

Building Capacity for the Evaluation of Social Prescribing

Evaluability Assessment



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



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Section 1: Introduction and Context

1.1 INTRODUCTION

In August 2019, S3 Solutions and Elemental were commissioned by Health and Wellbeing, Health Service Executive, the National Office of Suicide Prevention and the Department of Health to conduct an evaluability assessment of Social Prescribing in Ireland. This assessment is a key input to the development of a monitoring and evaluation framework for Social Prescribing in Ireland.

The evaluability assessment within this report is limited to twelve Social Prescribing projects in operation in Ireland identified by the HSE at the project commencement stage.

1.2 OBJECTIVES

The objectives of this project were, to undertake an evaluability assessment of Social Prescribing projects in Ireland by:

1. Providing an overview and synthesis of current Social Prescribing services and programmes in Ireland in terms of the underlying theory of change and programme logic models
2. Assessing the capacity of the current Social Prescribing system in Ireland to collect process, output and outcome data to support impact evaluation.
3. Developing a Minimum Data Outcomes Framework for Social Prescribing services in Ireland, using a consensus-based methodology, and providing recommendations on how to establish a system to collate and report on outcomes nationally.

1.3 REPORT STRUCTURE

This report is framed around the three dimensions of Evaluability Assessment (Davies, 2013)¹, including:

- a. Evaluability in principle (i.e. clarity of the intervention and its theory of change)
- b. Evaluability in practice (i.e. what data are available and what systems are in place to provide it)
- c. Evaluability usefulness (i.e. what interest do stakeholders have in using evaluation findings for example, to enable strategic decision making).

Applying this structure, the report also includes:

- An examination of the Social Prescribing landscape in Ireland
- An Evaluation Index, developed by S3 Solutions and Elemental, to show the current range of evaluation practice in Ireland
- Knowledge and learning from other systems, models, policy and practice around Social Prescribing
- The Primary Care landscape and strategic context within which Social Prescribing operates in Ireland
- The consensus based feedback on a Minimum Data Outcomes Framework for Social Prescribing in Ireland.

¹ Davies, R. (2013). Planning evaluability assessments. a synthesis of the literature with recommendations. DFID Working paper 40. Cambridge, UK: Department for International Development

1.4 WHAT IS SOCIAL PRESCRIBING?

There are many definitions and descriptions of Social Prescribing. For the purposes of this report, the definition employed by the All Island Social Prescribing Network was considered the most useful. This Network is a body established to share knowledge and best practice, to support Social Prescribing at local and national levels and inform good quality research and evaluation.

Social Prescribing is a means of enabling GPs and other frontline healthcare professionals to refer patients to a Link Worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector. It is an innovative and growing movement, with the potential to reduce the financial burden on the NHS and particularly on Primary Care².

In most cases, Social Prescribing focuses on:

- addressing the social determinants of health
- a referral to a Link Worker 'The essential item in Social Prescribing is the Social Prescribing Link Worker, who has the time and the personality to see the patient and refer to a menu of possible options'³
- the resources of the health, local government and community & voluntary sectors working together to provide a sustainable solution
- the presence of a high-quality range of local community assets to facilitate a referral to non-medical support for issues that underpin or exacerbate medical issues, and
- evaluation – measuring the impact of the Social Prescribing process in providing a suitable outcome and proving the case for funding.

1.5. WHAT IS AN EVALUABILITY ASSESSMENT?

Evaluability assessment (EA) is a systematic approach to planning an evaluation of projects. It seeks to assess:

"the extent to which an activity or project can be evaluated in a reliable or credible fashion"⁴

An evaluability assessment is designed to enable informed and strategic decisions to be made about whether and how to evaluate a programme or policy in a reliable and credible way (Wholey 1979)⁵. An evaluability assessment is not an evaluation, however, it is likely to have consequences for how an evaluation is designed, the framework against which monitoring and evaluation is carried out and sometimes on the design of a project or intervention itself.

1.6 METHODOLOGY

This evaluability assessment is informed by the following activity, carried out between August 2019 and March 2020.

1.6.1. Data Collection

A mixed method approach was used comprising semi-structured interview, small group discussion and online survey. A consultation framework was developed following an initial meeting with members of the project steering group (see 9.5).

An initial sample of twelve Social Prescribing projects were identified by the HSE, all of which are currently funded by the HSE, Department of Health and/or Healthy Ireland, to deliver Social Prescribing services in Ireland. One of the twelve projects includes six unique Social Prescribing services – each with different experiences and contributions. The following summarises the key data collection activity:

- The research team travelled to the project locations across Ireland to carry out interviews. Twelve semi-structured interviews and/or group discussions were facilitated, and 29 individuals contributed to these discussions. Participants included: Social Prescribing Link Workers (n = 12), Primary Care professionals such as mental health liaison nurses (n = 3), management staff within host organisations such as Family Resource Centre coordinators (n = 8), staff from community and voluntary sector service providers (n = 2) and Social Prescribing beneficiaries (n = 4).
- Four members of the research team attended (as both speakers and participants) the All-Ireland Social Prescribing Conference in December 2019. The researchers participated in small group discussions with other attendees (organised by the conference). In addition, the conference was used to distribute an online survey to delegates (10 responses were received).
- One member of the research team attended and participated in a small group discussion at a regional Social Prescribing event in October 2019. Participants included stakeholders involved in Social Prescribing and/or community health projects. The event was hosted by HSE representatives and community and voluntary sector organisations in CHO1 (Community Healthcare Organisation Area 1).
- A structured review of qualitative research studies and policy documentation in relation to Social Prescribing and wider health agenda in Ireland and in the UK was completed. An initial list of relevant research reports and policy documents were provided by members of the steering group. The following resources were used to search for relevant research, papers or reviews on the evaluability of Social Prescribing, evaluation of Social Prescribing and theory of change/ outcomes/measuring impact within Social Prescribing:

² <https://www.socialprescribingnetwork.com/>

³ GLA, Better Health For All Londoners: Consultation on the London Health Inequalities Strategy (August 2017) https://www.london.gov.uk/sites/default/files/draft_health_inequalities_strategy_2017.pdf

⁴ OECD-DAC (2010) Glossary of key terms in evaluation and results-based management. Paris: OECD-DAC.

⁵ Wholey, J. S. (1979). Evaluation: Promise and performance. Washington, DC: The Urban Institute

- National Institute for Health and Care Excellence (NICE)⁶
- NHS Evidence⁷
- Social Care Institute for Excellence⁸
- The National Lottery Community Fund⁹
- The Kings Fund¹⁰
- NESTA¹¹

The researchers also searched Google to identify any relevant grey literature whilst the reference lists of relevant research reports were used to identify any additional studies or research of interest. The review of literature was used to identify current practice and how it may relate to Social Prescribing in Ireland and lessons to be learned from elsewhere.

- A further eight semi-structured interviews and/or small group discussions were carried out with individuals that have been involved in developing, delivering, funding or researching Social Prescribing projects. Individuals were identified by members of the steering group and through researchers existing network of contacts. See appendix 2 for a list of organisations/individuals that contributed to the research.
- Facilitation of a co-production event focused on the development of a Minimum Data Outcomes Framework, attended by 24 stakeholders including Social Prescribing Link Workers, statutory agencies and community and voluntary sector representatives.

1.6.2. Data Analysis

Qualitative data analysis was conducted using both thematic and narrative approaches¹². Categories were developed, coded and reduced. Survey data, researchers' observations and thematic data from interviews was cross referenced in order to identify emergent themes and issues and to explore the relationships between issues¹³. Participant sampling and data collection continued until no new conceptual insights were generated and the research team felt they had gathered repeated evidence for the thematic analysis.

1.6.3. Consensus Based Methodology

The principles of co-production and consensus based methodology were applied in the following ways:

- Co-design of consultation framework with project steering group
- Presentation of early thematic findings to relevant audience (at All Ireland Conference) seeking feedback on emerging concepts and themes (i.e. Evaluation Index)
- Re-configuration of emerging themes which were further tested through additional semi-structured interviews

- Three meetings of the project steering group to reflect on findings and shape the direction of the research
- Facilitation of a co-design workshop involving 24 stakeholders to agree 'minimum outcomes'

Over 280 stakeholders were engaged in the surveys, focus groups, conference sessions, workshops and meetings undertaken as part of this commission. A list of organisations represented in this consultation is included in Appendix 2.

1.7. LIMITATIONS

Efforts have been made to ensure the validity and reliability of findings through multiple method consultation. One area of limitation is in the extent of engagement from GPs and Primary Care professionals. Input from these sectors was primarily by those already involved in the Social Prescribing Network and therefore already advocates of Social Prescribing. Attempts were made to engage a network of GPs through the Department of Health, however the planned engagements to test findings and scrutinize the Minimum Data Outcomes Framework coincided with the outbreak of COVID-19 and understandably reduced the potential for Primary Care professionals to input. This is now proposed as a recommendation.

The semi-structured interviews and focus groups during site visits focused primarily on Social Prescribing Link Workers and managers of community & voluntary organisations. The process included minimal amount of service user involvement, offering a potential limitation regarding the effect of adding new data collection processes to a Social Prescribing service.

1.8. SUMMARY

The objective of this project is not to evaluate Social Prescribing in Ireland, nor is it intended to be a guidance document on how to carry out evaluation of Social Prescribing. Moreover, the report documents an assessment of the evaluability of Social Prescribing, and the current capacities of the Social Prescribing system & stakeholders to collect data that would enable effective evaluation. Some of the emerging concepts, such as the Evaluation Index and the Minimum Data Outcomes Framework may well assist new and existing projects with evaluation design.

1.9. COVID-19

Data collection for this report was completed before COVID-19 restrictions were introduced. We understand that the requirement to move services online and operate digitally may have implications for evaluation. We are aware that in some cases, referrals to Social Prescribing projects have increased significantly. GP practices and Primary Care Networks in England have used text messages to contact their patients with a link to a self-referral form that enabled patients to self-refer directly to Link Workers rather than having to visit GPs for support. We are unclear how Social Prescribing projects are adapting evaluation practice in response to COVID but it may have implications for how the findings of this report are implemented in the coming months.

6 <https://www.nice.org.uk/>

7 <https://www.evidence.nhs.uk/>

8 <https://www.scie.org.uk/atoz>

9 <https://www.tnlcommunityfund.org.uk/insights/social-prescribing>

10 <https://www.kingsfund.org.uk/search?search=social+prescribing>

11 <https://www.nesta.org.uk/report/>

12 Lewis-Beck, M. S., Bryman, A. & Liao, T. F. (Eds.) (2004). The SAGE encyclopaedia of social science research methods (Vols. 1-3). Thousand Oaks, CA: SAGE Publications

13 Morgan, D. L. (1997). Focus groups as qualitative research (2nd ed.). Thousand Oaks, CA: Sage.

Section 2: Social Prescribing Landscape

2.1. OVERVIEW OF SOCIAL PRESCRIBING IN IRELAND

At the time of commission (August 2019), this Evaluability Assessment focused on twelve Social Prescribing projects funded by the HSE (Health and Wellbeing and National Office for Suicide Prevention and Healthy Ireland, DoH). These projects were targeted for site visits by the research team. Two of the projects are located in Primary Care settings, and ten in community and voluntary sector settings. See Appendix 1 for detail on the twelve projects.

During the course of this evaluability assessment, the number of Social Prescribing projects in Ireland increased. A €20m 'Sláintecare' Integration fund was launched by the Department of Health in March 2019¹⁴ and in September 2019, 122 successful projects were announced, including the expansion of three existing Social Prescribing projects and the introduction of six new projects that either explicitly define themselves as Social Prescribing or involve community referral process through a designated worker and thus align to the principles of Social Prescribing¹⁵.

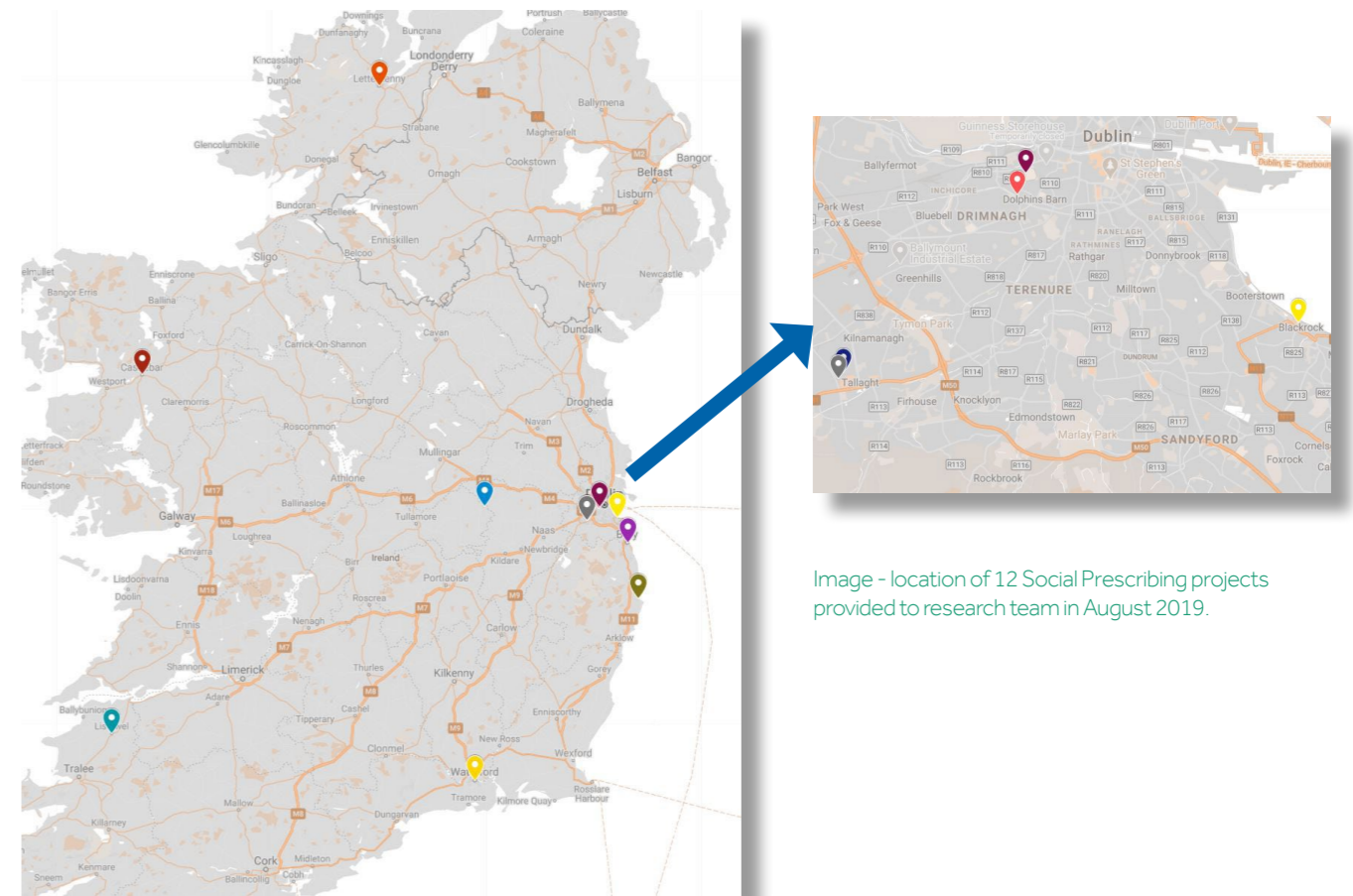


Image - location of 12 Social Prescribing projects provided to research team in August 2019.

¹⁴ <https://www.gov.ie/en/press-release/a98320-minister-for-health-announces-20-million-funding-for-122-slaintecare/>
¹⁵ <https://www.gov.ie/en/press-release/a98320-minister-for-health-announces-20-million-funding-for-122-slaintecare/>

Section 3: Evaluability in Principle

3.1. INTRODUCTION

Evaluability in principle relates to the nature of an intervention design¹⁶, and the extent to which it has a plausible, theoretically sound, theory of change. It questions if there a clear understanding of how and why the intervention's desired changes are expected to happen in a particular context. In this case, is the theory of change for Social Prescribing in Ireland plausible?

Evaluability in principle focuses on whether it is possible to evaluate the intervention as has been described or is being implemented.

3.2. SOCIAL PRESCRIBING IN IRELAND: EVALUABILITY IN PRINCIPLE

A key purpose of the consultations with projects was to articulate the underlying theory of change for Social Prescribing in Ireland. The logic model framework was used to guide these conversations. The following key points were taken from the thematic analysis of interviews carried out during site visits to the Social Prescribing projects.

1. The main participant groups accessing the projects in this assessment are those with mild or long term mental health problems, depression, anxiety, vulnerable groups (e.g. single parents), people who are socially isolated, and those who frequently attend either primary or secondary health services.
2. Those interviewed asserted the view that an individual's health is determined primarily by a range of social, economic, and environmental factors. Thus, Social Prescribing interventions aim to help participants to take control of their own health and address their specific or person centred needs in a holistic way.
3. The role of the Link Worker and particularly the initial assessment and follow up meetings were cited consistently as having psychosocial or therapeutic attributes in themselves. The in-depth initial assessments involve an exploration of 'root causes' of an issue, motivational interviewing and goal setting. Some Link Workers make appointments on behalf of participants and accompany them to appointments or activities, and some continue to meet participants over an extended period of time depending on need. Kimberlee (2015)¹⁷ classified Social Prescribing models into signposting, light, medium and holistic, according to a range of aspects and the level of support provided by Link Workers to patients. The projects analysed in Ireland primarily align with the 'holistic' model which includes a clear referral pathway, a holistic view of a person's needs and aspirations, and an intense level of support provided by the Link Worker.
4. All stakeholders interviewed referred to improvements in emotional health, wellbeing, and social connectedness as being the primary outcomes for individuals. These outcomes were referred to as observable (and therefore measurable) changes in behaviours, experiences and circumstances. These improvements are, it is hypothesised, the result of the interaction between the Link Worker and person as well as the community or health based service and the person.

¹⁶ Davies, R. (2013). Planning evaluability assessments. a synthesis of the literature with recommendations. DFID Working paper 40. Cambridge, UK: Department for International Development

¹⁷ Kimberlee R. 2015: What is social prescribing? Advances in Social Sciences Research Journal 2, 1

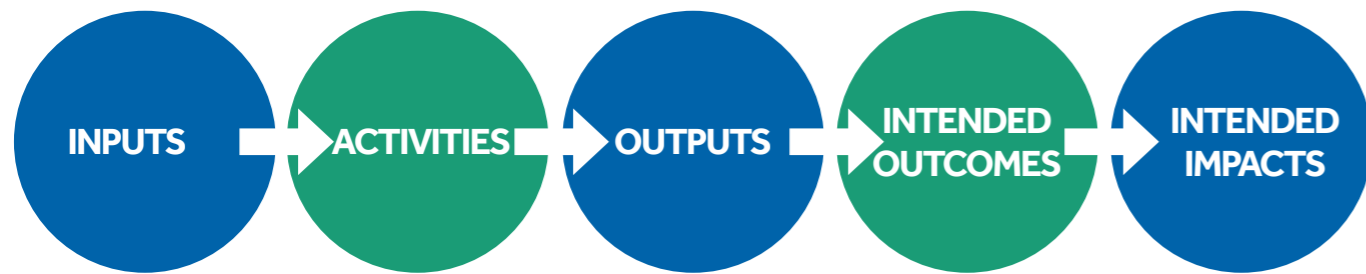
5. Participants also referenced other (often unintended) outcomes including improved employment status of individuals, skills acquisition, improved income through accessing appropriate welfare entitlement, improved housing/accommodation and improved family and other relationships.
6. The projects consistently referred to a belief that the improvements arising from a Social Prescribing project (such as reduced anxiety, reduced isolation and improvements in connections) results in a reduction in demand for primary and community care and thus offers resource savings and a contribution to the long-term sustainability of 'the system' (i.e. the healthcare system). But, given that funders are not directly involved in the interaction within the Social Prescribing process, they require data to evidence the anticipated/expected outcomes and to demonstrate a more nuanced understanding of the intervention i.e. what works for whom in what context. There was only one project that could provide evidence of outcomes at a systems level during the consultation. This evidence relates to a reduction in a mental health waiting list from 40 to 6 over an 18 month period of time. This was reported directly by a mental health liaison nurse who attributed much of this reduction to the availability of the Social Prescribing Link Worker: "I have been able to refer people on the waiting list to [SP Link Worker] and those people have not come back onto my waiting list". This evidence was collated directly by the mental health liaison nurse and shared with the researchers because of a personal belief in the potential of Social Prescribing.
7. Those interviewed expressed the opinion that the exchange between the Link Worker and the participant is the key mechanism for change in the Social Prescribing process. The premise is that this interaction produces the impetus and, in some cases, the desired change itself (i.e. an improvement in the person's wellbeing, situation or circumstances).
8. The level or intensity of the Link Workers intervention varies from project to project, it may therefore be challenging to measure attribution. A consistent approach to evaluation could enable an analysis or comparison of the effectiveness of varying approaches.
 - a. Interviews identified variance in the role of the Link Worker. In addition to the initial assessment meeting (as per point 3 above), there were examples (n = 5) where the Link Worker directly establishes and facilitates interventions. Examples of interventions include: 8 week therapy based workshops delivered by the Link Worker, weekly walking groups or exercise classes, arts and crafts workshops facilitated by the Link Worker. Where there is evidence of direct intervention beyond the initial therapeutic assessment, there may be a stronger association between the role of the Link Worker, and a positive outcome or otherwise. Conversely, in some cases the Link Worker role is more of a signposting function, this tended to be the case for projects that are located in Primary Care rather than community settings.

- b. The vast majority of participants are referred to one or multiple community based services. The onward referrals are usually nonclinical interventions, offering activities or programmes seeking to benefit the health and wellbeing of participants with social, emotional or practical needs. The implication for evaluation is in the attribution or contribution to an outcome or change (if applicable). Where a positive outcome is achieved and can be evidenced, it will raise the questions: 'to what extent was the change caused by the intervention of the Link Worker, or by the community based service'? and does it actually matter? This is likely to be a challenge for any evaluation of Social Prescribing projects but could potentially be captured through qualitative evaluation methods.
9. The inclusion of self-referrals (i.e. where a participant makes direct contact with the Social Prescribing project and does not come through Primary Care or community services) within evaluation was raised by four stakeholders as having the potential to create bias and 'distort results because of a perceived pre-existing motivation for change'. The majority of the projects (n=8) accept self-referrals. For most of these (n = 6), this was primarily due to the limited participation of GPs and Primary Care Teams within the Social Prescribing projects and therefore minimal referrals received from these sources. Alternatively self-referrals could be a very interesting comparison group.

Each of the points above has been coalesced into a summary theory of change for Social Prescribing in Ireland (based on the projects). This theory of change is presented using the Logic Model overleaf.

Logic Model: Social Prescribing

The resources needed to deliver the project	The planned activities that can be accomplished with the available resources	If the planned activities are accomplished, the intended amount of product and/or service delivered to the beneficiaries	If the planned activities are accomplished, to the extent that is intended, then the beneficiaries will benefit in certain ways	If the benefits to beneficiaries are achieved, then certain changes in organisations, communities or systems might be expected to occur
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Investment in a Social Prescribing Link Worker	Receive referrals for participants in need of support	Circa 60-90 participants per annum access therapeutic and holistic 1-1 support	Participants will <ul style="list-style-type: none"> • Reduce anxiety and stress • Improve mental and emotional wellbeing • Be more socially connected • Have increased confidence • Volunteer • Improve physical health and wellbeing • Have greater control over their health 	Reduced pressure and demand on primary care waiting lists
Developing links with C&V sector, Primary Care teams and others to receive referrals	Facilitate in-depth initial assessments with therapeutic component, motivational interviewing, goal setting	Circa 60-90 people per annum access appropriate non clinical interventions		Contribution to resource savings and thus long term sustainability of health system
Establishing referral destinations to appropriate, bona fide, locally based services	Signpost to appropriate services, provide support to access or organise and deliver services directly, provide ongoing support	C&V and others are providing services to people that need them		More non clinical care delivered directly in communities through local organisations

Section 4: Evaluability in Practice

4.1. INTRODUCTION

Evaluability in practice considers the availability of relevant data and the systems needed to make that data available. Evaluability depends on access to data and the practicality and cost of collecting it. The consultation, conducted as part of this project, explored existing approaches to evaluation across the twelve projects as well as other evaluation activity in relation to Social Prescribing in Ireland. Across the projects, there is significantly more evidence of data collection at the individual level than at a system level (i.e. healthcare system or community and voluntary sector). However, such evidence is mostly focused on anecdotal and qualitative information and is likely to include bias and unlikely to be acceptable to commissioners in terms of future funding in a more sustainable way. The following summary points are noted:

1. All projects are gathering quantitative data relating to number and profile of participants, number of engagements, referral sources and destinations, uptake of referrals etc. These are in the main gathered by Link Workers and stored on secure spreadsheets within a host organisations operating system – usually a community and voluntary organisation. Three of the twelve projects are using a purpose built digital tool to collate and store data.
2. Six projects are using qualitative and anecdotal participant feedback as their main source of evidence. All projects can draw on powerful and impactful participant case studies that highlight changes in for example, mental and emotional wellbeing, social connectedness, volunteering, employment etc. Projects are typically using self-developed case study templates and information is usually gathered directly by Link Workers. In the main, case studies are used to promote the service or develop connections and links to potential inward and outward referral agents.
3. Six projects are using validated tools to gather pre and post data on participant wellbeing outcomes. This data is typically gathered by Link Workers at initial assessment and follow ups occur either face to face or via telephone, usually at 6 week, 12 week or 6 month intervals. The range of tools currently being used by projects include:
 - a. The World Health Organisation- Five Wellbeing Index (WHO-5)¹⁸
 - b. Shortened Warwick Edinburgh Mental Wellbeing Scale¹⁹
 - c. Wheel of Life Coaching Tool or Wellbeing Star²⁰
 - d. Measure Yourself Concerns and Wellbeing (MYCAW)²¹
 - e. Hospital Anxiety and Depression Scale (HADS)²²

4. Three projects had external and independent evaluations conducted on their work. Two of the evaluations were still ongoing at the time of this report, one was completed in 2015. In the 2015 evaluation, findings highlight statistically significant positive changes in the scores for wellbeing, anxiety depression and community involvement. GP visits also reduced for participants. Qualitative data backed up quantitative findings enabling the evaluation to conclude that “Social Prescribing..... has shown very positive results for participants and other stakeholders”. This work has provided the impetus for the development and funding of several of the other Social Prescribing projects²³.
5. Three projects reported that they are storing pre and post data, from both validated tools or from their own developed surveys, on excel spreadsheets, but are not using or analysing the data. The three projects using a digital system to manage data, are also using validated tools.
6. Despite the majority of projects reporting a belief that their Social Prescribing projects are achieving outcomes at the ‘system level’ (i.e. GP attendance, Waiting Lists, ED attendance), only two projects located in non-Primary Care settings had data to support this. These data sources included mental health assessment waiting lists and GP attendances. This was perceived as a major barrier for most projects.
7. A randomised control trial (RCT) is currently ongoing in Ireland. RCSI (Dept. of General Practice, Royal College of Surgeons) is examining the effectiveness of Link Workers on improving the health and wellbeing of individuals with multi-morbidity. It is also examining the impact of Link Workers on healthcare utilisation of individuals with multimorbidity. This is a multi-site study with Link Workers based in GP practices in Dublin, Cork, Waterford and Limerick.

4.2. EVALUATION INDEX

To capture the breadth of current evaluation approaches in Ireland, S3 Solutions and Elemental devised an ‘Evaluation Index’ (EI), presented overleaf. This is similar to the recognised levels of scientific evidence²⁴. The EI was designed to help frame the summary of the conversations on how projects are currently measuring the outcomes and impacts of Social Prescribing. It is not intended as a method for completing evaluations nor is it a hierarchical progression pathway of evaluation. All approaches to evaluation can be considered valid depending on the purpose and objective of that evaluation. By framing ‘where we are now’ in relation to evaluation practice, the EI assists in the identification of areas for development.

The EI shows five approaches to evaluation currently used by Social Prescribing projects. These range from gathering standard quantitative data combined with anecdotal participant case studies at ‘Approach one’ through to Randomised Control Trials at ‘Approach five’. Currently, three projects are identified as adopting ‘Approach four’ (only one of these is a community based setting), three projects at ‘Approach three’ and the remainder (six projects) between ‘Approaches one and two’. Thus, evaluation in Ireland largely aligns with Bickerdike et al (2017)²⁵ who concluded there was insufficient methodologically robust evidence to assess success or value for money in Social Prescribing.

18 <https://www.corc.uk.net/outcome-experience-measures/the-world-health-organisation-five-well-being-index-who-5/>

19 <https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/research/validation>

20 <https://fabnhsstuff.net/fab-stuff/the-well-being-star>

21 <http://www.bris.ac.uk/primaryhealthcare/resources/mymop/sisters/>

22 <https://www.svri.org/sites/default/files/attachments/2016-01-13/HADS.pdf>

23 Donegal: Social Prescribing for Health and Wellbeing Evaluation Report (2015) Evaluation of six social prescribing demonstration sites across County Donegal, involving

24 <https://libguides.winona.edu/c.php?g=11614&p=61584>

25 Bickerdike L, Booth A, Wilson PM, et al. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open* 2017; 7(4)

Evaluation Features	Approach 1	Approach 2	Approach 3	Approach 4	Approach 5
Collects quantitative data including participant numbers, demographic profiles, activity levels, referral sources	✓	✓	✓	✓	✓
Gathers qualitative data anecdotally, usually as case studies to be included in internal report documents	✓	✓	✓	✓	✓
Gathers data on medical conditions of referrals	—	✓	✓	✓	✓
Uses internally developed surveys to gather perceived wellbeing data	✗	✓	✗	✗	✗
Uses validated tools to gather pre and post data on participant wellbeing outcomes	✗	✗	✓	✓	✓
Data and outcomes evaluated independently and externally	✗	—	—	✓	✓
Collects and shares clinical data with PCTs on waiting lists, clinical outcomes, attendances	✗	✗	✗	✓	✓
Compares data with national data sets or randomized control group, findings externally verified	✗	✗	✗	✗	✓



Key Finding

It is fair to say that no single Social Prescribing model exists in Ireland. The EI was shared with Social Prescribing stakeholders via survey and telephone interviews to identify the preferred approach to evaluation.

Stakeholders indicated that 'Approach 3' should represent a preferred approach (including independent evaluation) with Approach 4' representing the ideal or aspirational approach to evaluation.

The main barriers preventing projects operating at Approaches 3 and 4 include: lack of capacity to carry out analysis of data, and/or lack of relationship/engagement with Primary Care Teams to access 'system' data. This is explored further.

4.3. PRACTICAL IMPLICATIONS FOR EI APPROACHES

There are variances in the twelve Social Prescribing projects consulted in this assessment, each of which has potential implications for the development and implementation of an 'Approach three and four' evaluation. These include:

4.3.1. Relationship with GPs and Primary Care professionals

Whilst most projects have received some level of referral from Primary Care settings, four projects reported positive working relationships between Primary Care Teams and their Social Prescribing project in relation to evaluation. This includes sharing waiting list data and providing referrals to Link Workers (e.g. Listowel in County Kerry). There are examples of Social Prescribing services located within the same County but reporting significantly different relationships with their respective Primary Care Teams. These relationships appear to be reliant on the personal approach of individuals within specific projects/areas and were identified as a significant factor impacting on referrals to Social Prescribing. The perception is that further evidence is required by Primary Care Teams of the merits and outcomes of Social Prescribing before fully 'buying in', but in the absence of referrals and 'system data', how can that evidence be gathered?. It is noteworthy that those with fewer levels of referrals from Primary Care Teams are more reliant on anecdotal evaluation evidence.

The location of a Link Worker (i.e. who employs the Link Worker) may influence the relationship with Primary Care Teams and therefore the extent to which a project can access data on waiting lists, GP attendances or other clinical data that might speak to the cost benefit of the intervention. The majority of projects (10) who engaged in this process were located in a community setting, frequently within a Family Resource Centre or a local community development organisation. Four projects reported a positive working relationship with Primary Care Teams compared to eight projects reporting negative or no relationship. The reliance on personal relationships to access 'system' data is not a long term sustainable solution. The lack of access to system data may impede future 'Approach 4' evaluation efforts.

4.3.2. Project Resources

Eleven of the twelve projects reported employing part time Link Workers at the time of site visits, with five of those projects now employing full time Link Workers (result of funding from Sláintecare). Part time hours vary from 12 to 24 hours per week. The average case load for Link Workers was estimated to be in the range of 60–90 per annum, depending on the extent of the Link Worker role (i.e. delivery and/or signposting) and the number of hours worked.

There was significant variation in the duration of the Social Prescribing intervention with reports varying from 1-2 weeks to as long as 6-9 months of engagement. The approach across all projects is very much person centred with a consistent underlying principle of ‘moving people on’ at the earliest appropriate moment. The focus across projects is in empowering participants rather than creating a reliance. All Link Workers reported that the priority focus within their limited hours was on engaging participants and that an extremely limited amount of time was attributed to administration and subsequently to evaluation. Most Link Workers reported doing more than their allocated paid hours in order to manage and administer workloads. This creates a potential challenge for any enhanced data collection responsibilities.

4.3.3. Capacity for Evaluation and Data Collection

Eight projects referenced the need for training, capacity building and/or support in terms of implementing evaluation practice. Understanding outcomes and how to use validated tools were cited as key challenges.

Furthermore, Link Workers are employed by a variety of host organisations, some carry out another role on 2 or 3 days per week. Each organisation has its own existing monitoring and reporting responsibilities, often determined by funders, and therefore an integrated or complementary data collection system is an important consideration in any future framework. The majority of projects (n = 8) identified that they operate the Social Prescribing project ‘at a loss’ with no management fee or contribution to core overhead costs, therefore investing in evaluation based resources or support is down the list of priorities.

Many Link Workers also expressed concern that ‘*evaluation could subsume the intervention*’ which ‘*appears counter intuitive given the principles of how Social Prescribing should work*’. Training on the appropriate and subtle use of validated tools for data collection will be an important consideration for future evaluation.

4.3.4. Funding Environment

The projects engaged were funded from several sources including HSE Health & Wellbeing, HSE National Office of Suicide Prevention, Healthy Ireland, SICAP (Social Inclusion and Community Activation Projects) and some received ‘top up’ funds from Sláintecare. All projects at the time of visit were funded on an annual basis meaning that Link Workers are placed on statutory notice in February/March each year, increasing the risk that they may move on. This is important in a highly person centred and relationship based intervention.

This report acknowledges that different approaches to evaluation have different uses for different stakeholders. For projects, participant outcomes, service improvement outcomes and funding security are of primary concern, therefore EI Approaches 2-3 may be sufficient. For funders and Primary Care Team’s,

value for money and resource savings may be a priority and therefore Approaches 3-4 may be essential. Clarity in terms of what is expected from evaluation by funders will assist projects with evaluation design and implementation.

4.3.5. Systems for Data Collection

The experience of the existing network of projects is a variety of data management systems and processes. Most are using basic technical systems including Microsoft Excel to store and manage project data whilst three are using a purpose built digital system to manage projects in their entirety. Some sectors are already more advanced than others. It is important to note that whilst an area may be advanced in its Social Prescribing ecosystem and delivery model, it may be primitive in terms of having fit for purpose systems. It is evident that the projects involved in this study in the main, do not have budgets to invest in IT to make themselves “digitally enabled”, to spend on staff or volunteer training, nor are they sufficiently resourced to commission independent support with evaluation. The implication for evaluation currently is that data is likely to be provided in a wide variety of formats making it difficult to compare and analyse.

4.4. SUMMARY OF KEY FINDINGS: EVALUABILITY IN PRACTICE

- **Everyone involved in the process associated with this project is supportive of the need for a Minimum Data Outcomes Framework** and is committed to building more evidence for Social Prescribing. To this end it is essential to work towards embedding (outcome) data collection into service delivery.
- **There appears to be ‘buy in’ from both commissioners and practitioners** for guidance around the evaluation of Social Prescribing in a **more accessible, clear and structured way**.
- **Uncertainty remains around what to measure, how to measure it and which tools should be used.**
- There are challenges around the **capacity and resources of organisations** to measure outcomes and impacts.
- **The importance of shared resources and shared learning** for evaluation was identified as crucial.
- There are **many different Social Prescribing delivery models and projects are at different stages/ levels** of operating.
- The **level of buy-in from Primary Care Teams differs** from project to project and is largely determined by personal relationships. This has an impact on access to ‘system level’ data.
- The use of other external data (i.e. national datasets and RCTs) to build the case would be useful, but projects need support to do this.
- There are issues relating to **multi annual funding cycles and under resourced projects**. In addition, there appears to be limited onus on projects to provide impact data currently to funders.
- Projects **need clear direction from commissioners and Primary Care Teams** on what is useful for them and what helps them to recommission & fund.

Section 5: Evaluability Usefulness

5.1. INTRODUCTION

The third aspect of evaluability is the potential usefulness of evaluation²⁶ of Social Prescribing in Ireland; this is explored from a number of contexts, set out below:

5.2. FUNDERS AND COMMISSIONERS

The consultation process for this assessment identified that the evaluation requirements placed on projects by funders is reasonably limited.

As funders come under increasing pressure from the Social Prescribing 'movement', the onus will be on providing sufficient evidence to justify investing in Social Prescribing in a more sustainable, long term and systematic way. The 'onus' relates to a combination of all stakeholders involved in the Social Prescribing process. This evaluability assessment, and the accompanying Minimum Data Outcomes Framework, may influence how Social Prescribing projects are planned, implemented and evaluated in the future. A common outcomes framework and enhanced data collection will provide funders with evidence of impact of their investment and facilitate the exploration of cross departmental benefits and funding as well as assess the value of Social Prescribing against other services / areas of investment.

The consultations with projects consistently referenced perceived outcomes that go beyond health. Multiple projects reported enhancements to employment status of participants, improved tenancies, and increased likelihood of sustaining tenancies, of increased access to appropriate benefits and welfare and increased levels of volunteering. The challenge for projects, funders and evaluators is in how this data can be captured and how it can be linked to and attributed to the intervention.

It is likely that the growth of Social Prescribing as a process, will move beyond traditional 'health focused funds' and therefore the framework will be of interest to a wider body of funders and government departments.

5.3. PRIMARY HEALTH CARE NETWORKS (INCLUDING GPs)

The individuals interviewed for this report believe that the involvement (or lack thereof) of GPs and Primary Care Teams impacts Social Prescribing projects in the following ways:

1. Numbers of patients/ individuals referred to Social Prescribing projects.
2. Access to data or information that might help demonstrate the evidence or impact of a Social Prescribing project.

It should be noted that time and again during consultations, Link Workers and host organisations recognised the enormous pressure and strain on the healthcare system and that the availability of time and resources to explore or test new ways of working are sparse. Projects also acknowledged that clinical staff are more inclined to look to RCT's as a gold standard in evidence.

²⁶ Davies, R. (2013). Planning evaluability assessments. a synthesis of the literature with recommendations. DFID Working paper 40. Cambridge, UK: Department for International Development

Currently one RCT is taking place in Ireland (see section 4) which, combined with enhanced evaluation practice within Social Prescribing projects, may create the impetus for greater engagement with GPs and PCTs across Ireland. The involvement of GP and Primary Care representatives in a follow up to this report is likely to be critical.

5.4. SOCIAL PRESCRIBING PROJECTS

The purpose of this report is to present the evaluability capability of existing Social Prescribing projects. This assessment is likely to be of use in the following ways:

- The Evaluation Index will offer a reference point for projects in terms of the evaluation and data collection activity associated with a preferred Approach (3) and an aspirational Approach (4).
- The development of a Minimum Data Outcomes Framework (section 8) and the recommendation of tools will offer a structure within which Social Prescribing projects can design evaluation.
- The findings and recommendations from the report may have consequences for how funders view evaluation and how they set data collection requirements for projects.
- If a common framework and approach are agreed and implemented, this will provide projects, funders and partners with clarity on expected outcomes and the measures used to evaluate such outcomes. Such a framework would also allow for a collective review of how Social Prescribing is delivered in Ireland (good practice for new projects). It will also support additional lobbying and engagement with funders and government departments.

5.5. SLÁINTECARE

Social Prescribing is closely aligned with the HSE's transformation of the health service model of care under Sláintecare, which aims to ensure an integrated model of care based on the principles of 'Right Care, Right Place, Right Time'.

A core objective of Sláintecare is to shift the majority of care from the acute setting to the community - bringing 'care closer to home'. Community Healthcare Networks (CHNs) are recognised as the fundamental unit of organisation for the delivery of services based on an average population of 5,000. The Sláintecare Integration Fund has already funded six Social Prescribing projects across the country, which recognises the contribution that Social Prescribing can offer to the reform of the healthcare system.

A Joint Action Programme has been formed between the Dept. of Health, Sláintecare Office and the HSE which will set out actions required to develop capacity across acute and community care services, whilst in parallel reducing bed demand by utilising existing capacity more effectively, improving access to a range of services and improving the health of the population through preventative population measures. Pillar 1 of this programme relates to Healthy Living and Social Prescribing is included as a potential key programme to be delivered under this workstream. This work will involve developing a framework for the sustainable integration of Social Prescribing across the HSE. It also paves the way for the learning and recommendations from this report to inform its development.

Section 6: Evaluability Assessment

6.1. INTRODUCTION

The checklist below has been taken from pp. 19-23 of: Davies, R., 2013. *Planning Evaluability Assessments: A Synthesis of the Literature with Recommendations. Report of a study commissioned by the DFID.*

The checklist is used to assess evaluability across the three dimensions: Evaluability 'in principle', given the nature of the project theory of change, Evaluability 'in practice', given the availability of relevant data and the capacity of management systems able to provide it and the 'Utility and Practicality' of an evaluation, given the views and availability of relevant stakeholders.

6.2. EVALUABILITY ASSESSMENT

Project Design (as described in a Theory of Change, Logical Framework or narrative)		Findings
Clarity?	Are the long-term impact and outcomes clearly identified and are the proposed steps towards achieving these clearly defined?	<p>Social Prescribing projects in Ireland are clear about their long term intended impacts and result.</p> <p>Focused on tackling the social determinants of ill health, improvements to individual's wellbeing and connectedness can lead to long term impacts for Primary Care and health systems. The logic model in section 3 sets this out.</p>
Relevant?	Is the project objective clearly relevant to the needs of the target group, as identified by any form of situation analysis, baseline study, or other evidence and argument? Is the intended beneficiary group clearly identified?	<p>The main participant groups accessing the projects in this assessment are primarily those with mild or long-term mental health problems, depression, vulnerable groups (e.g. single parents), people who are socially isolated, and those who frequently attend either primary or secondary health care.</p>
Plausible?	<p>Is there a continuous causal chain, connecting the intervening agency with the final impact of concern?</p> <p>Is it likely that the project objective could be achieved, given the planned interventions, within the project lifespan? Is there evidence from elsewhere that it could be achieved?</p>	<p>Delivery models differ across projects. The project lifespan ranges from short term 1-2 week interventions to 6-9 months of engagements and spans both a Link Worker and community based services, thus outcomes are likely to vary.</p> <p>Embedding outcome data collection into service delivery would evidence this. An RCT is underway in Ireland which may provide further evidence, similarly, qualitative data may assist to measure contribution.</p>

Validity and reliability?	Are there <i>valid</i> indicators for each expected event (output, outcome and impact levels)? i.e. will they capture what is expected to happen? Are they <i>reliable</i> indicators? i.e. will observations by different observers find the same thing?	There are no defined indicators for Social Prescribing projects in Ireland. Projects would benefit from structured guidance around what to measure and how to measure it.
Testable?	Is it possible to identify which linkages in the causal chain will be most critical to the success of the project, and thus should be the focus of evaluation questions?	The exchange between the Link Worker and the participant appears to be the most important transaction in the causal chain.
Contextualised?	Have assumptions about the roles of other actors outside the project been made explicit? (both enablers and constrainers) Are there plausible plans to monitor these in any practicable way?	The roles of Primary Care Teams as referrers and C&V organisations as service delivery agents have been identified and are understood. Depending on the requirements of funders, evaluation may require each of these actors to participate through the provision of data or contribution of insights.
Consistent?	Is there consistency in the way the Theory of Change is described across various project multiple documents? (Design, M&E plans, work plans, progress reports, etc.)	Many of the projects are in their infancy. The majority do not have a defined theory of change for their project; however, this assessment has developed a common theory of change framework for projects.
Complexity?	Are there expected to be multiple interactions between different project components? [complicating attribution of causes and identification of effects] How clearly defined are the expected interactions?	Despite multiple interactions with different providers, these are clearly defined and can be set out in stages and are not complicated. It is potentially difficult to isolate the effects of one component compared to another.
Agreement?	To what extent are different stakeholders holding different views about the project objectives and how they will be achieved? How visible are the views of stakeholders who might be expected to have different views?	Stakeholders have demonstrated a consistent understanding of the purpose and objectives of Social Prescribing. More than 280 people have contributed to the evaluability assessment and Minimum Data Outcomes Framework. Some differences in opinion exist in the nature of the referral, these views are recognised in the framework.

Information availability		Findings
Is a complete set of documents available?	Are they relative to what could have been expected? E.g. Project proposal, Progress Reports, Evaluations / impact assessments, Commissioned studies	The assessment has considered twelve projects. Complete set of documents and data are available for circa four of the twelve projects. The others are in early stages of evaluation and contain complete sets of output data, but are reliant on anecdotal case studies as the primary evidence/impact source.
Do baseline measures exist?	<p>If baseline data is not yet available, are there specific plans for when baseline data would be collected and how feasible are these?</p> <p>If baseline data exists in the form of survey data, is the raw data available, or just selected currently relevant items? Is the sampling process clear? Are the survey instruments available?</p> <p>If baseline data is in the form of national or subnational statistics, how disaggregated is the data? Are time series data available, for pre-project years?</p>	<p>Baseline data exists in around 60% of projects, this comes in the form of validated tools such as SWEMWBS, WHO-5, HADS, MyCAW.</p> <p>The other projects do not have baseline data available, however it is feasible to gather baseline data, embedded into service delivery, with some support, resources and capacity building for staff.</p>
Is there data on a control group?	Is it clear how the control group compares to the intervention group? Is the raw data available or just summary statistics? Are the members of the control group identifiable and potentially contactable? How frequently has data been collected on the status of the control group?	There is an RCT taking place in Ireland currently which will provide access to data on a comparison group.
Is data being collected for all the indicators?	Is it with sufficient frequency? Is there significant missing data? Are the measures being used reliable i.e. Is measurement error likely to be a problem?	Reliable measures are used in 60% of the projects. These are collected with sufficient frequency and three projects are subject to external evaluation and verification. The others are characterised by anecdotal and qualitative case studies which are likely to contain bias.

Is critical data available?	Are the intended and actual beneficiaries identifiable? Is there a record of who was involved in what project activities and when?	All projects retain good data on project beneficiaries, demographic and socio economic profile as well as reason for referral and key actions agreed.
Is gender disaggregated data available?	In the baseline? For each of the indicators during project intervention? In the control group? In any mid-term or process review?	All projects can provide breakdown of participants by gender. In those projects that are using reliable tools, disaggregated data should be available.
If reviews or evaluations have been carried out...	Are the reports available? Are the authors contactable? Is the raw data available? Is the sampling process clear? Are the survey instruments available?	Of the twelve projects engaged, three have been subject to independent and external evaluation. The reports are available (two are still ongoing) and authors contactable.
Do existing M&E systems have the capacity to deliver?	Where data is not yet available, do existing staff and systems have the capacity to do so in the future? Are responsibilities, sources and periodicities defined and appropriate? Is the budget adequate?	There are limitations to existing monitoring & evaluation systems including: capacity (skills and time) of Link Workers, resources (limited funding), systems (use of excel etc – only 25% of projects are using purpose built digital systems).

Institutional context (practicality)		Findings
Accessibility to and availability of stakeholders?	Are there physical security risks? Will weather be a constraint? Are staff and key stakeholders likely to be present, or absent on leave or secondment? Can reported availability be relied upon?	<p>This report has been developed during the COVID-19 global pandemic which will impact the launch and dissemination of findings.</p> <p>There is strong buy in and willingness to consider new approaches across statutory, Primary Care and C&V networks. At a recent conference (December 2019), the Minister of State for Mental Health offered a strong statement and commitment of support for Social Prescribing.</p>

Resources available to do the evaluation?	Time available in total and in country? Timing within the schedule of all other activities? Funding available for the relevant team and duration? People with the necessary skills available at this point?	The availability of funding and the time available to projects is a constraint. Most projects operate with part time Link Workers (12-24 hours per week). Most projects report operating at a loss and majority of Link Workers reported a need for capacity building and support in relation to evaluation.
Is the timing right?	Is there an opportunity for an evaluation to have an influence? Has the project accumulated enough implementation experience to enable useful lessons to be extracted? If the evaluation was planned in advance, is the evaluation still relevant?	There is an opportunity for evaluation to influence. The Department of Health has launched a new €20m Sláintecare fund and have supported a number of new projects. Social Prescribing is referenced in the new Mental Health Strategy, Sharing the Vision. There is a growing momentum around the All-Ireland Social Prescribing Network and a recognition beyond health that the projects may deliver positive outcomes.
Coordination requirements?	How many other donors, government departments, or NGOs need to be or want to be involved? What forms of coordination are possible and/or required?	The assessment has identified multiple outcomes that move beyond health. There is merit in the project promoters (HSE and Department for Health) widening the discussion to include those responsible for housing, employment, skills and welfare, given the apparent impact in these areas.

Utility	Findings
Who wants an evaluation?	Have the primary users been clearly identified? Can they be involved in defining the evaluation? Will they participate in an evaluation process? There is a clear desire for evaluation and enhanced evaluation practice. The development of a Minimum Data Outcomes Framework has generated significant interest. Those with an interest include: HSE, Department of Health, Primary Care Networks, C&V organisations such as Family Resource Centres, and the All Ireland Social Prescribing Network.

What do stakeholders want to know?	What evaluation questions are of interest to whom? Are these realistic, given the project design and likely data availability? Can they be prioritised? How do people want to see the results used? Is this realistic?	The evaluation questions differ per stakeholder. Funders/PCTs <ul style="list-style-type: none"> • Does social prescribing work for participants? • Does it reduce pressure and enhance efficiency within Primary Care? • Is it value for money? C&V Organisations <ul style="list-style-type: none"> • How can we validate outcomes? • How can delivery models be improved to maximise outcomes? • What do we need to measure & evidence to secure longer term funding?
What sort of evaluation process do stakeholders want?	What designs do stakeholders express interest in? Could these work given evaluation the questions of interest and likely information availability, and resources available?	Given the nature of the projects, stakeholders are concerned that evaluation could subsume the intervention. Any tools used should be short and straightforward to administer. Stakeholders also report an interest in digital approaches that simplify and streamline evaluation across projects and enable shared learning and reflection.
What ethical issues exist?	Are they known or knowable? Are they likely to be manageable? What constraints will they impose?	Ethical issues relating to Social Prescribing (vulnerable groups, data transfer, data storage) all create constraints, but it is possible to overcome them through correct procedure and adherence to ethical guidelines and data protection legislation.
What are the risks?	Will stakeholders be able to manage negative findings? Have previous evaluation experiences prejudiced stakeholder's likely participation?	Where appropriate, stakeholders have responded to previous evaluations in a constructive manner and have used the evidence to make changes to projects. Stakeholders all recognise the importance of evaluation and have demonstrated a willingness to take part.

6.3 SUMMARY

The outputs from the checklist are an assessment of the evaluability of Social Prescribing in Ireland and the practicality and utility of an evaluation. This assessment indicates that:

Key Finding

The evaluability assessment demonstrates that Social Prescribing can be evaluated.

There are a number of enabling factors that the HSE and other partners can support to get to this point. A programme of support for projects to ensure the implementation of quality evaluation practice, aligned to the clarified expectations of funders would increase the potential for reliable evaluation. The nature of this support is set out in recommendation 3. It is anticipated that this would lead to the effective evaluation of individual projects, as well as in the longer term, the potential for a national evaluation of Social Prescribing projects in Ireland.

Section 7: Learning from Elsewhere

7.1. INTRODUCTION

Despite some projects existing for several years, Social Prescribing remains somewhat in its infancy in Ireland in comparison with other areas, notably the UK. The experience of the research team (Elemental in particular) enables several lessons to be learned from existing practice in the UK, and thus applied to this report and its recommendations.

In the UK, Social Prescribing reaches across all health and wellbeing domains, health, local government, the voluntary, community and social enterprise sector, charities and private organisations and housing associations. One of the big challenges for those working in Social Prescribing is connecting these systems together, or perhaps rather the information within them, to achieve optimal outcomes for the populations and communities they support.

There are a number of national policy drivers in the UK which have enabled the growth of Social Prescribing and which have supported health and social care communities to work together, understand each other's pressures, challenges and opportunities, and in a more joined up way, service their population. For the NHS and Local Authorities, this has been driven through the Sustainability and Transformation Partnerships (STPs), which bring together health organisations from all sectors, often including local government, to co-ordinate health and wellbeing across regions. Whilst this potentially has more relevance for implementation than evaluation, efforts have been made to provide guidance on outcomes, indicators and evaluation here.

Other initiatives/ policies and frameworks are outlined below:

7.2. NHS LONG TERM PLAN

Social Prescribing is a key component of Universal Personalised Care. A summary guide²⁷ has been developed for people and organisations leading local implementation of Social Prescribing. It sets out what good Social Prescribing looks like and why Social Prescribing improves outcomes and experiences for people, their families and carers, as well as achieving more value from the system.

7.3. PRIMARY CARE NETWORKS²⁸

To meet the needs of an ageing population, in England, GP practices work together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in Primary Care Networks (PCNs). PCNs are a key part of the NHS Long Term Plan, with general practices a core part of a network, typically covering 30,000-50,000 patients. The networks will provide the structure and funding for services to be developed locally, in response to the needs of the patients they serve. Over 1,000 Link Workers have been funded by the NHS²⁹ to support Primary Care to better connect their patients with community based programmes and services.

PCNs enable greater provision of proactive, personalised, coordinated and more integrated health and social care. GPs and other Primary Care professionals describe this as a change from reactively providing appointments, to proactively caring for the people and communities they serve.

7.4. QUALITY ASSURANCE FRAMEWORK FOR SOCIAL PRESCRIBING³⁰

The Quality Assurance Framework for Social Prescribing has been developed to support the ongoing evolution of Social Prescribing in England, where it is estimated that 60% of Clinical Commissioning Groups are investing in Social Prescribing.

The work programme was led by Craig Lister (Managing Director of TCV's Green Gym). This was supported by an Advisory Panel and involved extensive consultation and engagement with a wide range of stakeholders. The Royal Society for Public Health has endorsed the Framework. The work programme was funded by the National Lottery Community Fund and is available to projects in Ireland as a resource.

7.5. COMMON OUTCOMES FRAMEWORK³¹

NHS England has developed a Common Outcomes Framework for Social Prescribing. This is contained within 'The Social Prescribing and Community-based Support – Summary Guide' released in January 2019. The summary guide has been developed to support organisations leading the local implementation of Social Prescribing. The Common Outcomes Framework recognises the clear need for a common approach to documenting the impact of Social Prescribing schemes and aims to capture core data to create a consistent evidence base of its impact. The framework is a work in progress document and will be further augmented as Social Prescribing continues to evolve and develop. The framework suggests that the impact of Social Prescribing covers three key areas:

- Impact on the person
- Impact on community groups
- Impact on the health and care system.

²⁷ <https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/>

²⁸ <https://www.england.nhs.uk/primary-care/primary-care-networks/>

²⁹ <https://www.england.nhs.uk/wp-content/uploads/2019/07/pcn-reference-guide-social-prescribing.pdf>

³⁰ https://42b7de07-529d-4774-b3e1-225090d531bd.filesusr.com/ugd/14f499_a5e3a40ac260401a80e01853bb7ef8b9.pdf

³¹ <https://www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf> Page 28

7.5.1. Impact on the Person

The framework recognises that a variety of tools are being used by existing projects to capture this impact. The framework anticipates that, depending on the needs identified, one or more aspects of wellbeing will be improved as the person:

- Feels more in control and able to manage their own health and wellbeing
- Is more physically active
- Is better able to manage practical issues, such as debt, housing and mobility
- Is more connected to others and less isolated or less lonely.

The measurement tools include:

- Patient Activation Measure
- Office National Statistics (Personal Wellbeing Questions)
- Short Warwick-Edinburgh Mental Wellbeing Scale.

7.5.2. Impact on Community Groups

The authors of the framework will co-produce and test a freely available short confidence survey for community groups about the impact of taking Social Prescribing referrals. This survey will test the resilience of community groups as a result of their involvement in Social Prescribing. Areas to be examined will include:

- Changes in the number of volunteers
- Capacity of the voluntary sector to manage referrals
- Support needed to make Social Prescribing sustainable.

7.5.3. Impact on the Health and Social Care System

The framework advises that Social Prescribing schemes should collect data on the change in the following (as a result of referral to Social Prescribing):

- Number of GP consultations
- A&E attendance
- Number of hospital bed days
- Volume of medication prescribed
- Morale of staff in general practice and other referral agencies.

The authors of the framework will support the development of robust data sharing agreements to collect the above data.

The framework also highlights 3 SNOMED CT terms that have been established for Social Prescribing in GP IT systems:

- 871691000000100 | Social Prescribing offered (finding)
- 871711000000103 | Social Prescribing declined (situation)
- 871731000000106 | Referral to Social Prescribing service (procedure).

The availability of resources such as surveys, data sharing agreements and measure indicators are of practical use for Social Prescribing in Ireland.

7.6. DIGITAL CONNECTIVITY

The establishment of a digital flow of information from GP to Link Worker to C&V provider is of growing importance across the UK. For example, in the case of London, there is significant work between the NHS and Local Authorities to drive shared care records, join up the sharing of data and systems for patients and citizens and to include other organisations in this work. In Ireland this may include an exploration of digital options for projects, Primary Care Networks and funders to enhance the consistency and congruence of impact data for Social Prescribing.

7.7. EXISTING EVALUATIONS

Whilst there has been criticism of evaluation approaches in the UK³², there are several examples of independent evaluations that offer a basis for projects in Ireland to explore and utilise as a framework.

One example is a short report (2018) on the findings of an independent evaluation by researchers at Sheffield Hallam University with expertise in Social Prescribing³³. It covered the first 9 months of the Hale Community Connectors Social Prescribing service (March-November 2017) and aimed to answer some key questions about the Community Connectors Social Prescribing Service to support future commissioning by the Clinical Commissioning Group and its partners. In addition, an Evaluability Assessment was published recently³⁴ providing a review of the research methods and approaches used to evaluate UK-based Social Prescribing interventions in recent years, to inform healthcare and social services professionals, as well as organisations delivering Social Prescribing interventions and those conducting evaluations. It aims to give an overview of how Social Prescribing has been evaluated, and, importantly, what can be learned from this. The development of a platform or channel to share evaluation resources has been explored in England and may be of benefit to Social Prescribing projects in Ireland.

³² Bickerdike L, Booth A, Wilson PM, et al. Social Prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open* 2017; 7(4)

³³ Evaluation of Hale Community Connectors Social Prescribing Service 2017 [PDF] Source: Social Care Collection - 01 February 2018 - Publisher: Sheffield Hallam University. Centre for Regional Economic and Social Research

³⁴ <https://www.iriss.org.uk/resources/insights/evaluation-social-prescribing>

Section 8: Minimum Data Outcomes Framework

8.1. INTRODUCTION

One of the objectives of this report was to develop a Minimum Data Outcomes Framework for Social Prescribing projects in Ireland, using a consensus-based methodology, and provide recommendations on how to establish a system to collate and report on outcomes nationally. The outcomes framework outlined below sets out which outcomes should be measured, and which tools can be used to measure them. This is designed to be a practical and implementable tool for projects to assist with evaluation design, and is not a guide on how to carry out evaluation.

8.2. ASSUMPTIONS

The framework is focused on outcomes; which are underpinned by two key assumptions:

- All projects will continue to collate administrative data including, but not limited to, number, nature and source of referral, number and profile of participants, number of meetings and number of onward referrals (see appendix 4 for sample participant form).
- All projects will continue to record participant stories/testimonials to highlight the personal and human impact of their work. This may be the role of an independent evaluator depending on the nature of evaluation in each project.

The Minimum Data Outcomes Framework represents a starting point for Social Prescribing projects in Ireland. Approaches to evaluation will align to the objectives of evaluation for each project. Projects should move beyond the minimum outcomes if it is within their scope, resources, or capacity to do so.

8.3. DEVELOPING THE MINIMUM DATA OUTCOMES FRAMEWORK

In order to develop the framework, the researchers firstly established a long list of outcomes that are currently being reported by projects in Ireland. The outcomes are categorised in a similar way to the NHS Common Outcomes Framework, that is:

- Participant Outcomes (The patient, the citizen, the resident)
- System Outcomes (The health and social care system)
- Organisation Outcomes (Those organisations delivering Social Prescribing and also receiving referrals).

Participant Outcomes	System Outcomes	Organisation Outcomes
<ul style="list-style-type: none"> • Reduced isolation/loneliness • Enhanced self esteem • Enhanced mental wellbeing • Increased independence • Increased personal wellbeing • Increased motivation • Reduced anxiety • Enhanced confidence • Enhanced resilience/coping skills • Reduced suicide ideation • Increased sense of feeling connected • Increased levels of volunteering • Increased Income - relating to increased benefits/employment • Enhanced sustainability of housing tenancies • Enhanced skills and qualifications • Reduced stress and anxiety on carers/family members 	<ul style="list-style-type: none"> • Reduced mental health waiting lists • Increased efficiency of GP appointments • Reduction in the number of GP appointments • Reduced pressure on GPs or Primary Care staff • Reduction in the number of ED admissions • More appropriate management and use of Prescription medication • Reduced length of hospital stays 	<ul style="list-style-type: none"> • Increased understanding and awareness of available services • Increased partnership working • Improved access to services • Enhanced confidence and feeling valued (organisational) on carers/family members

8.4. PRIORITISING AND SHORTLISTING OUTCOMES

A co-design workshop was organised and facilitated by the researchers on 6th March 2020. The workshop was attended by 24 individuals representing Social Prescribing projects, community and voluntary organisations and funders/statutory organisations across Ireland.

The purpose of the workshop was to shortlist and prioritise the outcomes that **MUST** be measured within a Minimum Data Outcomes Framework. Participants were divided into small working groups of 4-5, each group was asked to complete the framework (below) and feedback. The findings have directly informed the Minimum Data Outcomes to be measured by Social Prescribing projects across Ireland.

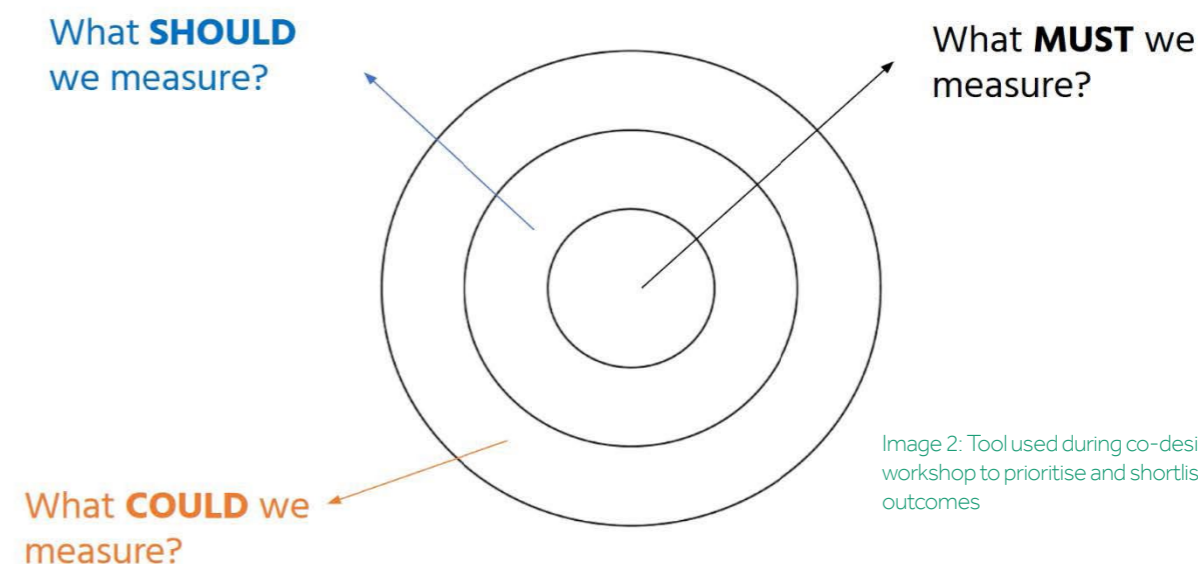


Image 2: Tool used during co-design workshop to prioritise and shortlist outcomes

The centre of the framework relates to those outcomes that participants consider 'MUST' be measured. Each group was provided with the long list of outcomes (section 8.3) and asked to prioritise the outcomes that cut across all Social Prescribing projects and therefore should be the central pillars of any Minimum Data Outcomes Framework. These are the primary focus in this report.

Arguably all and any outcomes achieved are important to measure. However, in light of the factors impinging on evaluation currently in Ireland, the Minimum Data Outcomes Framework represents a starting point.

The middle and outer rings in the framework relates to those outcomes that 'Should' be measured and those that 'Could' be measured. It was acknowledged that these may change on a project by project, and participant by participant basis – but would represent outcomes that stakeholders felt were important to capture within an evaluation of Social Prescribing.

It was also acknowledged that each project will have a different focus depending on the participants, its geography and its funder requirements, therefore significant overlap and transience would be expected between what could and what should be measured.

The tool will be useful for individual projects developing an evaluation approach and identifying outcomes beyond the 'minimum outcomes'.

8.5. MINIMUM OUTCOMES FRAMEWORK

The results of the workshop are presented in tabular format below:

	Participant Outcomes	System Outcomes	Organisation Outcomes
What must we measure?	<ul style="list-style-type: none"> • Change in personal wellbeing • Change in social connectedness / social wellbeing (see appendix 3 for further details) 		
What should we measure?	Dependent on participants, projects and funder expectations and therefore adaptable per project: <ul style="list-style-type: none"> • Independence • Confidence • Suicide ideation • Volunteering • Resilience and coping skills • Change in income - relating to benefits or employment status • Sustainability of housing tenancies • Change in stress or anxiety amongst family members and carers 	<ul style="list-style-type: none"> • Reduction in pressure on GPs and Primary Care Teams • Change in mental health waiting list • Number of GP appointments for participant • Improved efficiency of appointments for SP specific patients 	<ul style="list-style-type: none"> • Increased understanding and awareness of available services • Increased partnership working • Improved access to services • Increased number of volunteers • Enhanced confidence, feeling valued and capacity to received referrals (organisational)

	Participant Outcomes	System Outcomes	Organisation Outcomes
What could we measure?		<ul style="list-style-type: none"> • More appropriate management and use of Prescription medication • Reduced Length of hospital stays • Reduced Emergency Department admissions • Impact on workload of PCT members 	Gaps in service What the services are that are now available/ who are they for, and what do they involve?

The co-design workshops identified consistently that personal wellbeing and social connectedness/ wellbeing were the two critical outcomes that must be measured within a Social Prescribing project. Both outcomes relate to the participant.

Measuring both outcomes will require the use of validated tools, implemented at initial assessment and at agreed intervals. Link Workers suggested that a maximum of two validated questionnaires could be administered during assessments with participants. Feedback suggested that these could be administered in a subtle or conversational way (although this may have implications for the validity of findings and comparison of projects).

A number of validated tools to measure wellbeing and social connectedness are set out below as well as the rationale and process for selecting the particular tools:

- Tools that are free to use – Social Prescribing projects have limited resources, therefore reducing the cost of implementing enhanced evaluation practice was important.
- Tools that are implementable and can be embedded into service delivery – a key recommendation from Link Workers was that tools should be straightforward to administer and where possible, short in length. The 'informal' and non-clinical nature of the intervention was cited as important by at least nine of the Social Prescribing projects consulted. Concerns were raised about the use of long or complex evaluation tools and the risk that their administration could 'subsume the intervention'.
- Tools that were already in use – where validated tools were already in use, it makes sense to try to ensure continuity.

8.6. TOOLS TO MEASURE PERSONAL WELLBEING

The following tools are suggested as being appropriate to measure change in personal wellbeing (The researchers acknowledge that many other tools exist and are likely to be effective in measuring the minimum outcomes for Social Prescribing).

- **The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)³⁵**

SWEMWBS is a scale of seven positively worded items, with five response categories, designed to measure both the feeling and functioning aspects of positive mental wellbeing. The SWEMWBS is a shortened version of the longer Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS). Warwick and Edinburgh Universities were commissioned to develop this in 2006, and it has been academically validated as having good psychometric properties, good validity and reliability with the ability to distinguish between population groups. It is widely used in population surveys in the UK and elsewhere, including in the Health Survey for England in 2011. Note that permission must be sought for use of the measure, although it is free to use.

- **World Health Organisation Five Wellbeing Index (WHO 5)**

WHO-5 is a short self-reported measure of current mental wellbeing. The WHO-5 demonstrates validity in screening for depression and in measuring wellbeing outcomes in clinical trials. The WHO-5 is free of charge and does not require permission to use and it is already being used by a number of Social Prescribing projects in Ireland.³⁶

8.7. TOOLS TO MEASURE SOCIAL CONNECTEDNESS/SOCIAL WELLBEING

The following tools are suggested as being appropriate to measure change in social connectedness/social wellbeing.

- **Revised Social Connectedness Scale³⁷.**

This scale assesses the degree to which people feel connected to others in their social environment. The original scale included 8 items but was revised to include a list of 20 items on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The additional 12 items were inserted to combat the limitations of negative wording of the original 8. Items are summed; a higher score indicates more connectedness to others. Many studies still use the original 8 items for social connectedness, this may be more practical for Social Prescribing projects. Permission is required from the author before use.

- **Social Wellbeing Scales³⁸**

This scale consists of 33 items organised in five dimensions measuring;

- individual's sense of belongingness (i.e., social integration)
- sense of value to society (i.e., social contribution)
- sensibility and meaningfulness of the social world (i.e., social coherence)
- sense of potential for continued growth in social institutions and society (i.e., social actualization) and
- one's degree of comfort and acceptance of other people (i.e., social acceptance).

Each dimension contains 6 or 7 items through a Likert scale from 1 to 7 (from Strongly Disagree to Strongly Agree) by which participants are asked to rate their degree of social wellbeing. Higher scores mean that socially healthier people should not see society as unpleasant and see themselves as important members. They should care about, and feel safe, in the community, living a coherent life. This scale may be too long although it is unclear whether the scale can be adapted and some of the individual dimensions used separately. The scale is free to use but permission must be sought from the author.

8.8. CAPTURING CONTRIBUTION OF LINK WORKERS

Participants in the co-design workshop (and throughout the evaluability assessment) discussed the challenges of attribution and the importance of capturing the contribution or role of the Link Worker within any Minimum Data Outcomes Framework.

As referenced previously in this report, the 'feasibility of attribution', i.e. establishing the causal relationship between the Link Worker and a positive outcome (where one exists) is likely to be a challenge for future evaluation of Social Prescribing projects. The use of qualitative tools, such as case studies, are likely to be the most appropriate method of capturing contribution. Case studies can be carried out by independent evaluators, and examples of case studies for participants can be found in Evaluation of the Rotherham Social Prescribing Project³⁹ and the Richmond CCG Social Prescribing Project⁴⁰.

Other tools such as the Most Significant Change (MSC) technique⁴¹ can be used to help assess the performance of the initiative as a whole. Essentially, this process involves the collection of a significant change (SC) story using one validated question. In the case of Social Prescribing projects, this technique would be applied at the end of an engagement with an individual to identify the most significant change following that intervention. These tools are likely to be more appropriate for the independent evaluation of projects.

³⁵ <http://www.healthscotland.com/understanding/population/Measuringpositive-mental-health.aspx>

³⁶ <https://www.corc.uk.net/outcome-experience-measures/the-world-health-organisation-five-wellbeing-index-who-5/>

³⁷ Lee, R. M., Draper, M., & Lee, S. (2001). Social connectedness, dysfunctional interpersonal behaviors, and psychological distress: Testing a mediator model. *Journal of Counseling Psychology*, 48(3), 310–318

³⁸ Keyes, R. L., (1998). Social Wellbeing. *Social Psychology Quarterly*, 61(2) 121-140

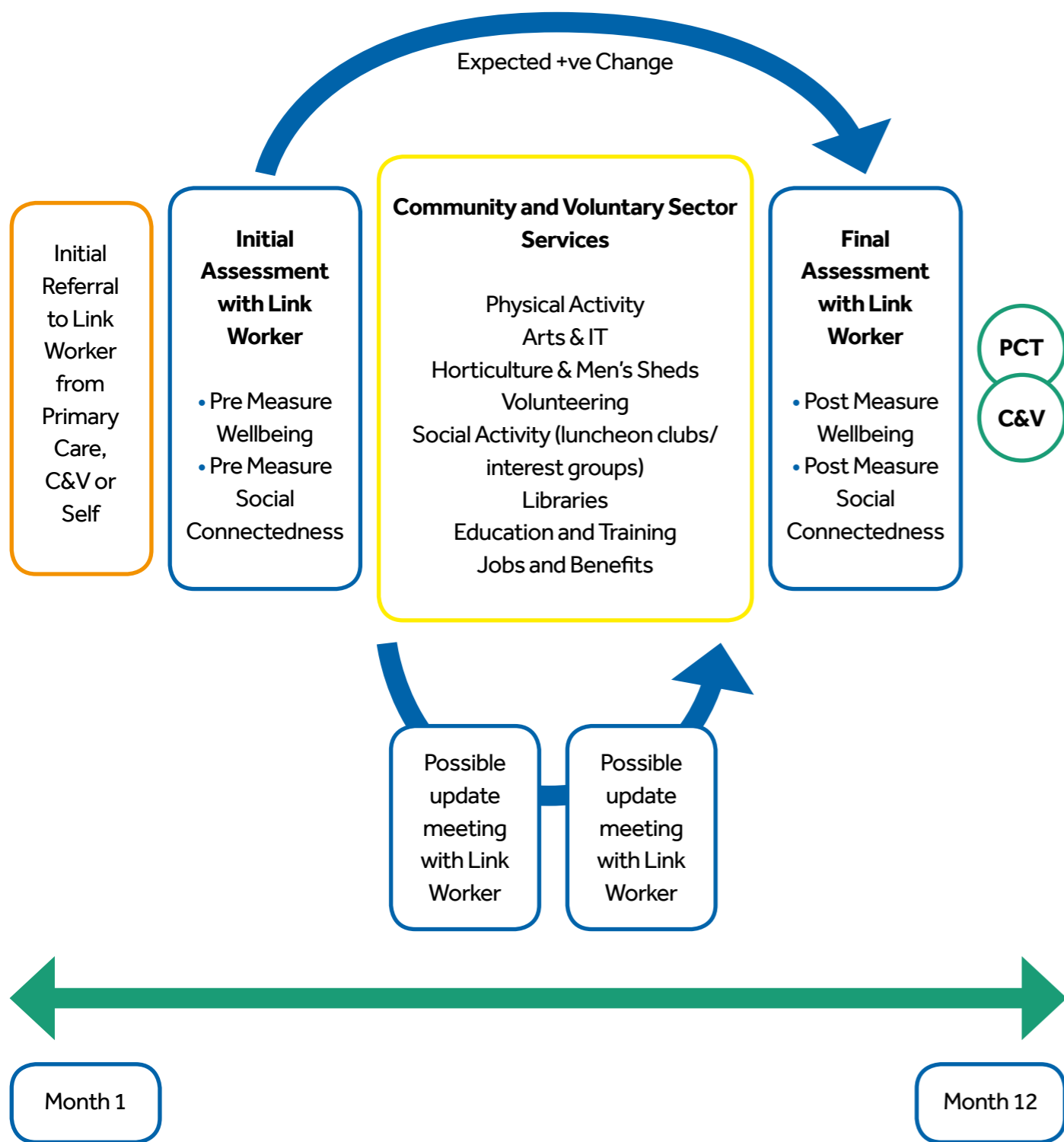
³⁹ https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/rotherham-social-prescribing-annual-eval-report-2016_7.pdf

⁴⁰ <http://www.richmondccg.nhs.uk/wp-content/uploads/2019/04/Richmond-Social-Prescribing-Pilot-Evaluation-Report-2018.pdf>

⁴¹ https://www.betterevaluation.org/resources/guides/most_significant_change

8.9. MINIMUM DATA OUTCOMES FRAMEWORK APPLIED

The following diagram presents a summarised version of the Social Prescribing process. It is intended that this process creates a positive change for each participant who moves through it in respect of their wellbeing and social connectedness. This in turn can contribute to a host of other benefits for the participant (employment, skills), the system (GP pressure, waiting lists) and on organisations providing services.



The following sets out the implications for Social Prescribing practitioners and evaluators in applying the Minimum Data Outcomes Framework. We acknowledge that projects are operating with different models, resources, and capacity. In some cases, Link Workers will inevitably implement some of this work (which is verified externally at the end of project) and in others this may be the role of independent evaluators.

8.9.1. Step 1 – Establishing Tools

Social Prescribing projects to establish a suite of data collection and measurement tools that collectively make up their evaluation framework. These include (examples of tools have been provided in the report and at appendices):

- Quantitative Participant Profile (template in appendix 4)
- Validated tool to measure personal wellbeing (2 examples are suggested)
- Validated tool to measure social connectedness (2 examples are suggested)
- Case Study Template (references to sample case studies in Rotherham and Richmond CCG Social Prescribing Evaluations)
- Survey for community and voluntary organisations (sample being developed in NHS Common Outcomes Framework)
- Survey for Primary Care Teams (template in appendix 5)
- System for storing all data.

8.9.2. Step 2 – Gathering baseline and ‘pre’ data as part of service delivery

Social Prescribing projects to gather participant profile data on all participants as well as baseline data on personal wellbeing and social connectedness using one of the recommended tools. The use of samples for the validated evaluation tools (e.g. 30% or 1 in 3) may be a more appropriate approach for projects with limited resources. This may equate to 20-30 participants per annum.

The baseline or ‘pre’ data is usually gathered at first engagement with the participant. The initial engagement with a Link Worker is often therapeutic in nature and therefore may influence baseline data. Projects should consider how best to gather participant data at the outset to enable any change to be measured.

8.9.3. Step 3 – Gathering follow up and ‘post’ data as part of service delivery

Follow up and ‘post’ data to be collected at specified intervals (at 6 weeks, 8 weeks, 12 weeks and/or 24 weeks depending on the Social Prescribing service and the evaluation tool used). This should include follow up data on personal wellbeing and social connectedness. Participant profile data should be updated where appropriate.

8.9.4. Step 4 – Stakeholder Engagement

As part of a longer term approach to evaluation, semi-structured interviews or case studies capturing a participant story to be recorded to complement data gathered using validated tools. This data collection is typically the role of an independent evaluator. In addition, SP projects could seek to issue surveys to Primary Care Teams and C&V organisations on an annual basis to assess the impact of its work. The surveys can be issued directly by the projects or by an independent evaluator.

8.9.5. Step 5 – Making use of data

Data to be collected by projects as part of service delivery and handed over to independent evaluators at the end of a project for verification. Data and findings should be analysed to identify outcomes and impacts (if any) and inform service developments and improvements.

8.9.6. Step 6 – Sharing and Communicating Findings

Social Prescribing Projects to communicate findings to participants, funders, stakeholder organisations and collectively within the network to share and embed learning. The use of infographics and impact cards can be useful here.

Section 9: Summary and Recommendations

9.1. SUMMARY

S3 Solutions and Elemental were delighted to undertake this evaluability assessment and contribute to building the capacity for the evaluation of Social Prescribing in the Republic of Ireland.

The objectives of this project were, to undertake an evaluability assessment of Social Prescribing projects in Ireland by:

1. Providing an overview and synthesis of current Social Prescribing services and programmes in Ireland in terms of the underlying theory of change and programme logic models.
2. Assessing the capacity of the current Social Prescribing system in Ireland to collect process, output and outcome data to support impact evaluation.
3. Developing a Minimum Data Outcomes Framework for Social Prescribing services in Ireland, using a consensus-based methodology, and providing recommendations on how to establish a system to collate and report on outcomes nationally.

This report is framed around the three dimensions of Evaluability Assessment⁴², including:

- a Evaluability in principle (i.e. clarity of the intervention and its theory of change)
- b Evaluability in practice (i.e. what data are available and what systems are in place to provide these data)
- c Evaluability usefulness (i.e. what interest do stakeholders have in using evaluation findings for example, to enable strategic decision making).

9.2. KEY FINDINGS

Summary findings from the evaluability assessment are outlined below;

- Social Prescribing is growing in Ireland, there are now in the region of 18-20 funded projects and the All-Island Social Prescribing Network continues to expand. At a recent conference, delegates and speakers consistently referred to the Social Prescribing 'movement'. Based on the researcher's observation, the commitment to, and advocacy of Social Prescribing was profound.

- The theory of change for Social Prescribing projects in Ireland is clear and logical, and the measurement of intended outcomes at an individual level are achievable using reliable and valid tools.
- Those interviewed in this evaluability assessment believe that the Link Worker is the most important component in the causal chain – or the key mechanism for change. The skill set, capacity and competencies of the Link Worker are therefore crucial.
- Measuring the longer term impacts of Social Prescribing (i.e. reduction in public health sector costs and pressures) requires the participation of Primary Care Teams and other parts of the health system, both in the referral of participants and in the provision of data to enable analysis. This is likely to be a challenge. Early indications from one project identified significant reductions in mental health waiting lists. If the system level data was gathered systematically and rigorously this could be used as the entry point to engage further Primary Care networks.
- One of the key areas of challenge relates to the availability of outcomes data. This means that evidencing the outcomes of most Social Prescribing projects in a reliable way, is not possible without additional data collection. To enable additional data collection, evaluation capacity building activities are required as well as a commitment to and investment in, embedding data collection into service delivery. The development of a Minimum Data Outcomes Framework within this report represents the first step in this process.
- There is significant interest in the evaluation of Social Prescribing, primarily from the organisations that are delivering projects and from the All-Island Social Prescribing Network, but also from the HSE, Department of Health and many Primary Care professionals. There is an opportunity to harness this interest to generate a momentum around evaluation and secure greater participation from relevant stakeholders.
- Existing evaluation practice varies greatly across Ireland. S3 Solutions and Elemental devised an Evaluation Index to capture and frame existing practice. Whilst the majority of groups are operating at 'Approaches 1-3', stakeholders agreed collectively that 'Approach 3' is preferred (including independent evaluation) with 'Approach 4' representing the ideal or aspirational level of evaluation.
- The purpose and use for evaluation differ per stakeholder. For projects, ensuring that outcomes are being achieved for participants, service improvement and funding security are of primary concern, in which case EI Approaches 2-3 may be sufficient. For funders and PCTs, value for money and resource savings may be a priority and therefore Approaches 3-4 may be essential. Clarity in terms of what is expected from evaluation by funders may assist projects with evaluation design and implementation.

⁴² Davies, R. (2013). Planning evaluability assessments. a synthesis of the literature with recommendations. DFID Working paper 40. Cambridge, UK: Department for International Development

- An evaluability assessment was an appropriate approach by the HSE. Social Prescribing can be evaluated, and outcome data collection can be embedded in service delivery. However, a number of enabling factors and steps can be taken to enhance the availability of evidence which potentially could lead to a national evaluation of Social Prescribing in the future.
- Many lessons can be learned from elsewhere, particularly the work of the NHS UK, relating to outcomes frameworks, quality assurance frameworks, partnership working with Primary Care Teams, template evaluations and data collection tools.
- A Minimum Data Outcomes Framework has been developed comprising two core outcomes to be measured at an individual level: personal wellbeing and social connectedness. These are seen by participants in the evaluability assessment as central to any Social Prescribing process. A number of additional outcomes have been identified at the 'system' and 'organisational' levels and a series of tools have been identified and recommended, as well as guidelines for evaluation design.
- There are a wide range of organisations and sectors with a stake in Social Prescribing and its evolution and development will require collective action and partnership working. This is not limited to the organisations delivering projects or those involved in direct health care provision. There is merit in a cross sector, cross departmental approach to explore how Social Prescribing can evolve with evaluation and evidence at its core. The Minimum Data Outcomes Framework may be the first step in this process.

9.3. CONCLUDING THOUGHTS

The report demonstrates that Social Prescribing can be evaluated. It offers a foundation in terms of a common approach to outcomes which promotes consistency and coherence for practitioners and funders alike and can be refined as investment and delivery of Social Prescribing continues to develop in Ireland. The Minimum Data Outcomes Framework offers a solid starting point for the evaluation of Social Prescribing projects and should evolve alongside the evolution of funding, projects and other research.

9.4. RECOMMENDATIONS

The following 5 recommendations are set out to enable the growth of good quality evaluation of Social Prescribing. The majority of recommendations fall within the remit of the HSE as project promoters – however it is envisaged that a collaborative approach involving all relevant stakeholders will be required.

9.4.1. Recommendation 1

Ireland's General Practice is under pressure. The Primary Care system is busy, overstretched and not always responsive to change. Ireland boasts, however, a network of champion GPs and via Sláintecare is entering a period of change, including the introduction of new data systems and new ways of distributing and allocating resources.

To progress the Minimum Data Outcomes Framework, it should be tested further with relevant stakeholders. This research process has included significant engagement from the C&V sector and feedback from Primary Care professionals but the outbreak of COVID-19 restricted PCT participation in the final stages and thus the development of the framework would benefit from further engagement and consensus from the Primary Care community.

It is recommended that the HSE, supported by champion GPs, facilitate a number of engagement events with a network of GPs and Primary Care professionals. The focus of this engagement should be centred on a number of key questions:

- a If projects implement the Minimum Data Outcomes Framework and can demonstrate positive outcomes in wellbeing and social connectedness using validated tools – to what extent will this strengthen your view on Social Prescribing and likelihood of participating in Social Prescribing projects?
- b Approach 4 of the EI requires access to data relating to waiting lists, GP attendance etc. What can projects, via independent evaluations practically do to access this data to support evaluation efforts?
- c What additional information, beyond that included in the Minimum Data Outcomes Framework would encourage greater PCT involvement in Social Prescribing projects?

9.4.2. Recommendation 2

The HSE (Health and Wellbeing & NOSP), The Department of Health (Sláintecare) and Healthy Ireland are currently the main funders of Social Prescribing projects in Ireland.

Given the apparent impact on areas beyond health, it is recommended that the HSE as commissioners of this report, utilise the findings to stimulate engagement with other government departments, funders, commissioners and statutory bodies including but not limited to housing, employment and skills and welfare. The focus of this engagement should be centred on a number of key questions:

- a To what extent does the proposed Minimum Data Outcomes Framework, if implemented appropriately by projects, satisfy funders and commissioners of the merits of Social Prescribing?
- b What additional information, beyond that included in the Minimum Data Outcomes Framework would encourage a more sustainable funding approach in Social Prescribing projects?

A roundtable discussion about how best departments can work together to contribute to enhanced evaluation efforts may enable a more streamlined delivery of other recommendations.

9.4.3. Recommendation 3

This report has highlighted that whilst evaluation of Social Prescribing projects is possible, for many projects, there is insufficient valid and reliable data collection, not to mention resources, to merit commissioning their own evaluations. **It is recommended that the HSE and other partners (listed above) consider implementing a 12 month programme of support to Social Prescribing projects to implement evaluation.** This may include:

- Securing permission to utilise validated tools by contacting authors where necessary on behalf of Social Prescribing projects.
- Providing practical support to implement the Minimum Data Outcomes Framework including support to access and utilise the recommended tools and resources. This could include the development and dissemination of the Minimum Data Outcomes Framework as a toolkit/resource and online or workshop based support for projects.
- Providing resources to assist with data collection, data storage and data analysis. This can include financial resources to enable projects to source support (i.e. part time administration shared across a number of projects), or the provision of personnel directly by the HSE to provide support.
- Taking the lead on coordinating training on the appropriate use of validated tools in a conversational way as part of the initial assessments with participants. The development of a shared learning network of Link Workers, which is already in place who meet regularly to share practice and resources provides a useful forum to communicate with and assess training needs of Link Workers.
- Supporting projects to communicate findings through the development of an online library/repository of information that can be used to highlight examples and templates of current quality evaluations as exemplars of good practice and guides for new projects.
- Investing in or supporting the implementation of a shared digital system for data collection that will enhance the consistency and congruence of how information is collated and reported.

9.4.4. Recommendation 4

The HSE is currently working on a framework for the development and sustainable integration of Social Prescribing in the HSE in consultation with key partners including the All-Island Social Prescribing Network, HSE cross sectoral partners, DOH and the C&V sector. **It is recommended that this framework includes specific measurable objectives for mainstreaming with appropriate timescales and actions.** Furthermore, the All-Island Social Prescribing Network should consider how the Minimum Data Outcomes Framework and proposed evaluation approaches can advance these goals and consider how it can support the implementation of enhanced evaluation approaches across its network of members.

9.4.5. Recommendation 5

Once tested further as per recommendation 1 and 2, **it is recommended that the Minimum Data Outcomes Framework be enhanced by converting the content into a practical workbook and toolkit which can be distributed and disseminated to projects.** This could be combined with the implementation of recommendation 3 as part of the body of support for projects.

9.5. ACKNOWLEDGEMENTS

S3 Solutions and Elemental would like to thank everyone who contributed to this report.

In particular, we would like to acknowledge the guidance and counsel provided by the Project Steering group. This helped shape our assessment and report, held us to account on the methodology and manage and limit the potential for bias. We would like to thank Orla Walsh (HSE Health and Wellbeing), Gemma Cox (HSE National Office of Suicide Prevention), Anne Sheridan (HSE Health & Wellbeing), Deirdre Connolly (Discipline of Occupational Therapy, Trinity College Dublin), Sarah Gibney (Department of Health) for their ongoing support and direction throughout this project.

APPENDIX 1 – OVERVIEW OF 12 SOCIAL PRESCRIBING PROJECTS

	Funder	Location (GP/C&V)	PT/FT (Hours)	No of Referrals p/a	Using Digital System	Receiving Referrals from PCTs (% of all referrals)	Accepting Self Referrals	Primary Reason for Referral
1	Healthy Ireland	C&V	FT	200	No	Yes (30%)	Yes	social isolation, mental wellbeing
2	Healthy Ireland	C&V	PT (24)	80	No	Yes (25%)	Yes	social isolation, depression, anxiety, stress
3	Healthy Ireland	C&V	PT (15)	50-60	No	Yes (30%)	Yes	social isolation, mental wellbeing, anxiety, stress
4	Healthy Ireland	C&V	PT (15)	50-60	No	Yes (75%)	Yes	social isolation, mental wellbeing
5	Healthy Ireland	C&V	FT	140	Yes	Yes (90%)	No	mild mental health issues, social isolation
6	Healthy Ireland, HSE Social Inclusion, SICAP	C&V	PT (12-24)	60-80	No	Yes (20%)	Yes	social isolation, mental wellbeing, anxiety, depression
7	HSE Social Inclusion	PCT	PT (24)	80	No	Yes (85%)	No	anxiety, depression, stress, social isolation
8	Healthy Ireland	C&V	FT	75-80	Yes	Yes (100%)	No	high GP attendance, mental health
9	SICAP	C&V	FT	100	Yes	Yes (95%)	Yes	social isolation, mild mental health
10	HSE National Office Suicide Prevention	C&V	PT (24)	60	No	Yes (10%)	Yes	social isolation, mental health, general health
11	Healthy Ireland, SICAP	C&V	PT (24)	50-60	No	Yes (5%)	Yes	social isolation, mental health
12	Sláintecare	PCT	FT	600	No	Yes (100%)	No	general health & wellbeing, mental health

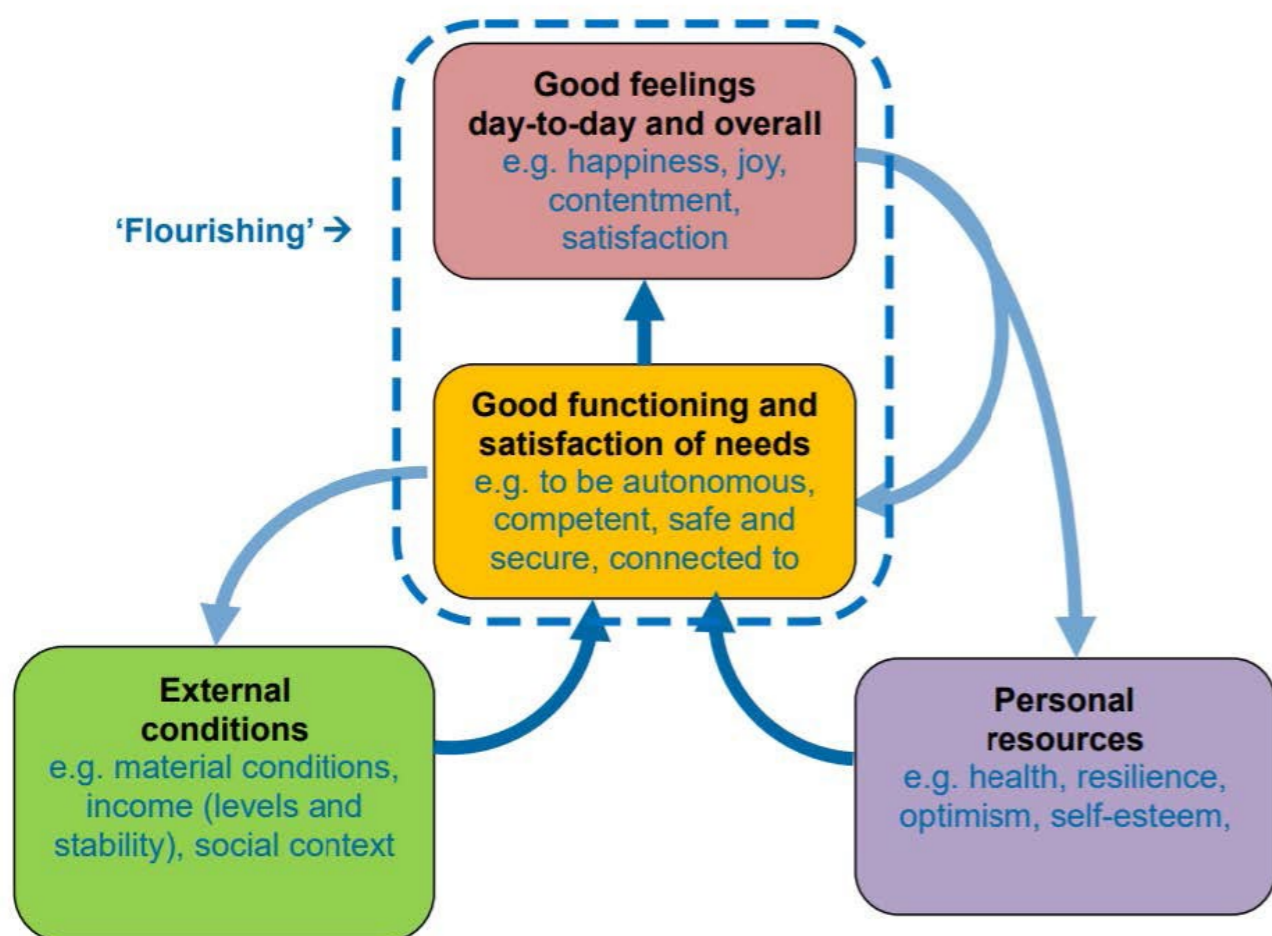
APPENDIX 2 – LIST OF CONSULTEES

1. Health Service Executive Health & Wellbeing
2. Health Service Executive National Office Suicide Prevention
3. Department of Health, Sláintecare
4. Trinity College Dublin (Discipline of Occupational Therapy)
5. Waterford Social Prescribing Service (Sacred Heart Family Resource Centre)
6. Listowel Family Resource Centre
7. Wicklow County Partnership
8. Bray Area Partnership
9. South Dublin County Partnership
10. Rosses Social Prescribing Project
11. The Flourish Project (Family Centre Castlebar)
12. Southside Partnership
13. Fatima Groups United
14. Tallaght Cross GP Practice
15. Local Asset Mapping Project St James Hospital
16. Bogside Brandywell Health Forum
17. The Healthy Living Centre Alliance
18. Offaly Local Development Company
19. Silver Arch Family Resource Centre
20. Letterkenny Youth and Family Service
21. Gaoth Dobhair Social Prescribing Project
22. Derryveagh Social Prescribing Project
23. Lifford Clonleigh Resource Centre
24. Inishowen Development Partnership
25. Bromley By Bow Centre
26. Marie Polley Consultancy
27. Dublin City Sport & Wellbeing partnership
28. Social Prescribing Network Ireland
29. Social Prescribing Network England
30. National Clinical Lead for Social Prescription (NHS)
31. Managing Director TVC's Green Gym and National Lottery Community Fund Quality Assurance Lead for Social Prescribing
32. Helium Arts
33. Clones Family Resource Centre
34. Dun Laoghaire Rathdown Sports Partnership
35. Attendees at All Ireland Social Prescribing Conference (Waterford, December 2019)

APPENDIX 3 - FURTHER DETAIL ON OUTCOMES

Personal Wellbeing

'Measuring Wellbeing' refers to how people are in themselves – their emotions, judgements and experiences⁴³. The New Economics Foundation (NEF 2012) reference external factors like housing, income, education and social networks as 'drivers of wellbeing' and 'internal' things such as health, optimism and self-esteem, which influence how people feel and function. This is captured in the NEF 2008 model of wellbeing (developed as part of the Government Office for Science's Foresight Project on Mental Capital and Wellbeing).



"The model describes how an individual's external conditions (bottom left) – such as their income, employment status and social networks – act together with their personal resources (bottom right) – such as their health, resilience and optimism – to allow them to function well (middle) in their interactions with the world and therefore experience positive emotions (top). When people function well and experience positive emotions day-to-day and overall, we can think of them as 'flourishing'⁴⁴.

43 Measuring Wellbeing A guide for practitioners. New Economics Foundation 2012

44 Measuring Wellbeing A guide for practitioners. New Economics Foundation 2012

Social Connectedness/Social Wellbeing

Workshop participants associated strong social connectedness with positive wellbeing. Social connectedness in these cases referred to the availability of and willingness to access support within a participant's local community, focusing on the extent to which people felt close enough to family, friends, organisations or professionals to enable them to participate socially in society or positive activity.

There is a wide body of literature and research identifying that individuals with a higher sense of social connectedness are likely to be more socially active, to perceive others in a more positive manner, and to engage in relationships more easily. In contrast, low social connectedness is associated with experiencing discomfort in social situations, feeling isolated and relationship dissatisfaction⁴⁵. Social connectedness, as assessed by the Social Connectedness Scale and the Revised Social Connectedness Scale is significantly associated with anxiety, self-esteem, perceived stress, depression, social discomfort, and hostility, such that high social connectedness appears to serve as a protective factor with regard to a range of symptoms of psychological distress⁴⁶.

In addition, other research identifies that people who feel socially integrated, close to, and deriving comfort from others in their community, are more likely to feel like they live in a healthy neighbourhood, perceive neighbours as trustworthy and safe and volunteer to maintain their neighbourhoods⁴⁷. This aligns with the Social Prescribing models presented throughout Ireland.

45 Lee, R. M., & Robbins, S. B. (1998). The relationship between social connectedness and anxiety, self-esteem, and social identity [Editorial]. *Journal of Counseling Psychology*, 45(3), 338–345

46 Lee, R. M., Draper, M., & Lee, S. (2001). Social connectedness, dysfunctional interpersonal behaviors, and psychological distress: Testing a mediator model. *Journal of Counseling Psychology*, 48(3), 310–318

47 Keyes, R. L., (1998). Social Wellbeing, *Social Psychology Quarterly*, 61(2) 121-140

APPENDIX 4 – PARTICIPANT PROFILE DATA SAMPLE FORM

Participant Details	First Name		
	Surname		
	DOB		
	Email Address		
	Contact Number		
	Preferred Contact Method		
	Address 1		
	Town		
	Country		
	Eircode		
	Gender		
	Ethnicity		
	Referral Info	Referral Date	
Being referred by whom			
Reason for Referral			
Relevant Medical Information	Medical Number		
Optional	Long Term Conditions		
	Medical Conditions		
	Prescribed Medication		
	Clinical Data		
	Height (cm)		
	Weight (kg)		
	Frequent Attender		
	Has Medical Card		
	GP/ED/PCT	No of GP appointments in the past 6 months	
		No of ED appointments in the past 6 months	
Urgency/Risks	Urgency		
	Risks associated when working with an individual		
Patient Consent	Patient Agrees		

APPENDIX 5 – SURVEYS TO GPs

The following is a sample list of questions that can be converted to an online survey and distributed to relevant GP practices or PCTs within the Social Prescribing Project locality. The sample survey questions are based on the Bromley By Bow Social Prescribing Service.

1. **In which GP practice are you based?** (provide drop down list of relevant local GP practices)
2. **What best describes your profession?** (provide drop down list of GPs, Mental Health Liaison Nurse, Social Worker, Occupational Therapist, Practice Nurse, Practice Manager)
3. **Are you aware of the {insert name} Social Prescribing service?** (yes/no)
4. **Have you referred to the Social Prescribing service since [insert timeframe of last project year]?** (provide drop down list of yes/no)
5. **If you haven't made a referral, please indicate why not?**
6. **If you have made a referral, was the process easy and straightforward?** (provide drop down list of yes, no, somewhat)
7. **Do you agree that overall, patients respond well to the suggestion of Social Prescribing?** (provide Likert scale: strongly agree – strongly disagree)
8. **Do you think that Social Prescribing brings benefits to the wellbeing of your patients?** (provide drop down list of yes/no/somewhat)
9. **Please Explain**
10. **Do you think that Social Prescribing brings benefits to you as a clinician?** (provide drop down list of yes/no/somewhat)
11. **Please Explain**
12. **How do you prefer to hear about services and developments that support referred patients?** (provide a drop down of direct email, letter, leaflets, presentations - Tick those that apply)
13. **Please state any improvements you would like to see made to the service**

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An Roinn Sláinte
Department of Health

