search terms, which were refined into a strategy, run with the Polleyⁱ report as a date limit. Searches were combined for this and the related outcomes topic looking at: Are there any medium- to long-term outcomes reported for social prescribing and, if so, what are they? with studies channelled to each summary at data extraction stage. These additional studies are presented below using the framework provided in the Polleyⁱ report to structure outcomes (Tables 3 and 4 in Polley et al.ⁱ).

These two components, ‘what was known’ in the platform and ‘what is added’ in the additional evidence, are brought together to assess what we can say overall in the Conclusions section at the end of this document.

Summary of evidence by experts (‘Platform’)

- (i) *What are the outcomes reported for individuals receiving support through social prescribing?*

This question relates to what organisations and individuals have been doing and incorporates both good practice and what might be considered poorer approaches.

Alongside this variability, there is the well-known issue of publication bias and the missing evidence that characterises a lot of the social prescribing evidence base. Care must also be taken to separate out *outputs* from *outcomes* reported. All of these issues will directly impact other areas, such as economic analyses.

However, the main messages from the expert ‘platform’ team were that there were reported decreases in loneliness, improvements in mental health and wellbeing across multiple measures, improvements in social connections, and in overall wellbeing. It remains unclear how generalisable these data are to other contexts outside of the specific evaluations they are reported in.

A summary of the outcomes reported in Thomson et al.ⁱⁱ, and Chatterjee et al.ⁱⁱⁱ (representing a review of over 100 programmes) are:

- Increases in self-esteem and confidence, sense of control and empowerment.
- Improvements in psychological or mental wellbeing, and positive mood.
- Reduction in symptoms of anxiety and/or depression, and negative mood.
- Improvements in physical health and a healthier lifestyle.
- Increases in sociability, communication skills and making social connections.
- Reduction in social isolation and loneliness, support for hard-to-reach people.
- Improvements in motivation and meaning in life, provided hope and optimism about the future.
- Acquisition of learning, new interests and skills including artistic skill.

Additional outcomes are below, but are not individual ones.

- Reduction in number of visits to a General Practitioner (GP), referring health professional, and primary or secondary care services.
- GPs provided with a range of options to complement medical care using a more holistic approach.

A summary of the findings from the ‘What does successful social prescribing look like?’ report by Marie Polley and colleaguesⁱ:

99 individual outcomes were identified. Of these:

- 23% (23/99) were only reported in qualitative social prescribing literature.
- 37% (37/99) were not normally reported in social prescribing literature.
- 60% (60/99) of outcomes are not routinely measured.

The 99 individual outcomes were then organised into 2 themes; 37 outcomes were associated with wider determinants of health. Of these:

- 19% (7/37) were only reported in qualitative social prescribing literature.
- 59% (22/37) of outcomes were not previously reported.
- 78% (29/37) of outcomes are not routinely reported.

62 outcomes were associated with health. Of these:

- 26% (16/62) of outcomes were only qualitatively reported and not measured.
- 24% (15/62) of outcomes associated with health were not previously reported.
- 50% (31/62) of outcomes associated with health are not normally measured.

The final report we summarise in this section is the previously mentioned Bickerdike et al. review^{iv}. This team examined only health and wellbeing, and not social, outcomes. They shortlisted 15 reviews from 341 identified documents relating to evaluations of social prescribing. Six of the shortlisted studies measured health and wellbeing outcomes including mental health and mental wellbeing, general health, social adjustment, anxiety, and depression. They all found improvements in health and wellbeing. Eight studies also looked at patients' experience. Six of these found improvement in overall satisfaction with social prescribing. They also observed reductions in loneliness and social isolation, improved mental and physical health. However, two studies reported that patients had poor knowledge of the services prior to attending their appointment resulting in the service not meeting their expectations.

(ii) What are the challenges associated with collecting outcomes for beneficiaries of social prescribing?

In terms of collection of outcome data, there are longstanding issues documented which show that time, expertise, and resources needed are all key limitations. Also, there is the issue of defining outcomes and separating neuro-biopsychosocial outcomes.

In addition, the over-reliance on data collection from link workers at follow-up can be problematic as they face significant time pressure in delivering their current support and so finding the time for data collection can, understandably, be a low priority. There is also the need for link workers to be trained to collect any data, adding to the time and resource burden. That said, of course their input is key particularly at the beginning of data collection and their views and opinions on what works in relation to data collection in specific sites is very important in order to maximise both link worker and participant engagement in data collection.

(iii) What outcomes are collected from beneficiaries of social prescribing and how?

Data collected differ depending on whether these are collected as part of routine monitoring, evaluation work, or more formal research, with all predominantly collecting psycho-social outcomes that focus on wellbeing rather than health outcomes. There is likely to be a difference between routinely monitored outcomes and evaluation collected outcomes; however, the reporting of both is often sparse and so tricky to estimate with accuracy. Once again, it is important to distinguish between outputs and outcomes of programmes.

Limitations:

- It is important to note that there is no standardised approach to collecting outcome measures yet, though there is a National Minimum Dataset being piloted by NHS England. Outcomes for this have not been agreed, only outputs and referral criteria, and as such is a work in progress but should be considered when examining outcomes for social prescribing.
- As above and throughout, the distinction between outcomes and outputs is central to this topic, and frequently this distinction is blurred/confused.
- Data collection is often skewed towards health outcomes, partly due to the blanket introduction of the Patient Activation Measure (PAM), and partly due to the priorities of health commissioners. There is a lack of visibility of reporting of outcomes relating to social determinants of health, and therefore a mismatch in what link workers is supporting to how that impact is documented.
- Previously, there was NHS England direction for schemes to collect ONS4 and Patient Activation Measure (PAM), however due to licensing there is to be a new process which will detail which outcome measures are vetted and considered valid and appropriate for social prescribing.
- There is very little data which documents the actual unmet need in social prescribing.
- Often, little or no justification for the selection of particular outcome measures is given.
- Measures are often used in cohorts for which the measure is either not appropriate or is untested.
- Issues of significant drop-out when collecting data lead to difficulties in generalisability of findings.
- With specific measures, there are often issues relating to what score change constitutes a minimum important difference for an individual.
- Most outcomes are measured over a short-term period for individuals, and it can take years for some cohorts to see impacts. This is especially true for those seeking to impact on education, employment, or training.
- Finally, the choice of outcomes is often dictated by specific referral criteria for programmes - which has the potential to skew findings for each programme, but also the summaries presented in these evidence reviews.

Summary of additional evidence located

Our searches to update and broaden the studies resulted in 245 papers being identified, of which 32 were included¹⁻³² following screening using the inclusion criteria detailed in Table 1. Of these 32 included papers, 9 were sourced from peer-reviewed journals and 23 from grey literature. These studies provided evidence for the evidence summaries looking at: *Are there any medium- to long-term outcomes reported for social prescribing and, if so, what are they?* and *Measuring outcomes for individuals receiving support through social prescribing.*

Table 1. Inclusion and exclusion criteria for the summaries looking at: Are there any medium- to long-term outcomes reported for social prescribing and, if so, what are they? and Measuring outcomes for individuals receiving support through social prescribing.

<i>Inclusion criteria</i>	<i>Exclusion criteria</i>
Quantitative data reporting outcomes of a social prescribing programme	Documents published before 2018
Research conducted in England and published in English language	Documents lacking primary data
Meets NASP definition of social prescribing	Abstracts, theses, posters
	Experimental services

These additional studies are presented in Table 2 below using the framework devised by Polley¹. Although we would have included it if available, there were no papers reporting outcomes for crime, legal, or welfare (wider determinants of health), modifiable risks or spiritual wellbeing (outcomes related to health).

Key:

+ = positive results

- = negative result

* = statistical significance, highlighted in blue

NR = not reported

Table 2. Domains, outcome measures and follow-up period for all included additional studies

Study	Wider determinants of health					Outcomes related to health			
	Work and volunteering	Social	Education and skills	Housing	Income	General health & wellbeing	Physiological	Psychological	Empowerment
Measure, follow-up period, results									
Benson et al. 2021 ¹		R-Outcomes before and after, social contact +, loneliness unclear							
Bristol Ageing Better 2018 ²		De Jong Gierveld Loneliness Scale, UCLA, +* post-intervention, + at 3m (sample size too small)				SWEMWBS, +* post-intervention, + at 3m (sample size too small)			
Bromley by Bow 2018 ³		WSAS, before and after, + but not clinically significant				MYCaW, SWEMWBS, +* before and after			
Bromley by Bow 2019 ⁴						MYCaW +*, ONS4 + (anxiety only +*), last SP session			
Dayson & Leather 2018 ⁵		Connectedness and relationships, measure not specified, + at 3m				EQ-VAS, EQ5D-5L, SWEMWBS, + at 3m			
Dayson & Leather 2020 ⁶		Measure not specified, + at 3m				EQ-VAS, EQ5D-5L, SWEMWBS, all + at 3m			
Elston et al 2019 ⁷						Wellbeing Star, WEMWBS, PAM, wellbeing goal achievement,	Rockwood Clinical Frailty Scale, + at 12w or exit		

						+ at 12w or exit			
Ferguson & Hogarth 2018 ⁸						MYCaW, + at 12w			
Foster et al 2020 ⁹		UCLA, + at 3m (although - in subsample)							
Fullwood 2018 ¹⁰						SWEMWBS, +* at post-intervention and 2m			
Giebel et al. 2021 ¹¹						SWEMWBS score at 3m +* and 6m +*			
Hackney 2020 ¹²		Unspecified loneliness and isolation questionnaire, + at unspecified follow-up				SWEMWBS, +* at discharge, 3m sample too small	Rockwood Clinical Frailty Scale, follow-up and result NR	Mental health score, follow-up and result NR	
Healthy Dialogues 2018 ¹³						Wellbeing Star at each appointment, +*			
Healthy Dialogues 2021 ¹⁴						Wellbeing Star at each appointment, +*			
Healthy London Partnership 2018 ¹⁵		Measure and follow-up unspecified, n=19 +	Measure and follow-up unspecified, n=1 +	Measure and follow-up unspecified, n=7 +	Measure and follow-up unspecified, n=15 +	Wellbeing Star plus 3 individual outcomes, +, follow-up unspecified	Measure and follow-up unspecified, n=12 +		
ICC YPSP 2020 ¹⁶		One Likert scale question for loneliness, mixed across sites at 6m, some small sample sizes				ONS personal wellbeing scores +, SWEMWBS + (not 'meaningful') at 6m	Physical activity based on definition of 'active' by UK Chief Medical Officer, + by 7% at 6m		

ICC Redbridge 2020 ¹⁷		Campaign to End Loneliness Tool +, social capital questionnaire + for networks/support, 6m				ONS, EQ-VAS, EQ5D-5L, SWEMWBS, MYCaW, +* for all at 6m (ONS life satisfaction only)			
ICC City & Hackney 2020 ¹⁸						EQ5D-5L -, SWEMWBS + (not 'meaningful'), at 3 and 6m			
Islington Giving 2019 ¹⁹						WEMWBS, meaningful + at 6w			
Kellezi et al. 2019 ²⁰		No. group memberships +*, UCLA scale +, 4m							
Massie & Ahmad 2019 ²¹		De Jong Gierveld Loneliness Scale, +* at 1-10m (overall and sub-scale)				ONS, +* at 1-7m (overall and sub-scale)			
Metropolitan Thames Valley 2019 ²²								HACT mental health social value, + post-intervention	
Oxfordshire Mind 2020 ²³						SWEMWBS, 78% +* at end of intervention			
Oxfordshire Mind 2021 ²⁴						SWEMWBS, 71% +* at end of intervention			
Oxfordshire Mind 2021 ²⁵						SWEMWBS, at least 62% +* (reporting conflict) at end of intervention			

Pescheny et al. 2019 ²⁶						SWEMWBS, +* post-intervention (though mean change not clinically relevant)			
Pescheny et al. 2019 ²⁷							International Physical Activity Questionnaire, + post-intervention		
Polley et al. 2019 ²⁸		De Jong Gierveld Scale, +* at 3m				MYCaW, +* at 3m, PAM, clinical significance at 3m			
Wakefield et al. 2020 ²⁹		No. group memberships + at 4m then - at 6-9m, community belonging scale, social support rating, ULS-8, 4m and 6-9m NR				EQ5D, + at 4m and maintained at 6-9m			
Walsall Council 2020 ³⁰		De Jong Gierveld Scale, follow-up unspecified, 52% less lonely, 13% more				5 Ways to Wellbeing +, WHO-5 +, follow-up unspecified		PHQ-9, follow-up unspecified, 6/10 +, 1/10 -	
Woodall et al. 2019 ³¹		Campaign to End Loneliness Measure, +* post-intervention				WEMWBS, EQ5D, +* post-intervention			
York CVS 2019 ³²	Measure unspecified, 21% > in volunteering at 3m	Campaign to End Loneliness Measure, +* at 3m				SWEMWBS, +* at 3m	Measure unspecified, 21% > in exercise at 3m		

Outcome summary

All but two studies^{22,27} reported wider determinants of health in the form of social connections, and/or outcomes related to health by measuring wellbeing and quality of life. These remaining two studies reported only mental health²² and physical health²⁷; the former used a mental health social value calculator, and the latter the International Physical Activity Questionnaire. Both studies indicated that participation was associated with positive outcomes on these metrics. One study included broader individual outcomes relating to social education, housing, income, wellbeing, and physiological factors; although there was limited detail on collection methods, follow up, or sampling approach¹⁵.

Social outcomes were measured with a range of tools looking at connections and loneliness, including: the Campaign to End Loneliness Tool, R-Outcomes, UCLA Loneliness Scale, ULS-8, De Jong Gierveld Scale, Work and Social Adjustment Scale, community belonging scale, social support rating, a social capital questionnaire, Likert-scale questions, and number of group memberships. Some measures were unspecified.

Of the 16 studies reporting social outcomes, six reported statistically significant improvements in measures related to loneliness or number of group memberships^{2, 20, 21, 28, 31-32}. A further seven reported improvements (with no statistical inference or clinical significance)^{1, 3, 5-6, 12, 17, 30} in social contact, work and social adjustment, loneliness/isolation, social capital, and connectedness/relationships. The picture is not universally positive; one study reported an initial improvement in the number of group memberships for participants at 4-month follow-up, but a decline at 6-9 months²⁹. Two more studies reported both positive and negative impacts on loneliness metrics across sites and cohorts^{9, 16}.

Unsurprisingly, wellbeing and quality of life outcomes were commonly included, with 27 of the 32 included studies using: the (predominantly Short) WEMWBS, ONS personal wellbeing measures, EQ5D, EQ-VAS, MYCaW, Wellbeing Star, PAM, wellbeing goal achievement measure, 5 Ways to Wellbeing, and WHO-5. Of these 27 studies, a majority of 16 reported statistically significant results across wellbeing and quality of life measures^{2-4, 10-14, 17, 21, 23-25, 28, 31-32}, and a further nine showed positive results but with no statistical inference/clinical meaningfulness^{5-8, 15-16, 19, 29-30}. Two included studies reported more mixed results. One¹⁸ reported a positive, though not 'meaningful', result for wellbeing, however quality of life declined at both 3- and 6-month follow-up. The second reported a statistically significant improvement in WEMWBS score, which was however reported as not clinically relevant²⁶.

Five of our 32 included studies reported outcome measures in other domains. Four of these five reported additional physiological outcomes (the Rockwood Frailty Scale, and change in physical activity), with the majority (3/4) reporting positive changes^{7,16,32}. Two of these five studies reported change in mental health metrics, one reporting an improvement in PHQ-9 score³⁰, another included a generic mental health measure but did not report the result¹². Lastly, one of these five studies reported a 21% increase in volunteering³².

Impact summary

Three studies included repeated follow-up with limited drop-out. Two reported statistically significant improvements in wellbeing at: post-intervention and 2 months¹⁰; and 3 months and 6 months¹¹. A third reported positive changes (with no statistical inference) in wellbeing at 3 months and 6 months¹⁸.

Of the two studies with the longest follow-up periods, one reported a statistically significant improvement in wellbeing at up to 7 months and loneliness at up to 10 months²¹, although the drop-out rates are not reported. The second, as described above, reported improvement in group memberships at 4 months but a decline at 6-9 months; and improvement in quality of life at 4 months with maintenance at 6-9 months. In this study the results for community belonging, social support, and loneliness were unreported²⁹.

CONCLUSIONS

The majority of studies included in both the platform and additional elements of this evidence summary included measures relating to social factors and wellbeing, with a smaller number including outcomes in other domains. All but two studies in our updated searches reported positive changes following engagement with social prescribing programmes, though not all were statistically significant or clinically meaningful and none were controlled studies. Of the other two, one reported a decline in the quality of life across three-time points¹⁸, the other a decline in group memberships²⁹. Very few include studies included anything but short-term follow up, and so there is a need for longer-term, controlled studies if we are to understand the impact of social prescribing more fully.

International Evidence

[In development]

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Platform element

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Appendix 1 - Additional searches, search strategy

Scopus

((TITLE-ABS-KEY ("social* prescrib*") OR TITLE-ABS-KEY ("social prescription*") OR TITLE-ABS-KEY ("community referral*") OR TITLE-ABS-KEY ("social referral*") OR TITLE-ABS-KEY ("non-medical referral*") OR TITLE-ABS-KEY ("link worker*") OR TITLE-ABS-KEY ("care navigator*"))) AND (TITLE-ABS-KEY (results OR outcomes OR measur* OR assess* OR impact OR trial OR study OR evaluat* OR intervention OR participants OR data OR longitudinal OR follow-up OR followed-up OR pre-post OR baseline)) AND NOT (perfectionism) AND NOT TITLE (review) AND PUBYEAR > 2017 AND (LIMIT-TO (AFFILCOUNTRY , "United Kingdom")))
=171

Web of Science

TS=("social* prescrib*" OR "social prescription*" OR "community referral*" OR "social referral*" OR "non-medical referral*" OR "link worker*" OR "care navigator*")
AND

TS=(results OR outcomes OR measur* OR assess* OR impact OR trial OR study OR evaluat* OR intervention OR implement* OR initiative OR participants OR data OR longitudinal OR follow-up OR followed-up OR pre-post OR baseline)

NOT TS =(perfectionism)

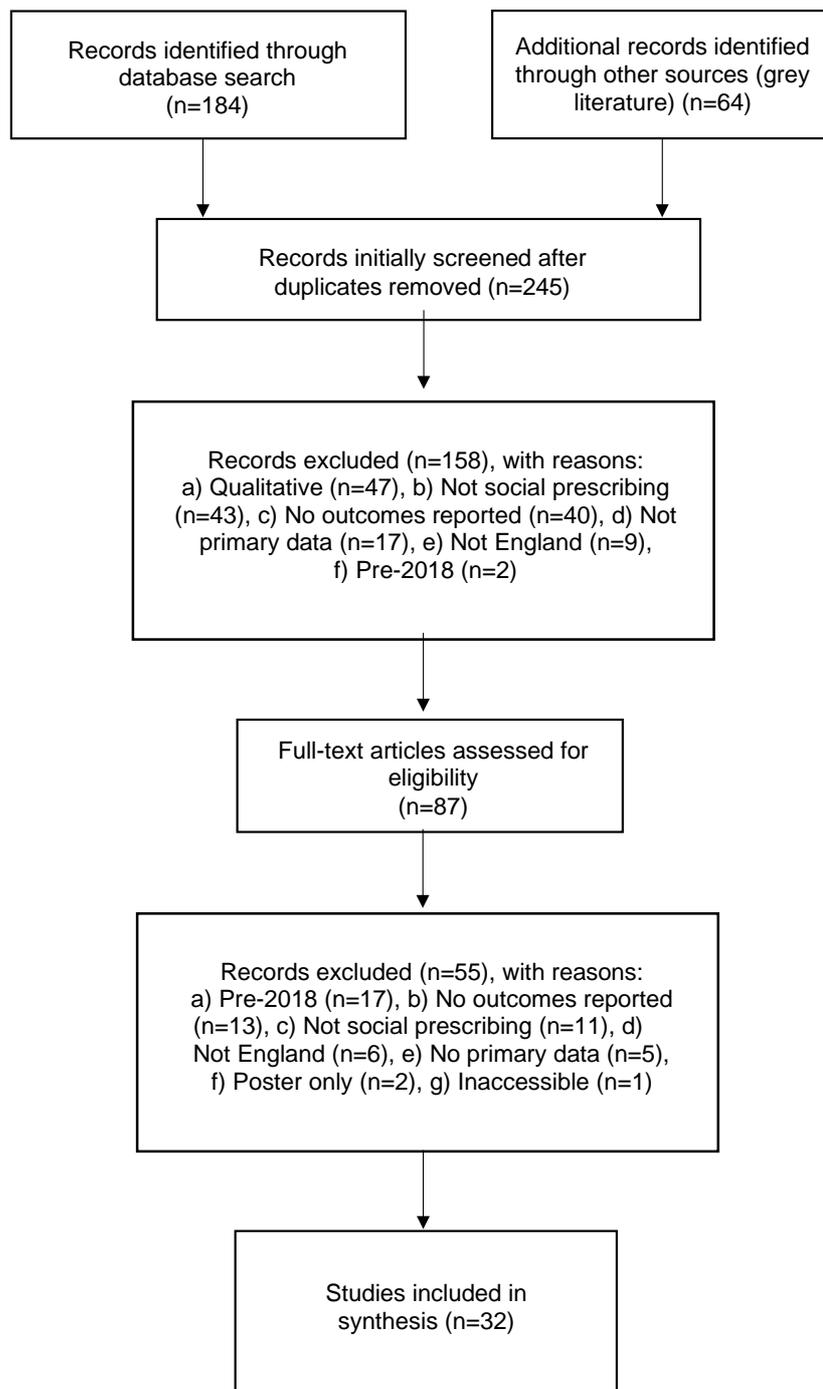
=136

Refined By:Countries/Regions: ENGLAND or SCOTLAND or WALES or IRELAND

NOT Document Types: Review Articles NOT Document Types: Letters

Appendix 2

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram for additional search element. This diagram depicts the flow of information through the different phases of this review. It shows the number of records identified, included and excluded, and the reasons for exclusions.



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