Patient and stakeholder engagement on the role that Social Prescribing might play in supporting the health and wellbeing of people diagnosed with Mild Cognitive Impairment

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This project is a collaboration of researchers within the Oxford Social Prescribing Research Network: https://socialprescribing.phc.ox.ac.uk/

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EXECUTIVE SUMMARY

There is no standardised clinical care for people with mild cognitive impairment (MCI) post-diagnosis. Social prescribing could potentially address this gap, as it enables people to access a range of non-clinical organisations and activities to support their health and wellbeing. However there has been little research on the role of social prescribing specifically for people living with MCI. This project entailed Patient and Public Involvement (PPI) in order to inform the development of future research in this area. We invited people with MCI to talk to us about their experiences of life with the condition and about any impact those memory problems had on their lives. An anonymised film of public contributors' inputs was created and shared with a range of healthcare professionals, to prompt their reflections on the potential benefits and challenges of offering social prescribing to patients with MCI. There was consensus among public and professional contributors that social prescribing could offer opportunities for patients to address social isolation and to mitigate the impacts of MCI and linked conditions (e.g. anxiety) on cognitive and social functioning. **We recommend as the next step a feasibility study to assess the acceptability and logistics of social prescribing among patients with MCI and the healthcare professionals who support them**, on a larger scale and for a more sustained period than was possible in this preliminary work.

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FUNDING

BACKGROUND

1.1. Context

Mild Cognitive Impairment (MCI) is defined as 'objective cognitive impairment on neurocognitive testing in the absence of significant impairment of instrumental activities of daily living' (1). There is no standardised clinical care for people with MCI post-diagnosis. NHS services usually commission annual reviews until either the person with MCI stabilizes cognitively or there is a diagnosis of dementia (2). Feedback from people with MCI suggests that receiving this diagnosis negatively affects their health and wellbeing (3) (4).

Social prescribing could be one means of supporting individuals with MCI. It gives healthcare professionals (HCPs) the ability to refer people to someone called a social prescriber or a link worker (other terms used include community navigator or wellbeing worker). Social prescribers have time to help people identify what matters to them in terms of their health and wellbeing. They can then connect people to relevant non-clinical services, such as local groups, organisations, charities or activities, to support their health or wellbeing (5).

Social prescribing and community-based support is one of six pillars of the Comprehensive Model of Universal Personalised Care adopted in 2019 as part of the NHS Long Term Plan (6). However, in spite of emerging evidence on the role that community-based activity might play in maintaining cognitive function (7), there has been little research on the role of social prescribing specifically for individuals living with MCI (8).

1.2. Project Aims

- Increase understanding of the unmet health and wellbeing needs of people with MCI post-diagnosis.
- Inform a feasibility study into the implementation of social prescribing to support people with MCI following diagnosis.
- Explore how individuals would like to engage with support if restrictions on face-to-face meetings continue or return.
- Build awareness of, and interest in, Patient and Public Involvement (PPI) among contributors, some of whom may agree to contribute to any subsequent feasibility study.

1.3. Consultation process (figure 1)

This was a Patient and Public Involvement (PPI) project to inform the development of future research; it therefore did not require formal review by a Research Ethics Committee. We invited people with MCI to talk to us about their experiences of life with the condition and about any impact those memory problems had on what they did, how they felt, and on their relationships with others. We then discussed support received both formally and informally and what they felt was missing to support their health and wellbeing. The second half of the discussion focussed on if and how social prescribing might help fill the gaps, and any potential challenges they could see in the practice of social prescribing.

Contributors agreed that an anonymised film of their inputs should be shared with HCPs involved in this project and that it may be used for wider dissemination. To create the film, the facilitator reviewed recordings of the discussions to determine the most prevalent themes for communication to the contributing healthcare professionals. The themes were presented as a slide show to a video producer who added imagery and movement.
The film of PPI contributions was shared and discussed with relevant healthcare professionals either in a small online group or individual conversation. We discussed with these professionals their perspectives on how social prescribing might support people with MCI, and potential challenges they saw in its implementation.
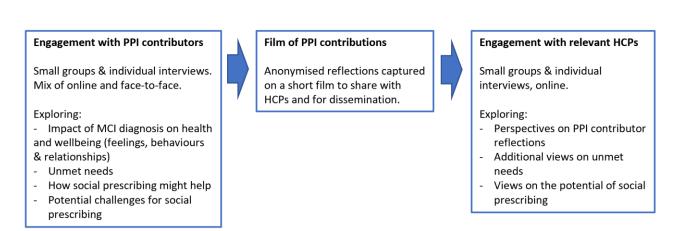

Engagement with PPI contributors

Small groups & individual interviews. Mix of online and face-to-face.

Exploring:
- Impact of MCI diagnosis on health and wellbeing (feelings, behaviours & relationships)
- Unmet needs
- How social prescribing might help
- Potential challenges for social prescribing

Film of PPI contributions

Anonymised reflections captured on a short film to share with HCPs and for dissemination.

Engagement with relevant HCPs

Small groups & individual interviews, online.

Exploring:
- Perspectives on PPI contributor reflections
- Additional views on unmet needs
- Views on the potential of social prescribing

Figure 1: Consultation process

Regular meetings of this project team have shaped the findings below and formulated ideas for how this work may be progressed in a feasibility study.

1.4. Recruitment and contributors

Table 1 provides details of participants in this project. We recruited 30 people with experience of MCI (27 as patients and 3 as family companions), the majority of whom were informed of the PPI activity by their GP surgery or memory clinic. We also invited people on the Oxford Brain Health Centre register with a diagnosis of MCI. Finally, we posted the PPI opportunity on relevant websites such as NIHR People in Research and on the NIHR Oxford Biomedical Research Centre and invited responses from people with MCI.

Healthcare professionals were recruited from amongst the project team's contacts and via an invitation in the GP Bulletin from the Oxfordshire Clinical Commissioning Group.

Table 1: Contributors to this project

	PPI contributors	Healthcare Professionals
Face-to-face	1 x group of 8, plus 3 companions 1 x group of 5, plus 1 companion 2 x groups of 3	
Online	1 x group of 4 1 x group of 2 5 x individual interviews	1 x Old Age Psychiatrist 2 x GPs 4 x Memory Clinic Nurses 3 x Social Prescribers 1 x Arts & dance programmes

PPI contributors all consented to future contact about this project, both to be informed about outputs and about future involvement in any feasibility study. Some also requested information about participating in relevant research.

No further information was systematically collected about PPI contributors, but during discussions it became clear that their experiences of life with MCI ranged from several months to ten years.

FINDINGS

2.1. Perspectives of PPI contributors (see Table 2 for a summary)

2.1.1. How MCI affects lives

Fear and anxiety symptoms were common, in terms of what the future holds and about everyday interactions with others. People with MCI that we talked to could be embarrassed by their memory problems and worried about how others perceived them. They trusted themselves less to make decisions and said how vulnerable their condition made them feel. One contributor described feeling *"less of who I am"* because of the significance of memories to a person's identity. Another contributor talked of *"feeling like I've lost a part of me"*.

PPI contributors suggested that the practical problems associated with poor memory caused frustration and fatigue. For example, previously familiar driving routes had to be looked up and written down each time they were required. Contributors who were experienced in presenting at meetings now had to prepare more thoroughly and rehearse for longer. Managing the everyday could become overwhelming.

Some people employed false bravado and complex coping strategies to carry on. However, in many cases, contributors reported a slow withdrawal from society, either to preserve their dignity or due to fatigue and apathy. Indeed, several contributors admitted to needing a push to attend this discussion group. Social withdrawal may only be recognised upon reflection; as one person said, *"the more I've talked today, the more isolated I see I've become"*. As social networks naturally diminish with age, contributors found excuses to avoid engaging in new social activities. Less social engagement could result in feeling *"invisible"*. One contributor even talked of feeling invisible in their own household where talk of dementia was culturally sensitive. Contributors also felt invisible in a health system where they perceived they were *"squeezed out"* by others with more urgent, or better understood, health problems.

Some contributors became emotional when they talked of the toll that MCI took on close relationships. Contributors mentioned the *"wear and tear"* experienced by partners who found themselves constantly repeating themselves or taking on roles previously performed by the person with MCI. For some it resulted in household friction and for many in a loss of self-esteem. Others explained how upsetting it was to appear uncaring when they forgot news or confidences shared by a best friend or partner. When close relationships were under such strain, contributors spoke of the comfort and joy they experienced in chatting to casual acquaintances, such as 'bus-stop buddies', fellow dog walkers and neighbours.

Table 2: Summary of the impact that MCI has on feelings, behaviours and relationships

Feelings	Behaviours	Relationships
• Fear and anxiety • Less of who I am • Invisible • Frustration • Embarrassment • Fatigue • Overwhelmed	• Elaborate coping strategies • False bravado • Social withdrawal • Reluctance to try new activities	• Partner wear and tear • Household friction • Role reversal • Joy from interactions with casual acquaintances

It was recognised that an individual's response to MCI may depend on their personal resilience and on the strength of their social network. Contributors worried that the situation was likely to be worse for people who were already isolated. It was notable that contributors who reported being less likely to talk about their condition with others seemed more prone to social withdrawal, whilst those happier to talk about their condition appeared more likely to attempt to carry on with life as usual. Contributors acknowledged that comorbidities such as depression, fatigue and physical mobility problems could exacerbate the negative impacts of MCI.

The label of MCI prompted different reactions. Some contributors felt that MCI *"is not mild at all"* and that the label minimised the impact of the condition. Others vacillated about

accepting the label, fearing that acceptance might be tantamount to giving up. On the other hand, many believed that accepting the label was a necessary precursor to accepting support.

2.1.2. PPI contributor priorities for improving health and wellbeing

Contributors reported little support post-diagnosis. Most were promised an annual assessment with the GP, which took place inconsistently, as recognised by the NHS (1). The memory clinic generally provided an information pack containing a Memory Tips booklet, written by the Alzheimer's Society. One or two contributors reported that the memory clinic nurse invited them to call whenever they needed a friendly ear.

Contributors were largely in agreement about unmet needs. Firstly, most recognised **the risk of social isolation** which they understood to be damaging for their brain and for their wellbeing. They felt that the solution would vary by individual and, therefore, could see the opportunity for social prescribing. They were also realistic about the need for help in establishing new behaviours given the extra challenges presented by the condition of MCI.

Secondly, contributors expressed a range of needs that may best be classified as **coping better with the everyday**; for some, the priority was combatting anxiety, while for others it was learning ways of compensating for their memory problems. This supports recent findings from a quantitative study about outcomes priorities of people with MCI (9).

Thirdly, contributors wanted **professional guidance about looking after their brain** as best they could. Often families had encouraged them to do crosswords and take exercise, but they wanted professional guidance about priorities.

Clinical care was also discussed, although it was not the subject of this project. People were vocal about the need to see the same GP to facilitate whole person assessments that looked beyond the symptoms of memory problems, into contributing factors or root causes.

2.1.3. PPI contributor suggestions for social prescriptions

2.1.3.1. Peer support group

A peer support group was the most suggested social prescription. It was felt that this could address several health and wellbeing priorities; it would connect people to others with the same experiences, making them *"feel you're part of something…. that you are not alone"*. Contributors wanted the peer support group to be a safe place where they could benefit from being able to put shame to one side and to be honest, as per their experience of this PPI discussion group. People said, *"hearing from others today has lifted me up"* and *"I'm so glad I came to this meeting today. In a way, it was like a peer support group".* At a more practical level, contributors said they would be able to learn from their peers about, for example, coping with anxiety. A facilitated group was preferred to prevent the discussion from resembling *"water receding from a beach".*

2.1.3.2. Individualised management plan

Contributors felt that social engagement ideas, coping techniques and brain health approaches could best be provided through social prescribing as an individualised management plan. Social engagement opportunities created most scepticism because contributors feared that activities would not be *"worth doing"* (e.g., personally unappealing or without evidence of efficacy in the context of their health and wellbeing needs). Doubt was expressed that worthwhile opportunities existed in more remote areas. Access to clinical trials was mentioned as a means of engaging people who were naturally less sociable in an interactive and worthwhile pursuit.

2.1.3.3. Help to implement memory techniques

Some contributors wanted face-to-face tuition to support the Memory Techniques booklet they were given. For example, one person explained how she tried to use post-it notes as described in the booklet but this ended up creating chaos. Others thought they might be unaware of further techniques which might be useful.

2.1.3.4. Engaging with support in the event of further in-person meeting restrictions

This project was due to be implemented during restrictions on in-person meetings because of COVID-19. However, workload issues in primary and secondary care caused recruitment to be delayed so PPI contributors were free to choose face-to-face or online/telephone consultations. All contributors preferred to meet in face-to-face groups, with any online/ telephone consultations being a consequence of inconvenient dates or locations. Contributors were clear that face-to-face support was superior, a view which is likely to have been strengthened by such recently imposed isolation.

2.1.4. Perceived strengths of the social prescribing process

Some contributors had heard of social prescribing, but the majority had not or did not know what it was. Once explained by the facilitator, there was general positivity about the concept and the potential benefits. However, many believed that social prescribing would carry more weight if someone was referred by a GP who clearly believed in it.

2.1.4.1. Being heard

People saw the social prescribing process as a means of being heard, something missing elsewhere in the health service. Social prescribers were perceived as individuals with the time and expertise to get to the bottom of the patient's needs. This relationship, in itself, was seen as potentially therapeutic by some.

2.1.4.2. Matching

Contributors saw value in the process of matching an individual with the right activities to meet their needs. Without this support, they could be left *"stumbling around in the dark"*,

not knowing what was available. However, contributors did raise questions about the capacity of social prescribers to identify all available opportunities in the area.

2.1.4.3. Behaviour change support

Having recognised the barriers to engaging in new activities, contributors imagined the social prescribing process would support behaviour change. However, they had different opinions about whether the social prescriber would provide the behaviour change support or whether they would arrange the support from a third sector buddying service. Some people thought that a peer support group might result in buddying relationships developing amongst group members.

2.2. Perspectives of healthcare professionals

HCPs were sent a short film summarising the reflections of the PPI contributors (appendix). For the subsequent discussion, HCPs were asked to express their own views from their experiences with patients, and to consider the following questions arising from the film:

- Can a social prescription offer patients with MCI the kind of support they seek?
- Can a social prescriber deliver the benefits of the social prescribing process that patients expect?

The views of HCPs we spoke to are as follows.

2.2.1. How MCI affects lives and patients' unmet needs

HCPs recognised the *"limbo land"* nature of a diagnosis of MCI and the lack of post-diagnostic support which PPI contributors expressed. HCPs acknowledged that a diagnosis of MCI is generally normalised, or presented as good news, in the NHS; some believed this approach to be positive for the wellbeing of patients, whilst others felt a more individualised approach may be better. There was some surprise among HCPs at the extent of patient issues around identity and invisibility, which simply reinforced to individuals we talked to just how much more could be done for such patients.

There was general acceptance of the patients' unmet needs of preventing isolation, coping better with the everyday, and guidance around looking after their brain. HCPs' perspectives on how this might be implemented via social prescribing are considered below and summarised in Table 3.

Table 3: HCP perspectives on how social prescribing might support people with MCI

Component of solution	How it might look	Questions raised/considerations
Referral pathway to social prescribing	Create a formalised referral pathway to social prescribing as standard practice. Referrals by GP, memory clinic consultant/nurse and community hospital.	• Universal access to social prescribing or postcode lottery? • Is there a will amongst GPs to do this? • Diagnosis of MCI is not consistently recorded which may lead to inequality of access to social prescribing • Consider management of movement from MCI to dementia care pathway
GP-led group as bridge to social prescribing	GP and social prescriber run post-diagnostic, face-to-face group (1 or 6?) as bridge into social prescribing for interested patients.	• Will/ capacity of GPs? • Possibility of using student OTs on placement where there are no social prescribers? • Pathway directly into social prescribing needed for those who avoid groups
Role of the social prescriber	• On-going point-of-contact for patient • Time to listen • To help the patient action their risk reduction plan with resources available in the local community • Signposting, not delivering, services • Onward referral as appropriate (e.g., to GP/ Talking Space / Community Therapy Service) • Spotting gaps in community services	• Capacity of social prescribers? • Patient information collection form for social prescribers to use with patients with MCI
Community services	• Peer support group, if not provided by GPs/ social prescribers • 3rd sector befriending service for behaviour change support • Skills workshops (e.g., computer refresher/ arts) • Health research participation • Support through religious organisations, as appropriate	• Availability of existing services? • Some community services exclude >65 years & those with memory problems • Kitemark for activities suitable for people with mild memory problems? • Lack of continuity of services
Outcome measures	• Patient wellbeing • Reduced GP appointments	

2.2.2. Referral pathway to social prescribing

There was general agreement about the need to establish a formalised referral pathway for people with MCI to facilitate any health and wellbeing interventions via social prescribing. HCPs seemed open to referrals being generated from primary and secondary care, particularly as not all patients receiving a diagnosis of MCI at a memory clinic immediately see their GP. Some HCPs pointed out that a GP may diagnose MCI in a patient without referring them to a memory clinic. The manager of arts and dance programmes in hospital settings also suggested community hospitals as referrers.

HCPs raised the following considerations. Firstly, that a diagnosis of MCI was not consistently recorded which, if ignored, could lead to inequality of patient access to social prescribing. Secondly, some GP practices did not have social prescribers, creating the risk of a *"postcode lottery"* for patients. Finally, one memory clinic nurse suggested a new process would be required to transfer a patient from any new care pathway for MCI onto the current pathway for dementia should their diagnosis progress from MCI to dementia.

2.2.3. GP-led group as bridge to social prescribing

Patients' suggestion of a peer support group resonated strongly with some HCPs because of their previous experiences with similar initiatives (see 2.3. below). In line with the importance patients attached to their GP's opinion, HCPs suggested a GP-led group might be established to introduce patients to social prescribing. Ideally it would be a programme of six sessions, but GP capacity may limit it to a single session. The purpose would be to:

- explain the condition
- provide more practical support for putting memory tips into practice
- introduce social prescribing
- provide a framework for reducing the risk of MCI progressing by highlighting the key components of brain heathy behaviours and co-morbidity management (social prescribers could then use the framework in subsequent one-to-one sessions with the patient)
- offer the opportunity for patients to consent to be re-contacted about research
- give patients the opportunity to form their own peer support network

A social prescriber involved in the project was enthusiastic about developing a peer support group in her practice. However, questions about logistics and scalability were raised. Firstly, would all GPs be sufficiently enthusiastic and/or have sufficient capacity? Memory clinics might be willing to host this group, but it was felt that they were not conveniently located for many patients. Secondly, it was recognised that not everyone likes participating in groups, therefore a referral direct to a social prescriber should be possible.

2.2.4. The role of the social prescriber

Whilst the social prescribers contributing to this project were willing to do what it takes to support this patient group, other HCPs involved felt social prescribing was a scarce, and

potentially over-stretched, resource that should be deployed carefully; colleagues advocated signposting, rather than delivering, services. They felt that the strength of social prescribers was in being there for the patient with the time to listen and support.

Some HCPs felt that the nature of the social prescriber support should be patient-driven and, where appropriate, focus on helping the patient implement a plan to reduce their risk of further cognitive decline. Components of such a plan may include social interaction, cognitive stimulation, exercise, diet and comorbidity management (e.g., hearing, anxiety). To facilitate this, social prescribers voiced the idea of an information collection form which they could use with this patient group.

HCPs were comfortable with the social prescriber monitoring the progress of patients who engaged with them. This may include regular check-ins by phone and referral back to the GP, or to other relevant clinical services, when appropriate (see the example of the Memory Loss Advice Service in 2.3 below). Everyone agreed that clinical responsibility for the patient would remain with the GP.

In response to the issues raised about social prescriber availability and capacity, one contributor suggested that a student occupational therapist (OT) seeking a placement could perform this role for patients with MCI.

2.2.5. Community services

HCPs in rural West Oxfordshire voiced concern about the availability of relevant community services and a lack of continuity of the services that do exist, which could be disruptive for patients. Elsewhere, contributors seemed more confident about the existence of suitable services, although they did highlight that some activities excluded adults older than 65 or with cognitive impairment. HCPs pointed to currently available skills workshops on topics such as computing and arts for beginners which could be checked for suitability. They liked the idea that these workshops might be suitable, rather than exclusively, for people with mild memory problems. This generated a conversation about whether a type of kitemark, or form of words, might be developed to designate suitability for people with mild memory problems. One contributor talked about how reintroducing people to their local church could help them to re-establish a supportive community. HCPs suggested that third sector organisations offering befriending services should be used to support people in attending new social activities. For people less inspired by group activities, HCPs had found participation in health research to offer cognitive stimulation and interaction.

2.3. Other models for supporting people with MCI

During discussions with the HCPs, it became clear that people with MCI had received more support in the past in Oxfordshire. There had been Memory Strategy Groups to explain in person the memory tips now provided by the Alzheimer's Society booklet. HCPs believed the greatest value of the face-to-face groups was in the peer support generated. One HCP described an OT-run support group for people with MCI in the City region of Oxford.

Outside of Oxford, Age UK Trafford in Manchester is commissioned to accept referrals of people with MCI into their social prescribing service. This service for people with MCI has recently developed into the 'Memory Loss Advice Service' which is distinct from the general social prescribing service. Much of what the Memory Loss Advice Service does is similar to their other social prescribing services. However, staff receive additional training in MCI and the service provides a weekly peer support group for patients, covering important components of health and wellbeing such as social interaction, cognitive stimulation and physical activity. Whilst there is no direct clinical oversight, staff have a clear process of contacting the patient's GP in relation to re-assessments, annual reviews or where the patient has declined the service. One of the team involved in the Memory Loss Advice Service contributed to this project. Her opinion is that the most important aspects of this work are 1) providing a single and accessible point of contact for the patient and 2) the patient's access to peers in the weekly group.

THE EXPERIENCE OF PPI CONTRIBUTORS

We have not formally evaluated the contributors' experience of involvement in this project. We will ask for feedback when we share the report with them. However, the following may suggest a positive experience:

- PPI contributors commented that they gained personally from being able to talk about their experience of living with MCI and from interacting with others with the condition.
- Everyone involved wished to receive the project report and to be informed about next steps.
- Most contributors gave written consent to be informed about other PPI or research projects relating to the health and wellbeing of people with MCI. Six individuals have subsequently taken part in a study to explore the effects of arts-based workshops on the wellbeing of people with MCI. At least one person has volunteered to take part in a PPI project to help design new tests of memory and thinking skills.

RECOMMENDATIONS FOR A FEASIBILITY STUDY INTO THE IMPLEMENTATION OF SOCIAL PRESCRIBING TO SUPPORT PEOPLE WITH MCI FOLLOWING DIAGNOSIS

In line with the project aims, the project team has considered these findings to inform research into the feasibility of incorporating social prescribing into a post-diagnostic clinical pathway for MCI.

There was consensus among PPI contributors and HCPs participating in this project that much more could be done to support patients following a diagnosis of MCI, and that social prescribing could offer opportunities for patients to address social isolation and to mitigate the impacts of MCI and linked conditions (e.g. anxiety) on cognitive and social functioning.

Diagnosis and management of MCI sits within a complex health system influenced by multiple professionals and organisations: from referral (primary care), assessment (newly established Brain Health Clinics (BHCs) as well as Memory Clinics), and diagnosis (Memory Clinic), to ongoing follow-up and monitoring (Memory Clinic and/or primary care) and opportunities for research participation (facilitated by BHCs). Implementation of social prescribing as post-diagnostic support for individuals with MCI will require cooperation and information flow between patients, social prescribers and other professionals within the system. It is currently unclear how patients with MCI might be consistently referred for social prescribing and if referrals would bring sustained benefits for these patients.

We recommend as the next step **a feasibility study to assess the acceptability and logistics of social prescribing among patients with MCI and HCPs who support them**, on a larger scale and for a more sustained period than was possible in this preliminary work.

Steps in the feasibility study to include:

- Engaging with patients at assessment (e.g. at a BHC) to introduce the idea of social prescribing and opportunities for research participation;
- Working with Memory Clinic staff to gauge their willingness to refer people with an MCI diagnosis to a social prescriber, and to recruit eligible patient research participants;
- Undertaking baseline interviews with patient research participants within a few months of their MCI diagnosis, and drawing on assessment data collected through the BHC to characterise the research sample;
- Engaging with primary care (i.e. the GP practices that support patient research participants and affiliated social prescribers) to understand local capacity for social prescribing and associated community support;
- Following up with patient research participants at 3-month intervals for a year beyond the baseline interview, to record any offers and uptake of social prescribing referrals;
- Conducting follow-up patient interviews at one year beyond baseline to record experiences of social prescribing (if any), impacts of MCI, and overall health and wellbeing since diagnosis.

Through this PPI project we have identified a small number of social prescribers and GPs who have actively endorsed the idea of social prescribing referrals for their patients with MCI. We are also aware of research-active clinicians within Oxfordshire and Buckinghamshire who could facilitate patient recruitment and staff involvement in the planned feasibility study. We would seek to involve these engaged professionals in the next phase of work. Working with multiple Memory Clinic and Primary Care sites will enable comparisons across contexts, to highlight any local variations in barriers and enablers for establishing social prescribing as part of post-diagnostic support for patients with MCI.

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APPENDICES

1.   Film created from PPI contributors' feedback, available on YouTube: https://www.youtube.com/watch?v=4oPvc0KaJdE&t=7s

The film is also viewable on the project webpage for the Applied Research Collaboration Oxford and Thames Valley: https://www.arc-oxtv.nihr.ac.uk/research/social_prescribing_and_mild_cognitive_impairement

2.   Blog published on the Oxford Social Prescribing Research Network's website, 'Patient perspectives on the role of social prescribing for Mild Cognitive Impairment (MCI)': https://socialprescribing.phc.ox.ac.uk/news-views/views/patient-perspectives-on-the-role-of-social-prescribing-for-mild-cognitive-impairment-mci

This and other project outputs can be viewed on the project webpage hosted by the Oxford Social Prescribing Research Network: https://socialprescribing.phc.ox.ac.uk/research/projects/patient-and-stakeholder-engagement-project-the-potential-of-social-prescribing-in-supporting-the-health-and-wellbeing-of-people-diagnosed-with-mild-cognitive-impairment-mci