Regional Social Prescribing Baseline Assessment

May 2022

VIGOUR

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Evidence -based guidance to scale- up integrated care in Europe

https://www.vigour-integratedcare.eu/

Section 1: Introduction and Context

1.1. Introduction

S3 Solutions was commissioned by The Health & Social Care Board (HSCB) and Public Health Agency (PHA) to carry out a baseline assessment exercise to determine the scope of Social Prescribing (SP) currently underway across Northern Ireland.

The baseline assessment was supported by VIGOUR[1], a project co-funded by the EU's Health Programme addressing key questions around how to put integrated care into practice at scale. VIGOUR is designed to guide and support 15 care authorities across seven European countries in making progress towards the provision of sustainable models for care integration. This is to be achieved through the delivery of an evidence based integrated care support programme. The HSCB and PHA are partners in this project and are applying the evidence based scale up and spread approach from VIGOUR to support the growth of Social Prescribing across NI.

The specific aims of this research are:

- To identify the number and type of social prescribing services currently operating across Northern Ireland
- To establish how organisations who offer social prescribing services function including; funding, staffing, referral criteria and pathways, nature of the intervention, evaluation and outcome measures and processes
- To ascertain how Northern Ireland is geographically covered in terms of social prescribing
- To analyse those findings and provide a detailed report and a presentation to the Regional Social Prescribing Development Board.

1.2. Background to Social Prescribing

Social prescribing (SP) is at a relatively early stage of its development in Northern Ireland. A further aim of this report is to consider the extent to which Social Prescribing projects are meeting or aligning with the definition of Social Prescribing.

1 www.vigour-integratedcare.eu

In the absence of an NI specific definition and for the purposes of this work, the UK Social Prescribing Network's definition of social prescribing and the definition from the Republic of Ireland's Health Service Executive (HSE) were provided as a guide.

UK Social Prescribing Network Definition

"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".

HSE definition

"Social prescribing is an effective means of engaging people in non-clinical activities and services in their communities in order to promote their health and wellbeing and reduce health inequalities. It generally involves healthcare and other professionals referring people to a social prescribing link worker, who supports them to access local services through discussion and joint decision-making".

1.3. Methodology

Data Collection

Data was collected through semi-structured interviews, small group discussions and an online survey. The following summarises the data collection activities undertaken between 4th March and 6th May 2022.

- Twelve semi-structured interviews were carried out with organisations from the community, voluntary and statutory agencies, that are delivering or overseeing the development and delivery of Social Prescribing Services. Due to Covid-19 restrictions, all of the interviews were carried out over Zoom. A full list of organisations represented in the consultation process is provided in appendix 2.
- One online group discussion was facilitated with representatives of Multi Disciplinary Teams, GP Federation representatives and the Department of Health.
- An online survey was distributed to partners of the SPRING Social Prescribing Project generating four responses.

Sampling

The selection of research participants involved the following:

1. A list of 12 contacts were provided to the researchers by the team at HSBC/PHA. These contacts represented individuals that were known to be delivering, overseeing or managing projects that either explicitly describe as Social Prescribing, or that demonstrate characteristics that show alignment to Social Prescribing definitions. During the course of the consultation process, all of those consulted were asked to identify any other known Social Prescribing projects. No additional projects beyond the original list were identified. Whilst there are many that use signposting and referral (i.e. PHA GP Exercise Referral, Primary Care Talking Therapy Hubs, Family Support Hubs), none of these identify explicity as Social Prescribing. If there are projects delivering Social Prescribing in NI, not engaged by this research, it is likely that they are operating at a very local level, thus we believe that the information presented in the report represents an accurate reflection of existing provision.
2. The implementation of Primary Care Multi-Disciplinary Teams (MDTs) in GP Practices represents a major Transformation initiative funded by the Department of Health. MDTs consists of Physiotherapists, Social Workers, Social Work Assistants and Mental Health Practitioners, who work with GP Federations, in GP Practices alongside the existing practice teams to provide enhanced access to health and social care services within a primary care setting. The relationship between Social Prescribing and MDTs emerged consistently during the research, in particular, the potential alignment/syngery of the Social Worker to Social Prescribing. Thus, representatives of MDTs were identified through the Department of Health and invited to contribute to the research.

Data Analysis

The substantive focus of the interviews was to source factual data about projects, operating models, staffing, terms and conditions, outcomes and evaluation. The interviews also explored some of the emerging challenges and priorities for Social Prescribing, analysis of this data was conducted using a thematic approach[2], cross referenced with secondary data to identify emergent themes and issues and to explore the relationships between issues[3]. A brief desk-based review of secondary data was carried out including monitoring reports, annual reports and evaluations provided by projects, as well as other research, strategy policy documentation relevant to Social Prescribing.

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

Section 2: Social Prescribing in NI

2.1. Current Situation

As of May 2022, we identified six live projects operating across Northern Ireland which appear to meet the definitions of social prescribing . These are listed in the table below:

Project Name	Delivered by	Funded by
Spring SP	13 Healthy Living Centres led by Bogside and Brandywell Helath Forum	National Lottery Community Fund
Spring Enhanced Rural Project	10 rural organisations led by Derg Valley Care	Department of Agriculture, Environment and Rural Affairs (DAERA)
Connected Community Care	A partnership between Belfast Health and Social Care Trust, GP Federations and community and voluntary organisations	Belfast Local Commissoning Group and MacMillan
IMPACTAgewell®	Mid and East Antrim Age Well Partnership working with GP practices and community pharmacies	Dunhill Medical Trust and Health and Social Care Board
Community Health Trainers	Southern Health and Social Care Trust (SHSCT) through the Verve Network	Department for Communities（DfC)
Caring Communities	South Eastern Health and Social Care Trust (SEHSCT)	South Eastern Health and Social Care Trust (SEHSCT)

**Connect North led by the Northern Health and Social Care Trust and with some additional funding from the NHS Charities Together Fund is in the process of establishing structures and recruiting staff and is not yet receiving referrals. This project will become operational in 2022 and has funding until September 2024*.*

During the course of this research, a number of key changes in the Social Prescribing landscape emerged including:

- Age NI – a service provided by Age NI and funded by the Northern Health and Social Care Trust ceased in March 2022. The service provided will now be embedded under the Connect North Project (captured in the reference above) and will be subject to a public procurement process.
- mPower was a five-year project supported by the European Union's INTERREG VA Programme, managed by the Special EU Programmes Body (SEUPB). The project was a cross-border collaboration to support older people (age 65+) living with long-term conditions across the Republic of Ireland, Northern Ireland and Scotland. The project was delivered by Southern Health & Social Care Trust and Western Health & Social Care Trust in partnership with others. The project started in late 2017 and finished in May 2022.

There are a range of delivery models and governance approaches across the six 'live' Social Prescribing projects. The variations in the design and the delivery of the models are evident in the differing levels of integration between the statutory sector and the V&C sector, the governance and employment arrangements, as well as the intensity of engagement with participants, terminology used, funding arrangements and access to primary care teams.

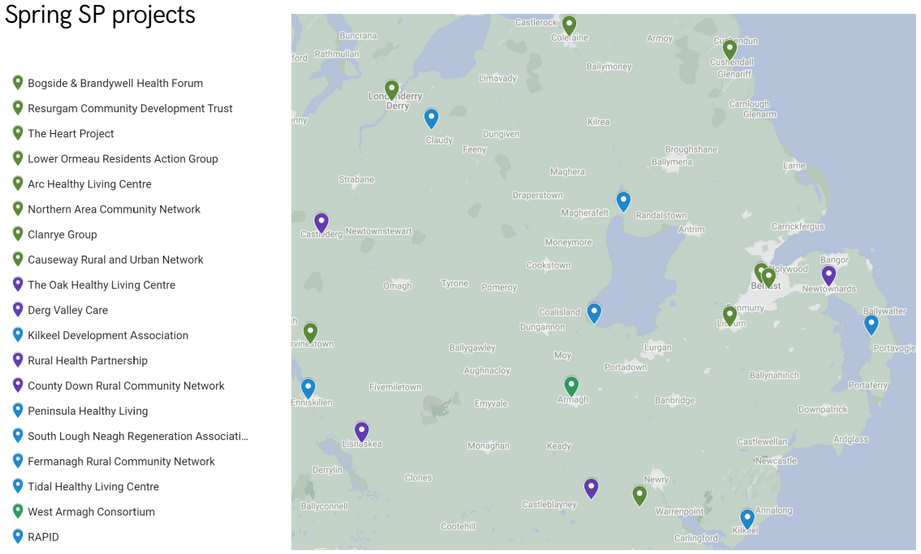
Of the six live projects only two have recurrent funding in place. The funding for the SPRING and SPRING rural enhanced projects is due to end in June 2023 and if not sustained will mean a significant decrease in Social Prescribing provision across the region.

The various projects are described below.

2.2. SPRING and SPRING Rural Enhanced

The map below shows the primary location of the Spring and Spring Rural Enhanced projects.

Projects in blue are Spring Enhanced Rural Projects
Projects in purple are part of both Spring SP and Spring Rural Enhanced
Projects in green are Spring SP projects



The Spring SP and Spring Enhanced Rural Project are delivered by a network of community and voluntary organisations, primarily aligned to the Regional Healthy Living Centre Alliance Network.

These projects help adults (18 years and over) to address their health & wellbeing by connecting them to sources of support within their local community.

- **Spring SP** is delivered in 13 locations across NI, it provides funding for 18 Social prescribers with 11 of those being full time and 7 part time. Three of the Spring SP partners also deliver Spring Rural Enhanced.
- A further 6 organisations deliver **Spring Rural Enhanced** only, providing an additional network of 11 part time Social Prescribers across NI.

Collectively the projects target approximately 2000-2400 people across NI per annum. The collective geographic reach of the Spring and Spring Rural Enhanced projects is significant, with individual partners having a varied remit typically spanning a number of district electoral areas, a neighbourhood renewal area, entire local authorities or entire Health and Social Care Trust areas. The project has developed positive relationships with primary care in some of its settings, but further development and integration is a key priority. Spring SP comes to an end in December 2022, Spring Rural Enhanced in June 2023.

2.3. Connected Community Care

This project was designed through a collaborative approach led by Belfast Integrated Care Partnershps and is delivered through a partnership between, Belfast Health and Social Care Trust, GP Federations and local community and voluntary providers. Anyone aged 18 and over and registered to a GP in Belfast can access the service, this means that the service extends to parts of Lisburn and areas of Antrim & Newtownabbey Borough Council. The service has just recently opened its cancer work stream to offer support to clients with a diagnosis of cancer across Northern Ireland, this work stream is funded by Macmillan until March 2023. Ten Link Workers are employed under Connected Community Care including:

- Four Wellbeing Coordinators (employed by GP Federations)
- Two Dementia Navigators (employed by BHSCT)
- Four Cancer Link Workers (employed by BHSCT)

The project is also supported by an overall Service Manager, Programme Manager for Cancer, Co-Production Manager and data support officers. Over the past four years since commencement the project received an average of 2100 referrals per annum. Connected Community Care is positioned and considered as a community aligned Social Prescribing Project with strong collaboration with community & voluntary organisations, this is reflected in the fact that staff often locate in community based settings such as Healthy Living Centres. In addition, a drive by the leadership team to ensure that community development principles/community development experience were key factors in the recruitment of staff is recognition of the value placed on the community alignment ethos of the project.

2.4. IMPACTAgewell®

The IMPACTAgewell® Programme employs five full time 'IMPACTAgewell® Officers' to deliver their service across Mid & East Antrim area including, Carrickfergus, Larne and Ballymena working in partnership with 20 GP Surgeries. The model – which is led by local charity the Mid and East Antrim Agewell Partnership (MEAAP) has been co-produced and is being delivered in collaboration with GPs and community pharmacists. It seeks to provide integrated support to people over the age of 60 who live alone or with another older person in your own home or a sheltered housing and have at least one long term health condition. At the outset of the project, IMPACTAgewell® negotiated access to health related data held by GPs, Community Pharmacies and the Northern Health and Social Care Trust, this has facilitated and enabled the organisation to carry out a Fiscal Return on Investment in relation to potential savings made as a result of older people accessing unscheduled Health and Social Care Services. The IMPACTAgewell® project is funded until 2025.

2.5. Caring Communities

Caring Communities Safe & Well – started in 2016 as follow up to the Safe & Well Service funded by the National Lottery Community Fund. The project is now funded permanently through South Eastern HSCT. The project covers the entire SEHSCT area and comprises two distinct components:

- **Safe & well (targeting 65+ who are lonely)** – the service focuses on improving health & wellbeing of older persons by signposting and referring them to appropriate services to meet their needs following initial assessment. The project employs 4 Caring Community Officers (trying to rebuild after COVID with currently 1 in position) and an administrative assistant. Volunteer befriending services also fall under the umbrella of safe & well and include a Volunteer Befriending Facilitator and a Volunteer Befriending Officer.
- **Wellbeing Hub** (targeting adults 18+ years that attend GP practices within Down, North Down & Ards to improve mental wellbeing). The service commenced in 2021 for people with a step 1 or 2 mental health condition. Staff within the Wellbeing Hub inlcude re-deployed personnel from within existing permanent posts for 1 day per week. The staff are typically Band 6 Service Coordinator and Band 3 Admin Assistant. The initial assesstment is carried out by the MDT team and the Wellbeing Hub staff provide an onward referral and signposting service typically into Talking therapies, CBT, counselling, condition management and social supports.

2.6. Community Health Trainers Project

The Community Health Trainers project is funded by DfC who commission the Southern Health and Social Care Trust to lead the delivery through the Verve network. The project is statutory led, however there is significant community engagement and health trainers are people from the local community. The project operates using a sessional model whereby 15 self employed health trainers are engaged on an hourly basis to provide support to participants across the Brownlow, Lurgan, Portadown Neighbourhood Renewal areas[4].

2.7. Connect North

The Connect North is a project of the Northern Health and Social Care Trust, supported by funding from NHS Charities Together. Its remit will be anyone aged 18 and over across the geography of the Northern Health and Social Care Trust area. The project is in the process of establishing structures, evaluation frameworks and management systems but intends to provide an overall team of six Link Workers, two of which will be employed directly by the NHSCT and four of which will be subject to a procurement process whereby local community and voluntary organisations will host and manage Link Workers directly, under the auspice and banner of Connect North, thus representing a hybrid approach. The project will not be live until later in 2022 and is funded until September 2024.

The project has developed following extensive consultation over a 2 year period with service users, community and voluntary organisations and statutory providers. This engagement process was designed to ensure syngery and connection between community and statutory provision, this is reflected in the proposed staffing model (4 located in and employed in the community).

2.8. Summary of the Current Situation

In respect of the number and type of projects currently operating in Northern Ireland:
There are six live projects operating in NI as of May 2022 using a range of delivery models and governance approaches.

- Collectively, the six projects involve 48-52 FTE Link Workers/Navigator/Social Prescribers. In total there are:
    - 32[5] Full time Link Workers/Social Prescribers (16 employed by C&V organisations and 16 by Health & Social Care Trusts)
    - 18 Part time Link Workers/Social Prescribers (16 employed by C&V 2 by HSCT)
    - 20 Sessional staff
- Collectively, the six projects are capable of engaging with circa 5500-6500 participants per annum using a broad range of Social Prescribing delivery models, described later in the report.
- Funding for 22.5 of the 43.5 FTE Link Workers/Navigator/Social Prescribers ceases in March or June 2023.
- There are a range of funders of Social Prescribing in NI and up until May 2022 the following organisations were or are funding SP services: DAERA, National Lottery Community Fund, Department for Communities, Northern Ireland Housing Executive, Health & Socical Care Trusts, HSCB, NHS Charities Together Fund, MacMillan Cancer Support, Dunhill Medical Trust, Interreg VA.

4 DfC Neighbourhood Renewal cannot guarantee any funding support for projects with consideration to (1) budget availability and (2) the Review of People and Place which may result in different approach to addressing deprivation
5 *33 currently in post

Section 3: Social Prescribing Models

3.1. Introduction

This section provides commentary on the alignment of the SP projects against the UK and HSE definitions of Social Prescribing.

3.2. Alignment with Social Prescribing Definitions

Across the six live projects, there are several areas of alignment with the UK and HSE definitions of Social Prescribing, these include:

1. Referral reason: the main reasons for referral to SP projects in NI according to those consulted are isolation and/or loneliness followed by poor mental health, anxiety, chronic pain and depression. The projects engaged in NI all described focusing on addressing health inequalities. This aligns with the 'social, emotional and practical needs' as referenced in the UK definition, whilst reducing health inequalities is referenced explicitly in the HSE definition.
2. Referral destination: both the UK and HSE definitions indicate that patients/people are referred to "services provided by the community and voluntary sector" or "non clinical activities and services in communities". In NI, the most common onward referral destination is to social groups, peer support groups, befriending and internal health programmes.
3. Outcomes Reported: In NI, projects report that mental health and wellbeing, social connectedness and physical health and wellbeing are the most common outcomes achieved by participants. Both the HSE and UK definitions reference improved health & wellbeing as intended outcomes.

3.3. Divergence with Social Prescribing Definitions

There are two key areas of potential divergence to Social Prescribing definitions, these include:

Referral source: Both the HSE and UK definitions identify "GPs, frontline healthcare professionals and "other professionals" as the source of referral in Social Prescribing, although the terminology "generally" in the HSE definition leaves this open. In NI, the clear majority of referrals overall come from primary care sources which is in alignment with both definitions. However, referrals from other community and voluntary organisations was the next most common source and of the nine projects that were operating up to May 2022 (Including mPower and the Age NI) project, the majority (n=7) accepted self referrals. Other referral sources listed as: PSNI, Housing Associations, Fire Service, Reablement Teams, Social Work teams, Community Pharmacy Hubs. This represents a potential divergence from the HSE and UK definitions. The two projects that do not accept self referrals are Spring and Spring Rural Enhanced, this may provide a rationale for divergence in ratio of referrals in to the various projects.

Intensity of Engagement: The HSE and UK definitions reference the role of the link worker in developing 'personalised solutions through co-production' and 'joint decision making'. Whilst the projects in NI all make reference to co-production, person centred approaches and/or holistic needs assessments, there was a some variation in the intensity of engagement by Social Prescriber/Link Worker across the projects in NI.

To describe this variation, we use the continuum of SP models as described in Kimberlee (2015)[6]. It sets out four SP approaches:

- **SP as Signposting** – the intervention is signposting patients onto appropriate networks and groups who may assist the individual to address their wellbeing needs.
- **Social Prescribing Light** – these are typically primary care or community based interventions which refer at risk or vulnerable patients to a specific programme to address a specific need or objective, e.g. exercise on prescription, prescription for learning and arts on prescription.
- **Social Prescribing Medium** – this approach typically includes a health facilitator who may provide some form of therapeutic intervention, albeit at limited intensity. It will then signpost to voluntary organisations or other services. It typically has a local remit in that it works within a geographically defined neighbourhood. It does not seek to address the beneficiary needs in a holistic way, moreover it aims to address specific needs or behaviours identified by a GP or other primary care referrer.
- **Social Prescribing Holistic** – these projects adopt a preventative approach, engage patients with long term conditions and encourage patients to play a central role in managing their own care. These involve addressing health and wellbeing needs identified by both the primary care referral and those identified by the third sector provider. The SP project will look at needs in a holistic way and may offer support in terms of budgeting, nutrition, addiction, loneliness, employment and there are usually no limits as to the length or intensity of engagement.

The model used has implications for both caseload and client engagements. Most projects in NI typically operate a caseload approach which ranges from 5 to 120 and averages at a caseload of 44 per Link Worker/Social Prescriber. A caseload approach is more embedded in Social Prescribing Holistic models but less defined in Social Prescribing Medium-Light-Signposting.

The model also has implications for the length of time that participants are engaged with a service, as well as the number of engagements with the Link Worker/Social Prescriber. In projects that operate towards the SP Signposting-Light of the continuum, the number of engagements is usually 1 which is reflected in the SEHSCT Caring Communities Safe and Well Project.

Of the six live social prescribing projects detailed within this report, five operate within the Social Prescribing Holistic approach that includes multiple engagements with patients ranging from 2-6[7] and participants can exit then re-enter the service in a flexible and person centred way. The needs addressed are identified and co-designed with the participant.

6 Kimberlee,!R.!(2015).!What!is!Social!Prescribing?!Advances)in)Social)Sciences)Research)Journal,)2(1),!102P110.
7 This report does not make a judgement or assessment on the impact or effectviness of one model over another.

Section 4: Trends Across Projects

4.1. Introduction

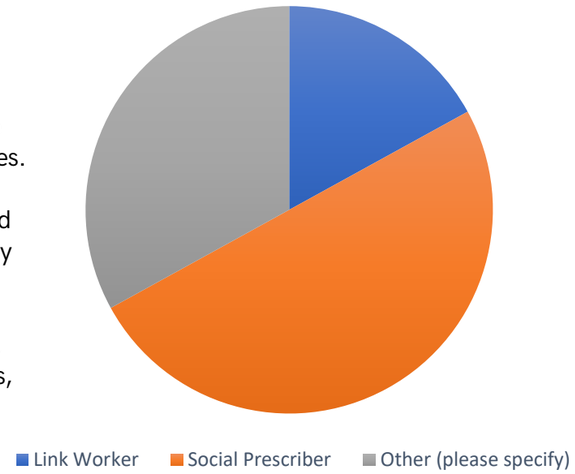
This section summarises some of the emerging trends across the various SP projects in NI including language and models used, employment conditions, approaches to evaluation and referral pathways. The information presented herein also includes contributions from projects that are no longer operational.

4.2. Link Workers/Social Prescribers

Terminology used to describe staff

Contributors use a range of terminology to describe those employed to provide Social Prescribing Services.

The term 'Social Prescriber' is used in the Spring and Spring Rural Enhanced projects whereas terminology such as Navigator and Link Worker was more consistent with staff employed by Health and Social Care Trusts. Others include Community Navigators, Caring Community Officers, Wellbeing Coordinators, Health Trainers, IMPACTAgewell® Officers.
For the purposes of this research we use Link Workers/Social Prescribers.



Salary Scales

Salary scales for Link Workers/Social Prescribers range with an emerging trend of higher salaries for those employed by statutory/HSCTs compared to those employed by community and voluntary organisations. Using the Health and Social Care Pay Band[8] as a guide, salaries for community and voluntary employed Social Prescribers range from entry Band 4 to Band 5 whereas for statutory/Trust employees, salaries range from entry Band 4 to intermediate Band 6. Lower band salaries for Statutory/Trust employees tend to align with an external funding arrangement, compared to internally funded posts that oocupy higher salary bands.

8 https://jobs.hscni.net/Information/8/pay-bands-in-health-social-care

It should be noted that there are only a small number of projects overall within which to carry out comparisons and that payscales provided by some HSCT led projects followed extensive research of other Social Prescribing projects across the UK and thus were reflective of the rates provided, these may offer a more accurate reflection of the Link Worker/Social Prescriber role.

The clear majority of Link Workers/Social Prescribers have access to pension contributions.

Training and qualifications

There is a reasonable level of consistency in respect of training and qualifications required by Link Workers/Social Prescribers. The need for a degree or equivalent qualification is usually required, particularly in statutory/HSCT employed roles in line with embedded organisational recruitment practice. The following is a sample essential criteria from a recently advertised Mental Health Navigator role: A professional qualification in nursing, social work or an allied health profession and live on the relevant register.
In community and voluntary sector employed roles, a degree or university equivalent qualification is not always required and contributors consistently referred to evidence of a background and experience in Health and Social Care as 'more important'. The following set of additional qualifications/training and or experience emerged consistently as 'important':

- Motivational Interview Levels 1&2
- Mental Health First Aid
- Vulnerable Adult Safeguarding
- ASSIST and/or SafeTalk
- Trauma Informed Care Levels 1&2
- Community Development
- GDPR
- Implementing evaluation tools
- Condition specific training where appropriate such as Macmillan specific training for cancer workers i.e loss and bereavement and reflective practice/palliative care
- OCN level 3 Health Facilitator
- Royal Society of health level 2 and 3

A number of common characteristics of a 'good' Link Workers/Social Prescriber emerged. The most common, overwhelmingly, was their understanding and alignment to community development principles ('have their ear to the ground'), referring to an embedded knowledge of what exists in the local community and therefore an ability to connect people to services, leverage resources and build connections. Providing an empathetic, non judgemental service, an ability to listen, motivate and communicate clearly also emerged as key characteristics.

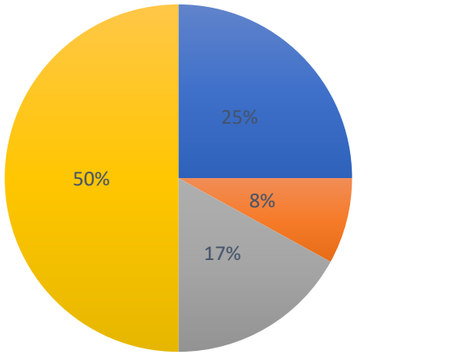
Having that local knowledge and genuine link to the local community was a key feature of all of the social prescribing projects but is particularly obvious in those projects that are led and delivered by community organisations e.g. SPRING and IMPACT Agewell©.

Many felt that the desired characteristics of 'good' Link Workers/Social Prescribers were potentially inconsistent with the requirement for degree level qualifications, thus the emergence of Social Prescribing specific qualifications, such as that provided at Queens University, is an area of interest for all of those consulted, suggesting that a specific qualification may add gravitas, value and respect on the role of Social Prescribers/Link Workers.

4.3. Social Prescribing Participants and Referrals

Terminology used to describe people accessing services

Projects use a range of terminology to describe those accessing a SP service.



There is no consistent, agreed terminology for those accessing services, most use the terminology 'clients' with 'service users' the second most common. Referral criteria is influenced by a number of key factors :

- **a** Age - Four of the six live projects are accessible to all adults (aged 18 and over) and two are aimed at older people.
- **b** Usual resident location of the client – this may be determined by the source of funding (i.e. Neighbourhood Renewal funding will target those within respective neighbourhood renewal areas).
- **c** Severity of presenting issue – SP services typically support those with low to moderate level anxiety/ mental health challenge. Clients are assessed for appropriateness of referral, those that are inappropriate are typically referred to other relevant services.
- **d** Condition specific criteria - Connected Community Care offer both Dementia and Cancer specific supports, these are part of the referral criteria for these services.

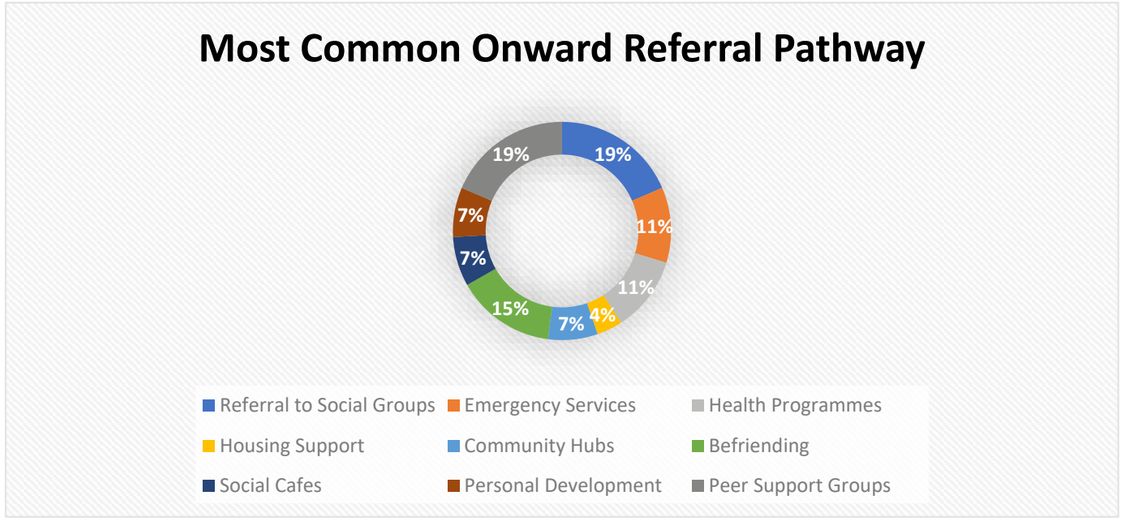
Referral Sources

Respondents provided information on current referral sources. The clear majority of referrals overall come from primary care sources followed by other community and voluntary organisations. Of the nine projects that were operating up to May 2022 (Including mPower and the Age NI) project, the majority (n=7) accepts self referrals with other referral sources listed as : PSNI, Housing Associations, Fire Service, Reablement Teams, Social Work teams, Community Pharmacy Hubs.

8 https://jobs.hscni.net/Information/8/pay-bands-in-health-social-care

Onward referral pathways

In respect of onward referral pathways; social groups, peer support groups, befriending, internal health programmes and emergency services represent the most common onward referral destinations for those accessing a service.



The majority of those engaged describe current referral pathways as 'fairly effective', the need to develop a more streamlined process between primary care and SP projects was cited as the main challenge or issue in order to enable more referrals from general practice and to allow feedback to the referrer. In particular the need for development of and/or use of an accessible digital tool for the above was identified.

There is a trend towards greater access to primary care/MDT teams in projects operating in a more integrated way e.g. Connected Community Care and IMPACT Agewell© with examples of easier mechanisms for referrals from GP/ Community Pharmacy as well as participation in MDT meetings. Those projects also tended to have easier access to onward referrals for support within the statutory sector.

Geographic Reach

It was challenging to determine and define the geographic reach of Social Prescribing Services. Overall, the capacity of Social Prescribing in Northern Ireland is reasonably small and whilst many services are 'technically' accessible to entire ICP areas or local authorities, the extent to which all parts of the ICP or local authority are 'reached' is not clear. Anecdotally, it is the view of those consulted that there are some regional 'gaps' at present in areas such as Dungannon Bangor, Ards, Limavady although this report has made reference to the significant drop off in community led services as at June 2023 which will further exacerbate gaps in provision.

4.4. Outcomes and Evaluation

Reason for Referral

The most common reason for referral to SP projects across NI is isolation and/or loneliness followed by poor mental health, anxiety, chronic pain and depression. In relation to other reasons for referral, issues such as bereavement, food poverty, fuel poverty and nuturion were referenced by contributors.

Approaches to Evaluation

The approach to evaluation is reasonably consistent across Social Prescribing Projects. An Evaluability Assessment of Social Prescribing[9] carried out in 2019 identified an Evaluation Index to frame approaches to monitoring and evaluation for Social Prescribing projects.

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	✗	✗	✗	✗	✓

All projects in NI are using validated tools to collect baseline and follow up data with the most common tools including:

- Shortened Warwick Edinburgh Mental Wellbeing Scale
- Outcomes Star
- Holistic Needs Assessment
- UCLA Loneliness Scale

All projects are gathering qualitative feedback through case studies to support pre and post measures, aligning with approach 3 in the evaluation index opposite.

One project is investing in action research to inform a return on investment based evaluation, aligning with approach 4 of the evaluation index although overall there is limited information in respect of waiting lists or cost savings within the 'system'.

9 https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/social-prescribing.pdf

Two of the projects are currently using digital software (Elemental) to collect and store evaluation data. One (Connect North) is in the development stage and is considering digital approaches, others are using in-house data collection and storing systems such as Microsoft Excel and internal CRM systems.

Outcomes Achieved

It is outwith the scope of this report to evaluate the impact or effectviness of the various SP services. All of the projects however can point to powerful and impactful stories of participant/client outcomes – primarily in relation to their mental health and wellbeing, social connectedness and physical health.

Consistently across the consultation process, stakeholders referenced "Money following the patient" as a critical success factor and an enabler of positive outcomes, there is a strong feeling that the availability of programme monies for the C&V sector to complement referrals and interventions by the Link Worker/ Social Prescriber contributes significantly to improved outcomes. There appears to be greater scope for this approach within those social prescribing projects which are delivered in a more integrated way.

4.5. Summary

Social Prescribing is in its infancy in Northern Ireland and there is a reasonably small sample of projects overall, however, the following summary points reflect the key findings:

- Degree of Alignment with the current definitions of Social Prescribing are influenced primarily by two key factors: referral sources and intensity of approach. Five of the six projects align well with the definition and with the 'holistic' approach. Projects that are more integrated with statutory services (for example Connected Community Care or IMPACT Agewell®) appear to have greater access and stronger connections with MDTs and primary care, This access, combined with the very strong community development ethos of C&V led and delivered projects e.g. SPRING represents a potentially attractive hybrid approach to SP.
- There is a reasonably consistent approach in respect of referral criteria – this is typically influenced by age, geography and extent of the presenting issue.
- There is an emerging trend towards more secure roles with potential for higher salaries for those employed by statutory/HSCT organisations. This may represent a more accurate reflection of the required terms and conditions of Social Prescribers/Link Workers.
- There is a lack of consistency in respect of terminology and language used across projects for both staff and those engaged by Social Prescribing services.
- In more integrated models there appears a greater likelihood for access to resources that enables 'money to follow the patient' although this could be enhanced significantly. This is considered important in enhancing outcomes for participants.

Section 5: Future Challenges

5.1. Introduction

This section sets out a summary analysis of the barriers, challenges, evolution and future development of Social Prescribing according to those consulted, this analysis may be helpful in shaping the process to agree a definition and key principles of Social Prescribing in NI.

5.2. Defining Social Prescribing

The absence of a clear and agreed definition of Social Prescribing was identified as a challenge by all contributors. We understand that Social prescribing is at a relatively early stage of its development in Northern Ireland and a Regional Social Prescribing Development Board has recently been established. Agreeing a definition and key principles for SP is one of the Board's initial priorities along with understanding the current baseline. Some of the key dimensions of 'defining' Social Prescribing emerged during the consultation process, including:

- **Social Prescribing Model** – many of those engaged suggest that the Link Worker/Social Prescriber is the critical link in the causal chain and thus a dilution of this role is to dilute Social Prescribing. Whilst six live projects were identified that explicity describe as Social Prescribing (or deliver services that demonstrate characteristics of Social Prescribing), there are many others that adopt assessment, signposting and onward referral processes (GP Exercise Referral, PCCT, Family Support Hubs) but don't define as Social Prescribing – a comparison of models may be useful in defining 'what is and what is not' Social Prescribing, thus shaping an NI definition.
- **Self Referrals** – there are contrasting views on the appropriateness of self referrals. For several of those engaged, self referral happens in local communities on a regular basis, this suggests a pre existing motivation to engage and is more reflective of traditional community development approaches. For others, the relationship to primary care as a referral source is key, as this enables impacts and outcomes on both the participant and 'the system'.

The development of an agreed definition of Social Prescribing is important and is underway through the Regional SP Development Board. The process of agreeing a definition would benefit from the input and engagement from a range of cross sectoral stakeholders. This 'co-design' process by its very nature could help to address some of the existing tensions and challenges as set out in section 5.3 below, helping to develop a unity of purpose around the role and position of Social Prescribing as it relates to MDTs and the new Integrated Care System. This process may also assist in the development of an official Social Prescribing policy which currently does not exist.

8 https://jobs.hscni.net/Information/8/pay-bands-in-health-social-care

5.3. Digital Solutions

The need for a 'truly accessible' IT system or mechanism which better connects GPs/MDTs to Social Prescribing was referenced consistently by stakeholders. The term accessible relates to the extent to which both GPs and Social Prescribers can access and share referrals and patient data/progress and how the system complements HSC systems in development e.g. Encompass.

There is also opportunity to build on the work of the mPower project to make better use of digital tools within Social Prescribing. This could enable service users to have more understanding about, and to take more control of, their health and wellbeing. COVID-19 necessitated a digitisation of services and providers adopted quickly to support participants and to manage services remotely. Those consulted identified a need to further invest in digital skills and digital literacy to enable effective use of digital tools.

5.4. Outcome Measurement

Despite slight variations in delivery models, all of the projects engaged report positive participant outcomes in wellbeing (mental, physical) and social connectedness. An exploration of the extent to which outcomes are achieved across the various delivery models, including the implications of self referral may be an interesting area of future research. In addition, this report highlights the lack of access to 'system' based outcomes for Social Prescribing. This relates to: reduced mental health waiting lists, increased efficiency of GP appointments, reduced pressure on GPs or Primary Care staff for example. Better integration of Social Prescribing to primary care through IT systems and sharing of data as part of any future evaluation of funding may help to better determine the effectiveness and social return on investment of Social Prescribing services.

5.5. Relationship between SP and Primary Care MDTs

Stakeholders universally acknowledge the potential syngery between the clinical expertise of MDTs and the community development values of Social Prescribing which is difficult to replicate in primary care. There are several examples of positive relationships and partnerships between community providers and MDTs. However, it was consistently the view of contributors that a tension exists between some of the MDT disciplines and Social Prescribing services. There are a number of emerging themes:

- There is a perceived overlap between the role of Social Workers and Social Prescribers/Link Workers. SP services referenced examples of Social Workers facilitating walking groups or low level community activity as a source of frustration. It is the view of SP services that this does not represent the most effective use of Social Workers time, and in essence is precisely where Social Prescribing and the wider voluntary and community sector can play a role. This, it is the view of several SP services, speaks to a lack of value and credibility of Social Prescribing by some within MDTs and/or Primary Care.
- Conversely, many Social Workers do not have access to a SP service in their area and due to recruitment delays, do not have the support of Social Work Assistants (Band 4) who would naturally support this type of activity. In order to service the needs of those presenting to the service, Social Workers have had to 'step up and deliver', using professional judgements on a case by case basis as to the most appropriate form of support.
- There are examples of close integration between MDTs and Social Prescribing, particularly in West Belfast, where the Connected Community Care lead is to become part of the operational management group of the local MDT, offering a community insight at the MDT table. In addition, a single point of contact within the community and voluntary sector has been provided for the Primary Care Multi-Disciplinary Team (MDT) in the Down area. Community Mobilisation Hubs or other area based networks were also identified as a useful point of engagement for both MDTs and Social Prescribers who are already typically represented at these groups. There are several ways in which MDTs and Social Prescribing can achieve strong integration but the principles of openness, transparency and positive relationships should be at the core.
- It is difficult to decouple some of the existing tension from the significant need and demand for support against the availability of resources. There is consistent agreement that the demand outstrips the supply of support, particularly in areas with limited Social Prescribing coverage. This research process has established the relatively low reach of Social Prescribing services in NI, reinforcing this point. While it was not within the scope of this work to review the level of funding within SP projects or the value for money across SP services, the need for a longer term, sustainable funding model was identified consistently by those consulted as a major priority for SP.

5.6. Equity of Access and Sustainable Funding

Anecdotally, it is the view of those consulted that there are some regional 'gaps' at present in areas such as Dungannon, Bangor, Ards and Limavady. Further engagement to map the reach of services in partnership with GPs may be important to enable future planning and investment decisions in Social Prescribing.

The potential loss of both Spring SP (December 22) and Spring Rural Enhanced (June 2023) will result in a reduction of 22.5 Full Time Equivalent Social Prescribers across 17 locations in NI with a capacity to engage circa 2000+ people per annum. This will be a significant loss in the short term. In addition, some of the other services are supported by external funding which will expire in 2023/2024 or are subject to annual review. Contributors are concerned that the loss of personnel will result in a significant loss in terms of local relationships, connections and ability to refer participants to services – which is at the core of the Social Prescribing process. The need to develop sustainable funding models and competitive terms and conditions was flagged as important in attracting and retaining good quality staff.

We understand that the Healthy Living Centre Alliance and its respective partners are, as would be expected, developing plans and strategies to extend funding as part of an amalgamated Spring SP and Spring Rural Enhanced Project. In addition, other HSCT areas are developing plans to renew or develop SP services in their respective areas.

The emergence of Peace Plus funding[10] (themes 4.1 and 4.2) has the potential to be to be a significant source of funding for SP projects. There is merit in considering a strategic and collaborative approach to this fund, to maximise the reach and impact of SP services.

10 https://seupb.eu/sites/default/files/styles/PEACE%20PLUS%20Public%20Consultation/PEACE_PLUS_Consultation_Information_Document_FINAL.pdf

Appendix 1: List of Consultation Participants

1. Southern Health and Social Care Trust
2. SPRING Social Perscribing Rural Enhanced
3. Spring Social Perscribing
4. Connected Community Care (Eastern FSU/Belfast Trust)
5. Northern Health & Social Care Trust
6. Impact Agewell®
7. Age NI
8. mPower Project
9. Verve Healthy Living Network
10. South Eastern Health & Social Care Trust
11. Healthy Living Centre Alliance
12. Western Health and Social Care Trust Trust
13. Multi Disciplinary Team Representatives x 2
14. Western GP Federation
15. Department of Health
16. North Antrim Community Network
17. County Down Rural Community Network
18. Oak Healthy Living Centre
19. West Armagh Consortium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