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SPRING Social Prescribing Project

Evaluation Report

November 2020 - December 2022

Bogside & Brandywell Health Forum An Fóram Sláinte

Healthy Living Centre Alliance

Scottish Communities for Health & Wellbeing

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1. Introduction

Background to Project

1.1. SPRING Social Prescribing (SPRING) helps people 18+ to address social, emotional, and practical needs by connecting them to sources of support within their community to improve their health and wellbeing.

1.2. SPRING is funded by The National Lottery Community Fund and is a partnership between the Scottish Communities for Health and Wellbeing (SCHW) and the Healthy Living Centre (HLC) Alliance in Northern Ireland. The lead organisation is Bogside and Brandywell Health Forum (BBHF).

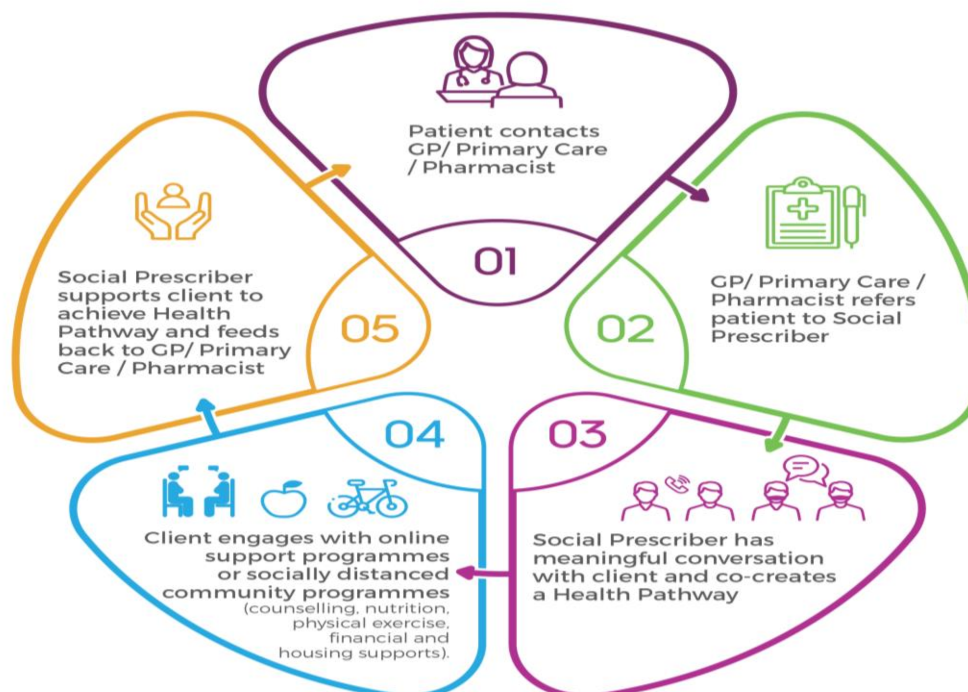
1.3. Social Prescribers serve communities in socially deprived areas throughout Scotland and N. Ireland and are based in delivery partners. Delivery partners are community-led health organisations and members SCHW or HLC Alliance.

Project overview

1.4. SPRING aims to take a holistic approach to addressing the needs of people presenting to Primary Care, creating a link between the health service and the community. SPRING works with individuals to ask the question 'what matters to you?', rather than 'what is the matter with you?'. This enables a GP or Primary Health Care professional to refer patients who are experiencing; social isolation, low mood, mild depression, chronic pain, other long-term conditions, or physical inactivity to appropriate community-based support programmes and activities.

1.5. A social prescriber spends time engaging with each person referred to SPRING, listening to their needs and exploring services and activities that can help them improve their health and well-being. Using a co-production approach, the client choses which supports to avail of, and a health pathway is developed. Elemental Software (Elemental) is the digital platform used by each delivery partner to record social prescriptions. The impact on health and wellbeing is measured using the Short Warwick Edinburgh Mental Wellbeing Scale and the Outcome Star.

1.6. The diagram below summarises the SPRING delivery model:



1.7. SPRING was initially awarded funding of £3.19m for 3 years commencing on 1 July 2018. This was then extended until June 2023 when an additional £1.8m was agreed to cover years 4 and 5 of the project. The National Lottery Community Fund provided an additional £263,053 to enable partners to continue delivery in year 5 of the project from 1 January 2023 to 30 June 2023. Funding for SPRING from The National Lottery Community Fund will end on 30 June 2023.

1.8. This final evaluation report covers the period November 2020 to December 2022. Two previous evaluations of SPRING have been carried out, covering the periods July 2018 to June 2019 and July 2019 to October 2020. This report builds on the previous evaluations and should be read in conjunction with these documents.

Theory of Change Model

1.9. The Theory of Change model for SPRING shows the anticipated progression from inputs (what is put in) through to outputs (what happens), outcomes (short term change created) and impacts (longer term change) over the life of the project.

1.10. From this, the anticipated impacts of SPRING can be summarised as follows.

- **People** who receive a social prescription experience improved health and wellbeing.
- **Healthcare professionals** are better able to meet their patients' needs.
- **Communities** have strong locally led health provision and **delivery partners** are stronger and are better able to respond to challenges.
- **Government and policy makers** are better informed about social prescribing and community led health.

Evaluation Approach

1.11. An outcomes-based accountability approach was adopted for the evaluation covering the period July 2019 to October 2020 and this evaluation report takes a similar approach by considering the quantity, quality, and impact of SPRING on people, healthcare professionals, delivery partners and communities and Government policy makers. Three questions are considered:

- How much did SPRING do? (Quantitative information) – Section 2
- How well did SPRING do it? (Qualitative Information) – Section 3 and,
- What difference has SPRING made? (Impact) – Section 4.

1.12. Finally, Section 5 sets out the conclusions from this evaluation. In addition, as this is the final evaluation of SPRING, Section 5 also summarises some of the learnings and observations from the project, resulting from this and previous evaluations.

1.13. Case studies demonstrating the impact of SPRING on participants have been included throughout the report along with quotations from people who participated in the qualitative research.

Caveat

1.14. The quantitative information used for this evaluation has been extracted from the Elemental Software system used by delivery partners and provided to us by the SPRING Data Officer. We have not sought to verify the accuracy or completeness of this information.

1.15. As noted above The National Lottery Community Fund funding for SPRING ends on 30 June 2023 and this has resulted in some key managers and staff involved in the programme moving on to new roles during the period we carried out our research and analysis. In our view, this did not have a significant impact on the evaluation however, the evaluation report should be read in this context.

> *"Being part of [SPRING] changed my life" – Beneficiary A*

2. How much did SPRING do?

For People

- 4250 people were referred to SPRING during the review period; 1671 (39%) in Scotland and 2579 (61%) in N. Ireland.
- 71% were female and 28% male.
- 2736 (64%) were aged 45 or over.
- 64% of the reasons for referral were for people experiencing low level mental health issues and social isolation (similar to previous evaluation)
- Main recorded activities were social support (30%) and mental health (16%) (similar to previous evaluation)

For Healthcare

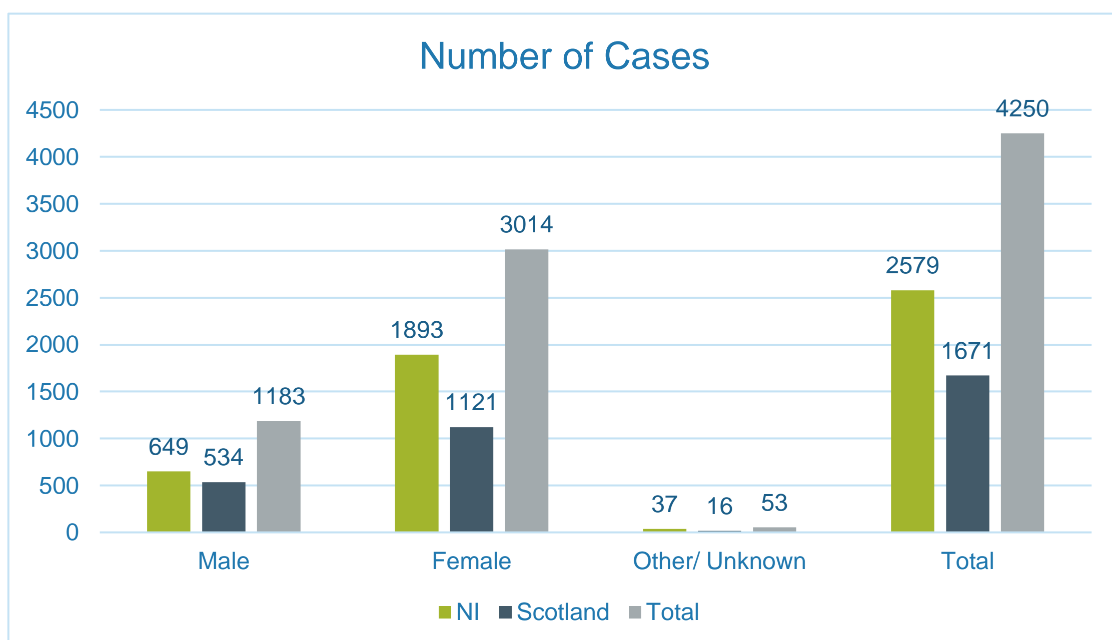
- 169 GP Practices were engaged by SPRING; 119 in N. Ireland (70%) and 50 (30%) in Scotland. (154 in previous evaluation).

For Communities

- 19 Community delivery partners participating; 8 in Scotland; 11 in N. Ireland

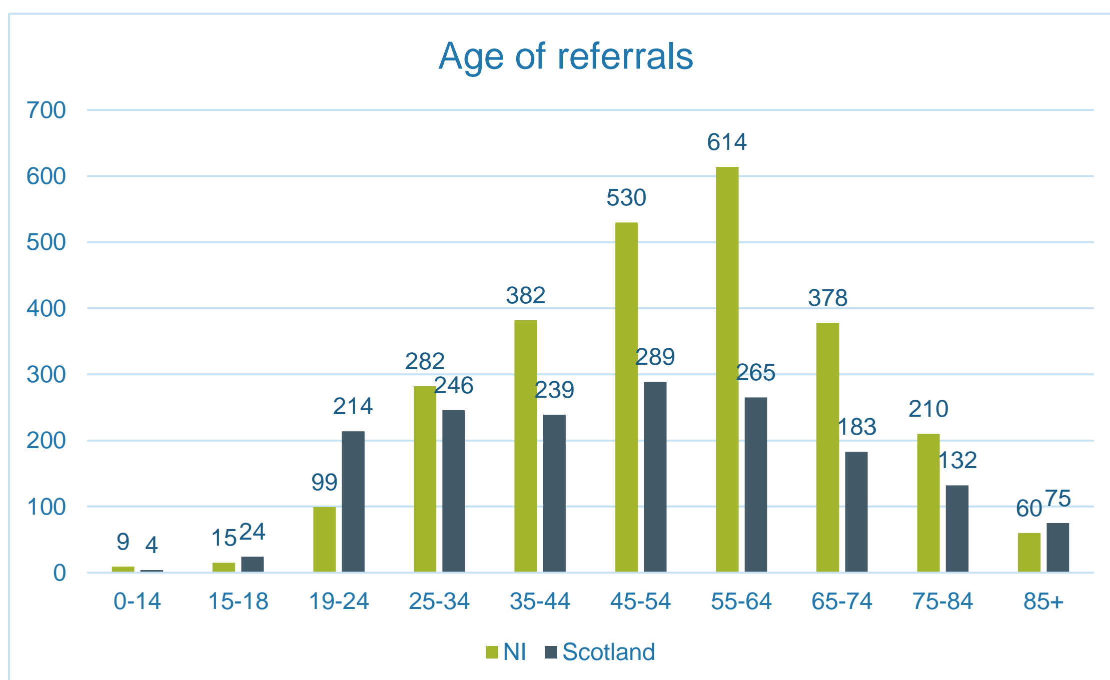
For People

2.1. This section looks at the overall level of activity for SPRING for the period covered by this evaluation (November 2020 to December 2022). The information was provided to us by the SPRING Data Officer and is taken from the Case Overview report on Elemental which reflects case data recorded by each delivery partner.



2.2. The chart above shows that 4250 people were referred to SPRING during the period under review, with 2579 (61%) being referred to partners in N. Ireland and 1671 (39%) to partners in Scotland. 71% of people referred to SPRING were female and 28% were male.

Age of referrals



Location	0-14	15-18	19-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
NI	9	15	99	282	382	530	614	378	210	60
	0%	1%	4%	11%	15%	21%	24%	15%	8%	2%
Scotland	4	24	214	246	239	289	265	183	132	75
	0%	1%	13%	15%	14%	17%	16%	11%	8%	4%

2.3. The majority of people referred to SPRING during the review period were aged 45 or over (NI 70%; Scotland 56%). In NI, the most popular age band for people referred to SPRING is aged 55-64 (24%) followed by 45-54 (21%), whilst in Scotland the converse is true with 45-54 being the most popular (17%) followed by 55-64 (16%). The above chart also shows that on the whole people referred to SPRING in Scotland tend to be younger than in NI.

Number of people engaged

2.4. Social Prescribers found many people referred to SPRING are considered to be difficult to engage. As a result, it is necessary for Social Prescribers to spend time with them, often meeting with them on several occasions to understand their needs and encourage them to engage with the service before co-producing a social prescription. This reflects the ethos of SPRING, and it does impact on the number of people Social Prescribers can work with.

2.5. The original business plan estimated that 3200 people would receive a social prescription per annum. During the 26 months covered by this evaluation, 4250 people were referred to SPRING. Annualising this figure means that 1,962 people were referred to the programme in the period under review.

Case Study 1 – Bogside & Brandywell Health Forum

Karen was once a physically and socially active individual, a regular attender at her local running club, weekly circuit classes, and a great advocate of the importance of living a healthy lifestyle. However, two years before beginning with SPRING, Karen suffered from persistent symptoms of extreme fatigue and pain. Eventually she was diagnosed with Fibromyalgia.

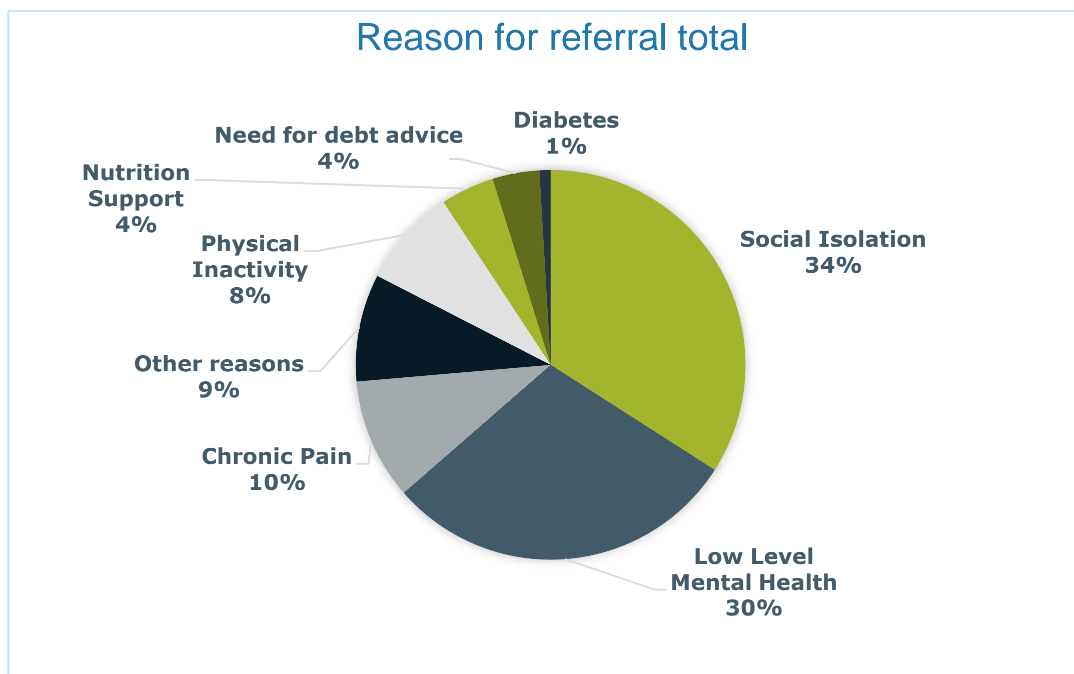
Following the diagnosis, Karen was experiencing frequent low moods, lack of motivation and had become socially isolated. When presenting these symptoms to her GP, he informed her of the SPRING Social Prescribing programme and with consent, made a referral. Karen then met with the Spring Social Prescribing team at the Bogside & Brandywell Health Forum who discussed her support needs and explored options of support and guidance, which lead to her participating in a chronic pain support group.

Karen was and continues to be a regular attendee at the group with great participation each week, sharing her experiences with pain associated with her condition and equally supporting her fellow group members. When asked about her experiences of participation, Karen commented,

"*the main advantage of attending the group is the continued peer support, having people to talk to that genuinely understand how I am feeling, sharing tips of what works and what helps with their condition. That in itself has helped me a lot. Each week I was learning how to take steps to move forward, rather than being stuck in my condition and pain".*

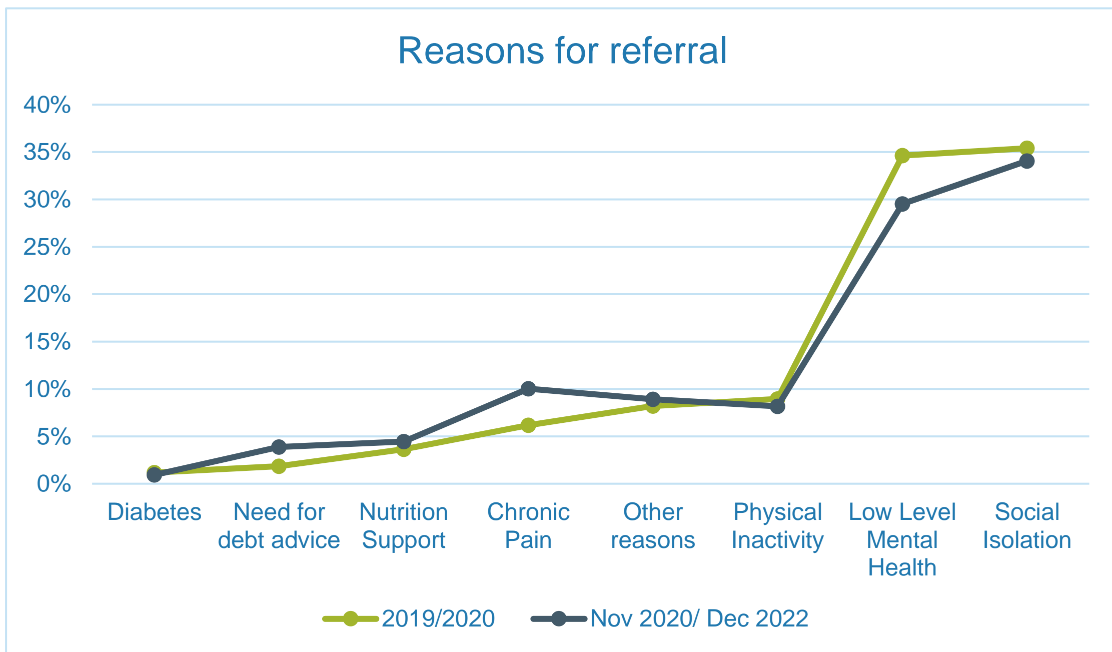
As well as participating in the chronic pain support group, Karen also availed of a weekly meditation and relaxation programme known as 'Chi Me'. As a result of her progress with social prescribing, Karen eventually expressed an interest in becoming a facilitator, providing her the opportunity to help others in the same position whilst beginning a new chapter in her life. The social prescribing team assisted Karen in achieving this goal and nominated her to complete the relevant qualification. Karen now holds a recognised qualification and facilitates Chi Me programmes, delivering sessions to both her peers, primary and secondary year school students. and older participants.

Reasons for Referral



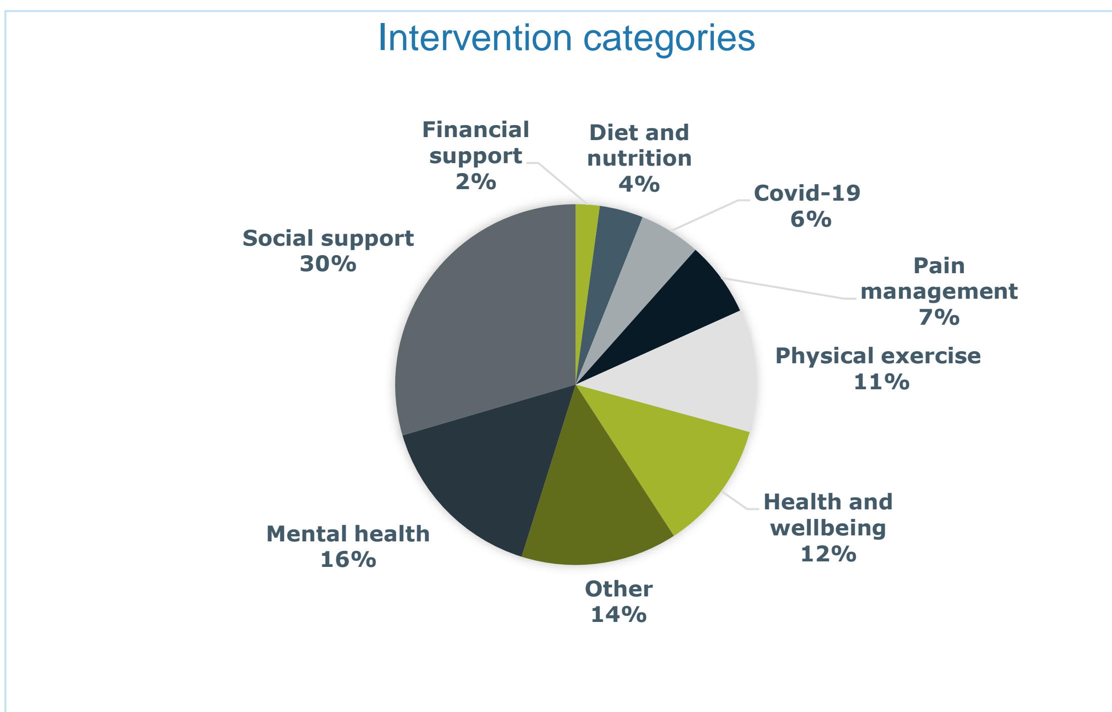
2.6. The chart above shows that majority of people referred to SPRING in the review period were experiencing social isolation and low-level mental health issues, with these categories accounting for 64% of the total recorded reasons for referral in the period. Chronic pain ranked next representing 10% of the total recorded reasons for referral. It should be noted that people are often referred to SPRING for more than one reason.

Reason for referral	2019/2020	Nov 2020/ Dec 2022
	%	%
Diabetes	1%	1%
Need for debt advice	2%	4%
Nutrition Support	4%	4%
Chronic Pain	6%	10%
Other reasons	8%	9%
Physical Inactivity	9%	8%
Low Level Mental Health	35%	30%
Social Isolation	35%	34%
Total	**100%**	**100%**

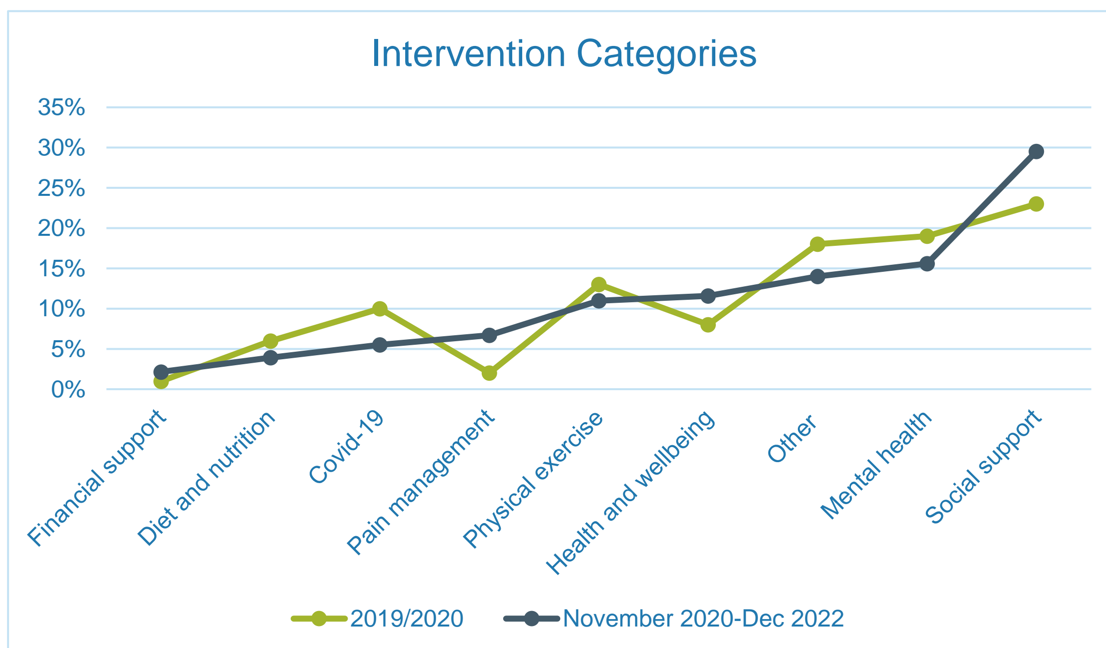


2.7. The chart and table above compare the reasons people were referred to SPRING between the period covered by the previous evaluation (July 2019 to October 2020) and the period for this evaluation. There have been some changes in % of reasons for referral, but they remain comparable, with the main reasons for referral being social isolation and low-level mental health. The % of people referred to the programme experiencing chronic pain has increased in the current review period.

Types of Activities Undertaken



2.8. Activities undertaken by people as part of their social prescription are recorded on Elemental as 'interventions'. Often people undertake more than one activity. During November 2020 to December 2022, the main types of activities recorded were Social Support (30% of total recorded activities), Mental Health (16%) and Health and Wellbeing (12%).



Intervention Category	2019/2020	Nov 2020/ Dec 2022
	%	%
Financial support	1%	2%
Diet and nutrition	6%	4%
Covid-19	10%	6%
Pain management	2%	7%
Physical exercise	13%	11%
Health and wellbeing	8%	12%
Other	18%	14%
Mental health	19%	16%
Social support	23%	30%
Total	**100%**	**100%**

2.9. As in the previous section, the chart and table above compare the main types of activities recorded as being undertaken by people referred to SPRING between the period covered by the previous evaluation (July 2019 to October 2020) and the period covered by the current evaluation (November 2020 to December 2022). As before, although there have been some changes in %, overall, the reasons for referral are comparable, with the main interventions being mental health and social support.

2.10. Social support activities include peer support, support groups, social cafes, and befriending. Mental Health activities including but not limited to; counselling, Cognitive Behavioural Therapy, meditation, and yoga.

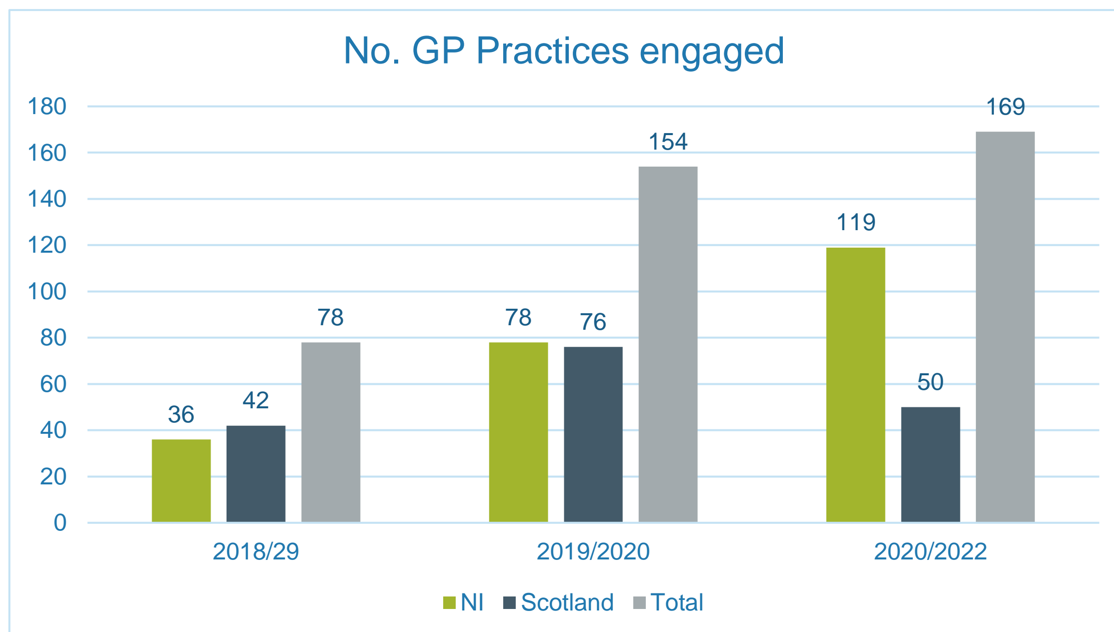
Case Study 2 – Healthy Valleys

Alastair was referred to SPRING at Healthy Valleys as he was struggling with depression and social isolation. The Social Prescriber met with Alastair where we agreed on specific goals that he would like to achieve during his journey at Healthy Valleys. Alastair was supported by the Social Prescriber to join a woodwork group where he was able to engage in conversation with other men struggling with similar issues. Following a few sessions at the woodwork group, Alastair decided that he needed more specialist intervention to improve his mental health. Following this conversation, the social prescriber arranged for Alastair to attend CBT sessions with one of the therapists at Healthy Valleys.

During the first few sessions with Alastair, it became apparent that he was easily frustrated, would give up when things became challenging, and was unable to think positively about the future. After engaging in 1-1 support with the social prescriber, attending the woodwork group and participating in CBT sessions, Alastair is now able to persevere in the face of challenges and is exploring possible career paths. Alastair feels less isolated and has also expressed an interest in giving back to Healthy Valleys as a volunteer. When talking about his journey with Healthy Valleys, Alastair said

"with your help, this is the best I've felt in a long time".

For Healthcare

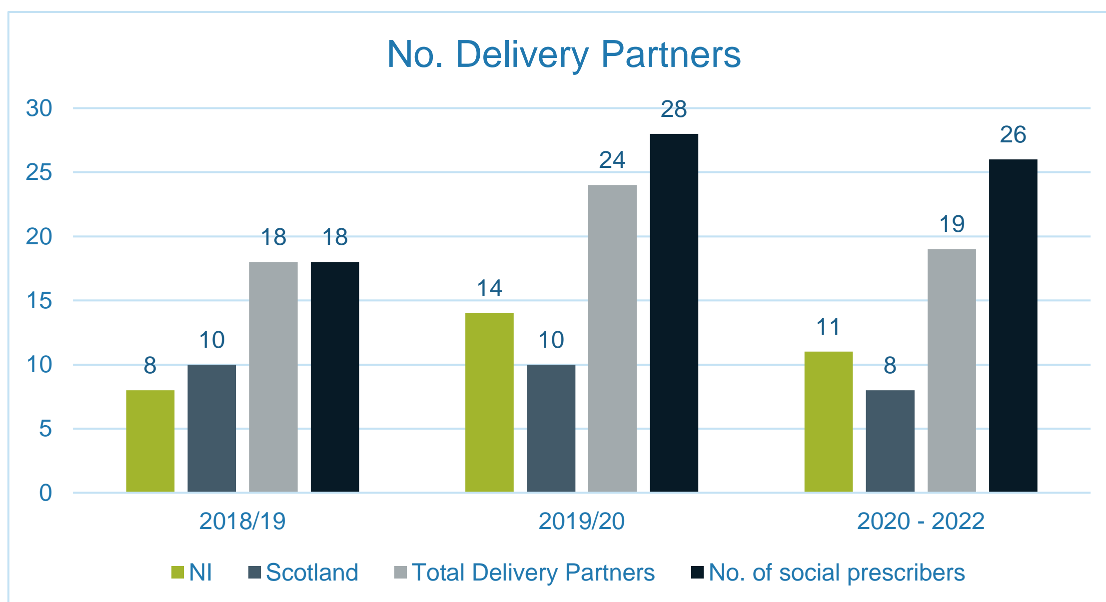


2.11. The chart above shows that between November 2020 and December 2022, 169 GP practices were engaged by SPRING, making social prescribing referrals to the project. 119 (70%) of these were in N. Ireland and 50 (30%) in Scotland.

2.12. Overall, there has been an increase in the number of GP practices engaged by the project as the SPRING 2020 Evaluation report covering the period July 2019 to October 2020 highlighted that in this period 154 GP practices were engaged by the project. The number of GP practices engaged in NI has increased 78 (51%) to 119 (70%), whilst the number in Scotland has decreased from 76(49%) to 50 (30%).

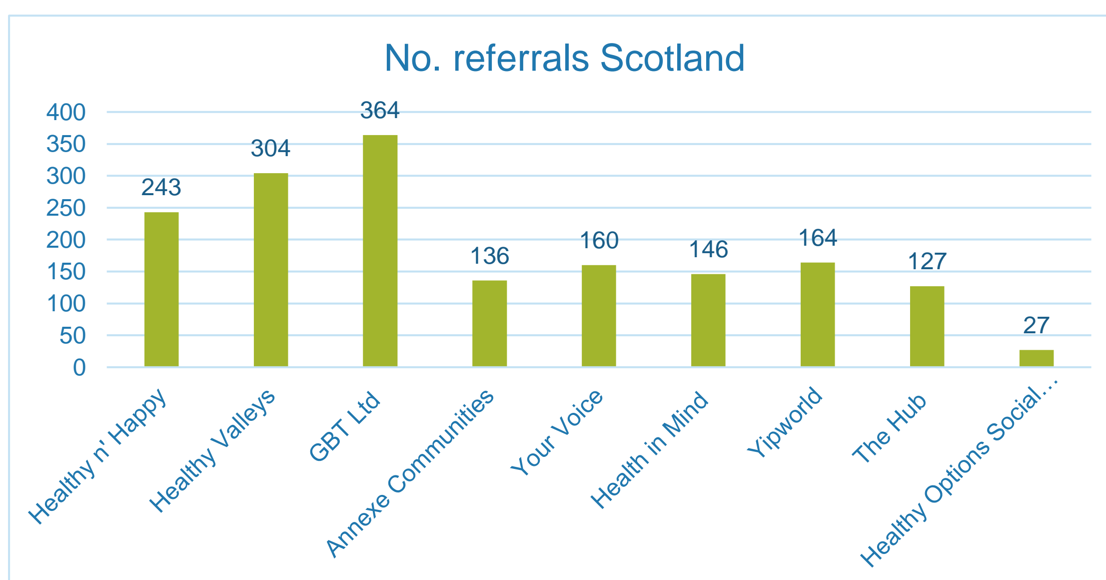
2.13. The year 1 evaluation report noted that 78 GP practices had been engaged by SPRING in 2018/19, 36 (46%) in N. Ireland and 42 (54%) in Scotland. The original business plan anticipated that at least 60 GP Practices would be involved with the social prescribing project.

For Communities



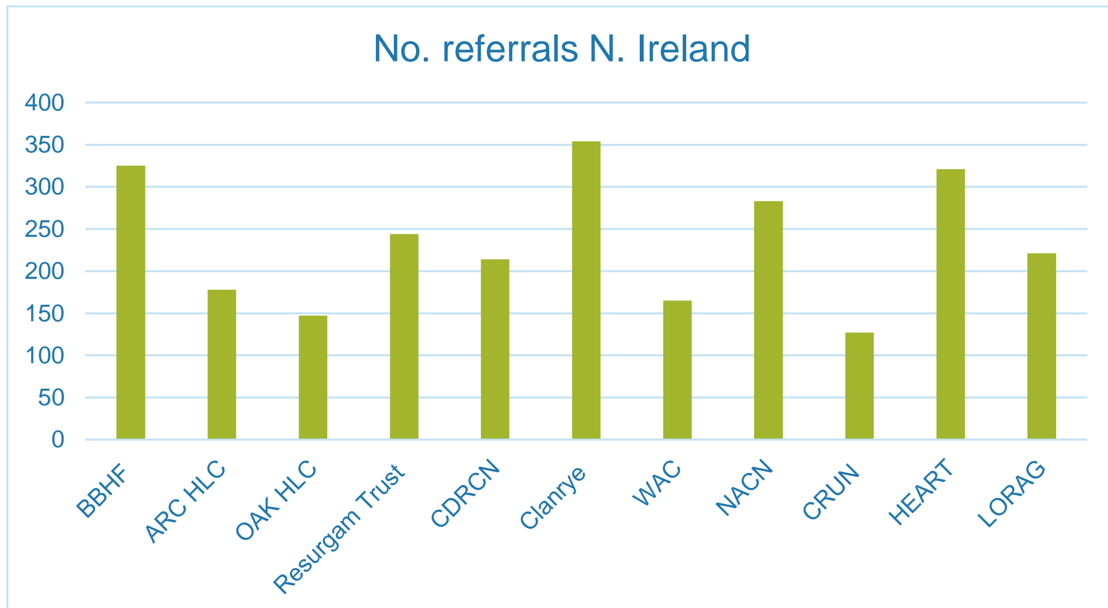
2.14. The above chart shows that in the review period there were 19 community-based organisations delivering the SPRING project, 11 in NI and 8 in Scotland. This is a reduction from the total in the previous evaluation period (24; 14 NI and 10 Scotland) reflecting the fact that several delivery organisations left the programme during the current evaluation period. Two social prescribers also left the programme between the two evaluation periods, however methods were used to carry on the work within the organisations.

Activity Levels



2.15. In Scotland, each delivery partner has a full time Social Prescriber (or the equivalent). In the current evaluation period, the average number of referrals per partner was 186, with GBT

Ltd recording 364 referrals and Healthy Valleys recording 304. Healthy Options Oban left the programme part way through the evaluation period.



2.16. In N. Ireland, there is a slightly different delivery model, with some partners having a full time Social Prescriber (or the equivalent), and others working on a part-time basis. In N. Ireland, the average number of referrals per partner was 234, with one partner, Clanrye accounting for 354 referrals.

> *"[SPRING] referral helps us to connect with the hard-to-reach and the really vulnerable…it's very valuable for this." Jane Cowan, Social Prescriber, Annexe Communities*

3. How well did SPRING do it?

3.1. This section considers qualitative information about SPRING.

For People	• All beneficiaries reported health and wellbeing improvement from being involved with SPRING. Key areas include reduced isolation, increased activity levels, improved confidence, and reduced anxiety. • Positive and supportive relationship with Social Prescribers were considered the key to success. • SPRING also had a positive impact on the beneficiary's family and friends. • There was a high degree of support for the community-based model – being outside the medical system reduces labels and stigma through community participation.

For Healthcare	• SPRING has enabled GPs to make referrals to a joined-up system where follow-up by social prescribers is in place. • SPRING enables feedback to the GP on the patient's ongoing journey and progress. • SPRING has led to reduced visits to GPs especially for issues such as loneliness and isolation and reduced GP referrals to secondary care providers for low level mental health issues. • There is concern over the ongoing pressures on the health care and community sectors and their impact on social prescribing.

For Communities - social prescribers	• Having the space and time to speak with a social prescriber helps people open up about range of issues that they are facing. • The 'quality over quantity' ethos of SPRING is felt to be different from other models with high referral targets. • Social prescribers reported high levels of job satisfaction but recognised that internal supervision and support are important because of ongoing pressures of the role. • Building good, reciprocal relationships with GPs in local area is vital for success of the social prescribing model.

For Communities – delivery partners	• Locating social prescribers in community settings is seen as a vital part of the SPRING model, and more cost-effective overall compared to being based in primary care. • Financial resources to support SPRING in the community are limited with some delivery partners supplementing the cost to support beneficiaries. • There is recognition that increased referrals to organisation can have considerable impact on staff and group dynamics. • Social prescribing is still a work-in-progress to find right balance between health care and community sectors.

For Government	• There is broad support that social prescription projects like SPRING are part of the wider direction of travel for both NI and Scotland as they are linked to key policy directives in both areas. • Valuable relationships have been developed with policymakers, academics, and key healthcare managers because of SPRING. These have created considerable 'added value' including new research into social prescribing. • Long-term, secure funding is needed to consolidate the work of SPRING to avoid loss of personnel, knowledge, and relationships.

3.2. For the evaluation report covering the period July 2019 – October 2020, the qualitative section was based on independent research carried out in November 2020 by Community Enterprise Limited (CEL). A similar approach has been taken to this evaluation report and this section has been exclusively informed by research carried out by CEL in March and April 2023. We would like to acknowledge the work carried out by Community Enterprise Limited in this regard.

The qualitative research sought to explore the lived experience of stakeholders who are a part of the SPRING programme. Semi-structured interviews and focus groups formed the basis of the data collection. These were conducted via video conferencing with participants in Northern Ireland and Scotland between March and April 2023.

3.3. It should be noted that those organising the research found recruitment for this exercise to be a challenge with key managers and staff involved in the programme moving on to new roles due to the imminent ending of funding. As a result, the 2023 research does not present reflections from external referral partners.

3.4. In total 20 individuals shared their experience of SPRING as part of this research. The table below summarises the stakeholders who participated.

	Beneficiaries	Health and Primary Care	Delivery Partners	Social Prescribers
Data collection	3 interviews 3 Focus group (7 beneficiaries) Total 10 beneficiaries	3 interviews Total 3	3 interviews Total 3	4 interviews Total 4

Key Findings from research

For People

3.5. Overall, the researchers highlighted that there was evidence that participating in the SPRING programme had clear and tangible impact on the lives of individuals who took part in the research. Social prescribers played an important role in this, with all beneficiaries highlighting that the positive impact benefits from SPRING would not have been achieved without 1:1 support from the SPRING social prescriber.

3.6. All beneficiaries were very positive about their experience with SPRING personally, with several also highlighting the positive impact this had on their wider network of families and friends.

> *"Before coming here, I was not connected locally, I was a bit isolated…the 1-1's are really helpful…to break that initial barrier and make these connections…it's made a world of difference…given me a sense of confidence…wouldn't have happened without SPRING." Beneficiary E*

3.7. Beneficiaries felt that a critical success factor for SPRING is that the service is person-centred, flexible, and tailored to meet their individual needs. In particular, people have a choice of activities and services to take part in and the pace to go at.

3.8. Being outside the medical system in a community-based model is also considered to be more accessible for people and helps to reduce stigma.

3.9. The 1:1 relationship with the social provider provides accountability and support. This leads to people engaging in activities they may not otherwise have undertaken.

3.10. Engaging with SPRING provided beneficiaries with increased access to a range of external services that helped to improve their quality of life, including help with benefits, energy advice and funding and disability support.

3.11. All beneficiaries reported some degree of improvement in their health and wellbeing as a result of participating in SPRING. The main areas of improvement include reduced isolation, reduced anxiety, increased confidence, increased physical activity, and increased social connections.

3.12. Several beneficiaries reported that they have been better able to manage chronic health conditions as a result of SPRING and onward referrals into community-based support. Some reported that this in turn led to reduced use of medication with the confidence to go back to the GP if issues arose.

> *"[Now] I am out with people and have my life back. My daughter is no longer worried about me. Instead, she has to make an appointment to see me." Beneficiary D*

For Healthcare

3.13. Overall, those representatives of health and primary care who took part in the research felt that SPRING was improving patient's health and wellbeing through their interaction with social prescribers and as a result of the variety of programmes and activities available.

3.14. It was recognised that a referral to SPRING is to a joined-up system with 1:1 support and follow up arrangements with social prescribers in place and the opportunity for feedback to GPs as the patient's journey progresses. Before SPRING, the only option was signposting people to community services. SPRING was also highlighted as facilitating greater access to very vulnerable and hard-to-reach populations.

3.15. SPRING is seen to be particularly helpful for people struggling with loneliness and isolation and for some people has helped to reduce the number of visits to medical services.

> *"The difference in being able to refer to a social prescriber meant that I could say to a patient 'I have a colleague who works there, if you agree they could give you a call and maybe invite you to meet face to face.' Being able to make that formal referral, you've got patients buy-in." Dr Laura O'Donnell, GP, Enniskillen*

3.16. There was broad support for the community-based model of social prescribing amongst healthcare professionals who took part in the research.

3.17. SPRING has led to increased awareness and recognition for the skills, resources and contribution of the community and voluntary sector in improving health and wellbeing and some primary care staff recognised the expertise of the community sector.

3.18. It was reported that primary care teams with multidisciplinary teams have a better understanding around social prescribing and this was felt to improve the link to SPRING with higher referrals to the programme from these practices.

3.19. Health board staff consider the expertise and knowledge of SPRING social prescribers to be valuable for planning and designing local services.

3.20. There was ongoing concern about the high level of pressure being felt within the healthcare sector and some concern was expressed about the ability of the sector to provide the capacity and support needed for models such as SPRING to successfully function.

Case Study 3 – Your Voice Inverclyde

Roughly a year ago, Gordon was referred by his local Community Mental Health Team to SPRING at Your Voice Inverclyde and has thrived in his time working with SPRING on an approach to better mental health that suits him.

In the past, Gordon has suffered from severe bouts of poor mental health in his life. Once referred, the SPRING social prescribing team got to work, meeting with Gordon to find out not what was the matter with him, but rather what matters to him. The SPRING social prescribing team helped Gordon secure a volunteer job working with Shopmobility and through ongoing support, have helped him improve his mental health. Gordon said:

"Meeting the team and staff at Your Voice was an important part of my recovery and they still continue to help eight months later."

Helping participants like Gordon showcases the power of social prescribing to transform lives and help those who might struggle to find support through traditional or more clinical health pathways.

The 'wellbeing indicators' SPRING use as monitoring tools to measure progress, show that there has been a tangible and positive change in many aspects of Gordon's life.

For communities

Social prescribers

3.21. Overall, the social prescribers who took part in the research confirmed that the initial referral to SPRING often only captures a fragment of the person's wider story. Having the space and time to speak with a social prescriber helps the person open up about range of other issues that they are facing.

3.22. There was general recognition amongst SPRING social prescribers that being community based has been successful in promoting a non-medical model of health, reducing stigma and barriers to taking part in groups and activities for participants.

"I do generally find that they're very open, very honest. None of them hold back any information. I can tell they're genuinely interested in getting help and support." Danielle Kelly, Social Prescriber, BBHF

3.23. Social prescribers highlighted the importance of SPRING's ethos that social prescribing is about the quality of support to individuals rather than the number of individuals you are supporting. It was felt that this 'quality over quantity' aspect helped to differentiate SPRING from other models of social prescribing that focus of high referral targets.

3.24. Social prescribers cited building good, reciprocal relationships with GPs in their area as being vital to the success of the social prescribing model. Some areas reporting positive working relationships with GP practices, however there was general reflection that there is an ongoing need to continue to develop awareness of social prescribing amongst primary care colleagues.

3.25. The social prescribers who took part in the research indicated a high level of job satisfaction. They felt that ongoing support and supervision within the team is essential to retain staff and expressed some concern around the negative impact of fixed-term funding on people carrying out these roles.

3.26. The social prescribers who took part in the research suggested exploring the option of self-referral to SPRING in addition to statutory referrals. Some felt that sole access to SPRING through statutory services could present a barrier for individuals especially those who are reluctant to visit a GP.

3.27. Social prescribers expressed concern over the long-term sustainability of the service with the end of the current funding cycle.

Delivery Partners

3.28. Overall, there was recognition that participating in social prescribing through SPRING presents opportunities and challenges for delivery partners.

Opportunities identified include:

- Helping to build awareness of the value of the community and voluntary sector in maintaining people's health and wellbeing.
- Enabling community and voluntary sector organisations to have a 'seat at the table' in terms of shaping health and wellbeing priorities and policy.
- Increasing the number of people that delivery partners support locally, helping to evidence their impact and role as a key anchor organisation for future funding bids.
- Improving the relationship with local GP practices (and their awareness of community-based assets).
- Beneficiaries of SPRING often stay within the organisation and take part in internal groups and activities. This is more common than onward movement into external community and voluntary groups.
- New groups and activities were created to support needs and interests identified by SPRING.

"Power and influence still lie with the GPs, Trusts and Department of Health…but SPRING gives us a seat at the table…we have been able to have serious conversations with senior members of the health sector and government". – Nicholas McCrickard, Manager, County Down Rural Community Network

Challenges identified include:

- The budget associated with operating SPRING was considered to be tight and delivery partners suggested that financial support should follow the beneficiary throughout their social prescription. Partners often utilise funding from other sources to support SPRING beneficiaries, but this is not sustainable in the longer term.
- In rural areas, the option for onward referrals is often limited.
- There are financial implications for the delivery partner in supporting new internal groups or higher numbers of participants.

- Increasing referrals into services can require delivery partners to address matters like additional staffing needs, and facilitating new groups, activities, and more beneficiaries.

"[Social prescribing] has created some new dynamics [within CDRCN] which are not always positive. We have moved from supporting groups of people to directly supporting individuals with complex need. This isn't necessarily to do with the [SPRING] model itself but change like this can cause tensions across the staff team and between organisations in the third sector…and cause shifts in team dynamics."
– Nicholas McCrickard, Manager, County Down Rural Community Network

3.29. There was a sense that community-based organisations participating in social prescribing partnerships should consider the opportunities and challenges before entering the partnerships.

3.30. Delivery partners recognised that social prescribing is still a work-in-progress to find right balance between health care and community sectors. However, locating social prescribing in a community setting is seen as a vital part of the model and is fundamentally considered to be much more cost effective in comparison to a GP led or healthcare-based model.

3.31. Delivery partners highlighted the need to increase flexibility in social prescribing models to enable local people to shape these services and how funds are spent.

"Each geographical area will have different need for their clients, and therefore they should be able to spend their allocated budget the way it fits their needs at the time."
– Judith Poucher, Manager, Clanrye Group

Case Study 4 – Oaks Healthy Living Centre

Katrina lives with a condition known as 'Functional Neurological Disorder.' She first developed symptoms over three years ago, beginning with tremors down one side of her body and causing difficulty with her walking. Functional Neurological Disorder (FND) is the name given for symptoms in the body which appear to be caused by problems in the nervous system, but which are not caused by a physical neurological disease or disorder. When symptoms of FND become more chronic they can cause a lot of additional problems for peoples like Katrina often adding further distress.

After diagnosis, her symptoms worsened. With little support available, Katrina got in touch with the SPRING Social Prescribing team at the Oaks Healthy Living Centre in Fermanagh and began courses to help with her chronic pain. When she first started with SPRING, she was in a wheelchair with a tremor limiting her ability to walk, wash or even feed herself.

Today, Katrina credits the support she received through the SPRING Social Prescribing team at the Oaks with helping her get back on her feet, albeit with the help of a leg brace; and says that she is "in a much, much better place" than she was three years ago.

Because symptoms of FND are so complex and can be affected by lots of different aspects of a person's history; SPRING social prescribing, with its person-centred approach has helped Katrina manage her condition, empowering her to improve her health & well-being.

For Government policy

3.32. Overall, there was broad support from regional health board managers that social prescription projects like SPRING are part of the wider direction of travel. Managers highlighted a range of key policies within both Scotland and NI that were compatible with social prescribing.

> *"SPRING fits very well with [our] strategic direction, of being more community-focused, preventative-focused and collaborative in trying to make links with other parts of the health and social care system. It also has the potential to deliver a lot of the objectives of our public health strategy."*
> *– Sinead Malone, ICP Development Manager, NI*

3.33. The researchers considered that the relationships SPRING has with policymakers, academics, and key healthcare managers is evident and SPRING is viewed as valuable in helping to spread awareness of the impact of social prescribing.

3.34. The Elemental software package used by SPRING was noted as helping to evidence the impact of this way of working – especially to those in the health sector. It was suggested that improving integration of this platform into primary care could help grow referrals into social prescribing. Some social prescribing staff highlighted challenges with the use of this software in terms of accessibility and time.

3.35. Robust monitoring and evaluation of social prescribing is considered essential to evidence its impact and provide the basis for evidence-based policymaking around social prescribing. It was noted that the development of standard frameworks to facilitate this currently in its infancy and finding a balance between effective, robust, and standardised monitoring and local flexibility is a key goal.

> *"SPRING has facilitated flourishing partnerships with academics, health boards, local practices…there is so much added value from SPRING…you need long-term funding to developing trusting partnerships build over time."*
> *– Dr Karen Galway, Senior Lecturer, QUB*

3.36. There is recognition that social prescribing brings together two disparate 'worlds' - the healthcare sector and community development. The SPRING model has been a leader in this process and there is considerable learning that can be taken from this experience.

4. What difference has SPRING made?

For People	• 87% of people who completed the Warwick Edinburgh (short form) monitoring tool during the period showed an improvement in their health and wellbeing. The average improvement was 26%. (Previous evaluation 85% showed improvement and average improvement was 22%) • 89% of people who completed the Outcome Star monitoring tool during the period showed an improvement in their health and wellbeing. The average improvement was 32%. (Previous evaluation 84% showed improvement and average improvement was 18%) • The main areas of improvement recorded on Outcome Star were lifestyle and feeling positive.

For Healthcare	• Some participants provided information on GP and hospital attendances pre and post SPRING. Those who did reported.
	    ○ 47% reduction in GP attendances
	    ○ 65% reduction in A&E visits, and
	    ○ 64% reduction in hospital visits
	• In addition to GP practices SPRING has worked collaboratively with other parts of the Health and Social care system to further explore and develop social prescribing.

For Communities	• SPRING, SCHW and HLC Alliance continued to play an important role in
	    ○ Project Echo – shared learning network
	    ○ Scottish Social Prescribing Network, and
	    ○ All Ireland Social Prescribing Network.

For Government Policy	• SPRING, SCHW and HLC Alliance shared learning from the project with policy makers in Scotland and N. Ireland, including: Scotland o Working with MSPs to highlight impact of Social Prescribing o Contributing to Health, Sports, and Social Committee review of health inequalities o Participating in Place and Wellbeing : Communities programme N. Ireland o Continuing to work with DAERA to deliver social prescribing in rural areas. o Exploring opportunities to deliver social prescribing in Housing and through Museums (Department for Communities) o Working with an inter-departmental group on sustainability post The National Lottery Community Fund funding.

For People

4.1. Two monitoring tools are used to record the level of health improvement achieved by people attending SPRING during their time with the project.

4.2. The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) is a scale of positively worded questions for assessing mental well-being. There are two versions of the scale, the original version which has 14 questions and a shorter version (SWEMWBS) which has 7 questions. It should be noted that, with the agreement of the funder, SPRING moved to using the short form of the Warwick Edinburgh monitoring tool (SWEMWBS) at the beginning of this evaluation period (November 2020) to make this process less intense and time consuming for participants.

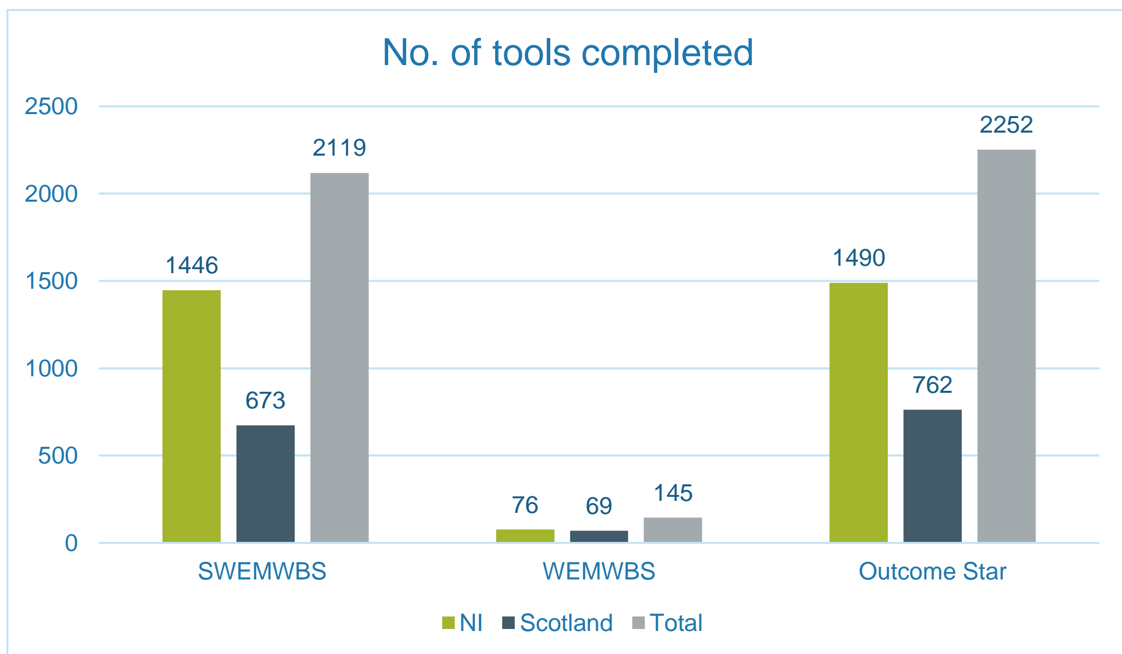
4.3. The Outcome Star (wellbeing star) encourages people to consider a range of factors that can impact on quality of life. As with Warwick Edinburgh, the Outcome Star takes the form of a questionnaire, with the Star scaling wellbeing from 1-5 based on eight key areas; Your lifestyle; Looking after yourself; Managing symptoms; Work, volunteering, and other activities; Money; Where you live; Family & friends; and Feeling positive.

4.4. Where appropriate, Social Prescribers complete both monitoring tools with individuals referred to SPRING before co-producing a social prescription (pre). The monitoring tools are then completed once the social prescription has been delivered (post). It should be noted that that monitoring tools are not completed for everyone attending SPRING. As noted previously, many individuals referred to the project have traditionally been difficult to engage. In some circumstances, social prescribers feel that based on their experience with the person they are working with, it is inappropriate or difficult to complete either one or both of the assessment tools.

"I used to stay home all the time. It really has helped my mental health. Compared to last year [before social prescribing] I feel like a completely different person now, I feel confident, relaxed, and I wouldn't be if I hadn't come to this. It's helped me cope, really." Beneficiary B

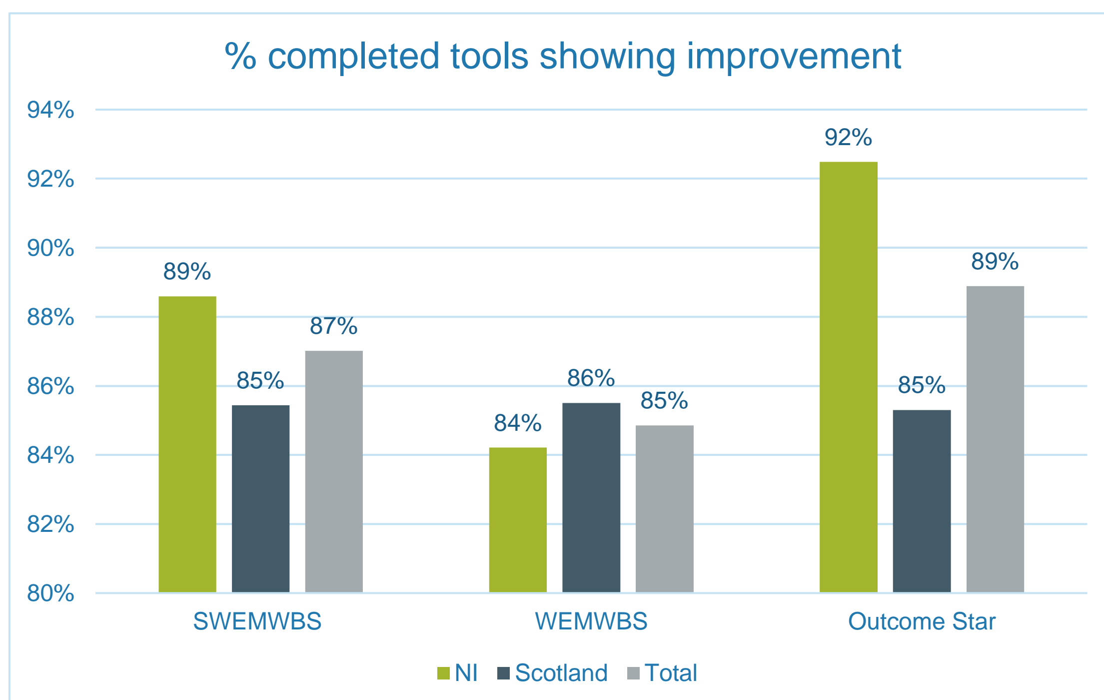
The monitoring tool scores are recorded on Elemental and this section considers the scores recorded for people who completed social prescriptions in the period November 2020 to December 2022.

Tools Completed



4.5. During the period November 2020 to December 2022, pre and post SWEMWBS questionnaires were completed by 2119 people, 673 (32%) in Scotland and 1146 (68%) in N. Ireland. In the same period, 145 pre and post WEMWBS questionnaires were carried out as this was the remainder of assessments from the time the switch was made to using SWEMWBS. 76 (52%) people in Northern Ireland and 69 (48%) people in Scotland completed the WEMWBS questionnaire. 2252 pre and post Outcome Star questionnaires were completed by people who had finished their social prescription, 762 (34%) in Scotland and 1490 (66%) in N. Ireland.

Tools showing improvement



4.6. Overall, 87% of the people who completed SWEMWBS monitoring tools in this period showed an improvement in their score, 89% of in N. Ireland and 85% in Scotland. This is also close to the improvement reported by those who completed the WEMWBS questionnaire who reported an 85% improvement in score overall – 84% in Northern Ireland and 86% in Scotland.

4.7. For the Outcome Star monitoring tool, 89% of participants reported an improvement in their wellbeing in total, 92% in N. Ireland and 85% in Scotland.

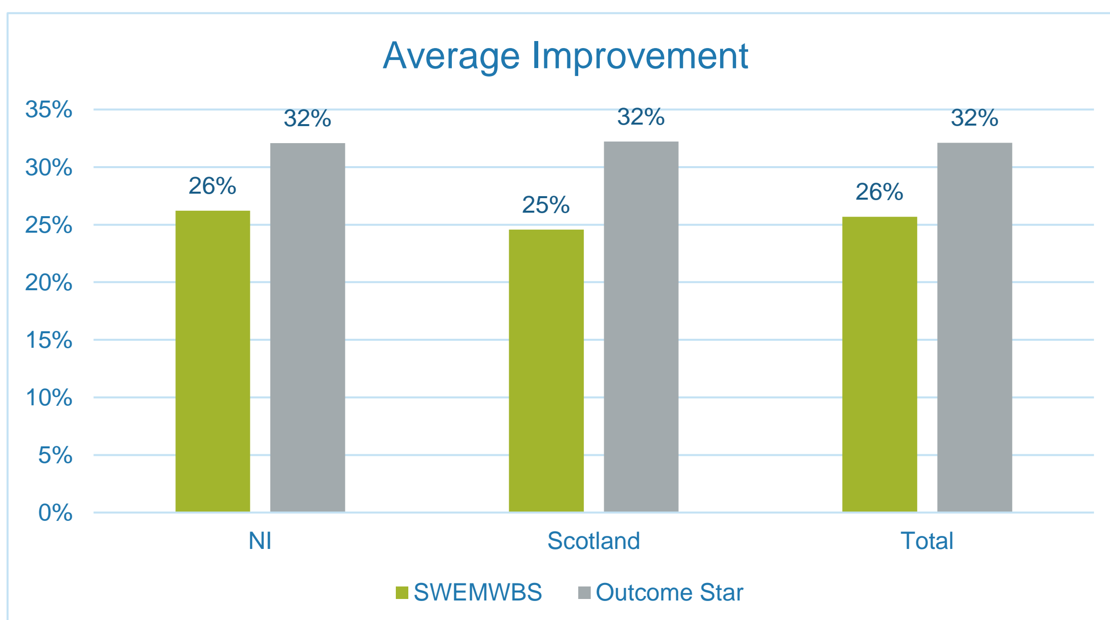
Location	Nov 2020 – Dec 2022	2019/20
	SWEMWBS	**WEMWBS**
NI	89%	89%
Scotland	85%	83%
Total	87%	85%

4.8. The above table shows that the Warwick Edinburgh scores in the current period are comparable to the period covered by the previous evaluation, with the results in Scotland showing a further improvement from a strong base.

Location	Nov 2020 – Dec 2022	2019/20
	Outcome Star	
NI	92%	87%
Scotland	85%	81%
Total	89%	84%

4.9. The Outcome Star scores reported show that slightly higher percentages of people who completed pre and post questionnaires in the current period reported an improvement.

Average Improvement



4.10. The above chart shows that on average those who completed a SWEMWBS questionnaire in the period showed a 26% improvement and those who completed Outcome Star questionnaires showed 32% improvement.

Location	Nov 2020 – Dec 2022	2019/20
	SWEMWBS	**WEMWBS**
NI	26%	23%
Scotland	25%	21%
Total	26%	22%

4.11. The above table compares the average improvement in Warwick Edinburgh scores in the current evaluation period with the previous evaluation period. The results show higher levels of improvement in both NI and Scotland.

Location	Nov 2020 – Dec 2022	2019/20
	Outcome Star	
NI	32%	19%
Scotland	32%	18%
Total	32%	18%

4.12. The table above shows that the average improvement in well-being reported by those who completed Outcome Star questionnaires in the current period is significantly higher that reported in the previous evaluation period, with a reported average improvement of 32% in the current period, compared to 18% in the previous period. This outcome mirrors the position on Warwick Edinburgh scores and may be as a result of continued enhancements to the programme to meet people's needs.

4.13. As noted previously, the Outcome Star (well-being star) focuses on 8 key areas.

4.14. The 8 areas covered by the questionnaires are as follows:

Q1 – Your Lifestyle: sleeping habits, exercise, smoking and diet

Q2 – Looking after yourself: Shopping, going out, cleaning, getting dressed

Q3 – Managing your symptoms: Information, doctors, and medication, resting and energy levels, pain management

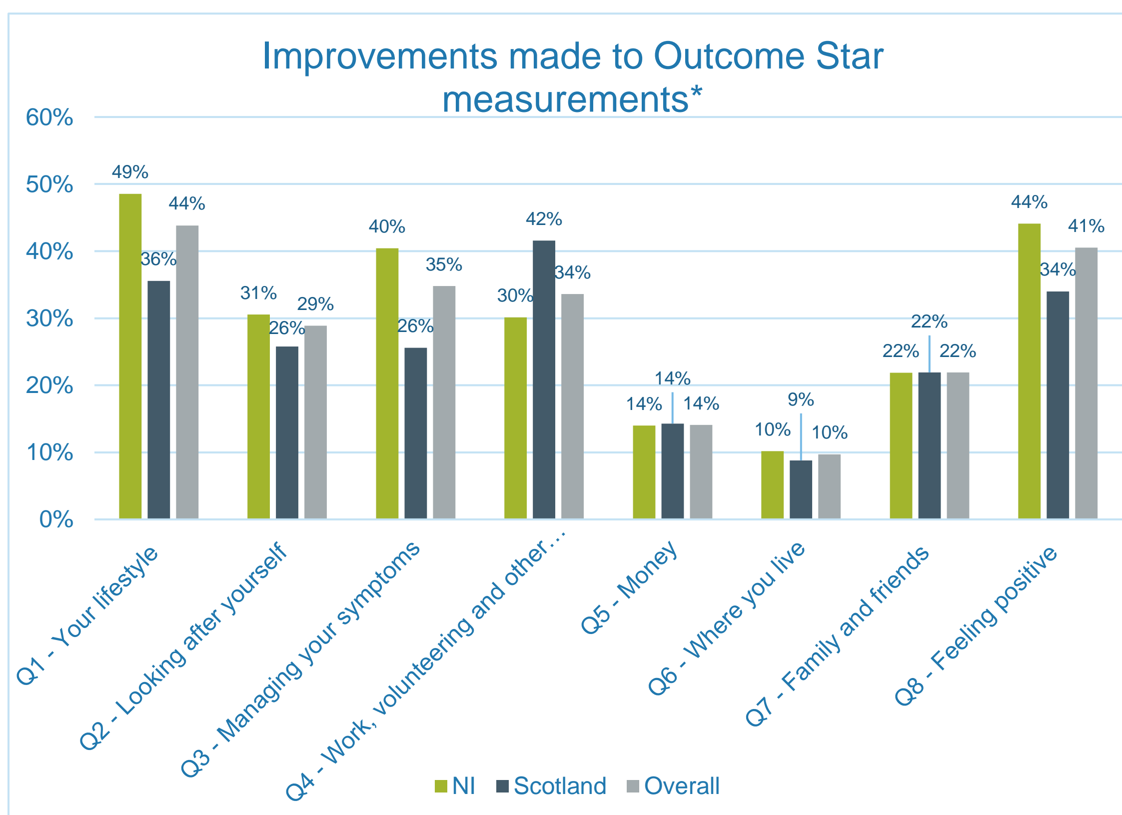
Q4 - Work, volunteering, and other activities: Volunteering, training, work conditions, new role

Q5 – Money: Getting benefits, spending appropriately, managing money

Q6 – Where you live: Local facilities, damp, pollution, stairs

Q7 – Family and Friends: Communication, understanding, adjusting, new roles

Q8 – Feeling positive: Hope, learning to cope, feeling calm



4.15. The chart shows that whilst improvement is reported across all areas, the areas where greatest improvement is reported are:

- Lifestyle (Q1) 44% improvement
- Feeling positive (Q8) 41% improvement
- Managing your symptoms (Q3) 35% improvement
- Work, volunteering and other activities (Q4) 34% improvement

"I wouldn't have joined any activity like this without social prescribing because I was scared to go out and socialise. I was really, really in a bad place. When I came here, everything has been easier for me, I got a lot better compared to last year." Beneficiary C

4.16. In Section 2, we highlight that many people are referred to SPRING because they are experiencing low level mental health issues and/or social isolation. The above results provide further evidence of the efficacy of social prescribing in helping people to address these issues.

Case Study 5 – Health in Mind

Eileen (an alias) 42, was struggling to cope with anxiety. She and her GP were unsure of the cause and so referred her to SPRING social prescribing to give her some more support. Eileen's relationship with SPRING began as a very physical response to stress and developed from there. They worked through what she was experiencing and focused on her lack of confidence and rebuilding her self-esteem. Eileen and her social prescriber went for walks every 2 weeks for 4 months and gradually her confidence began to improve. She applied for a new job, and she was successful.

For Healthcare

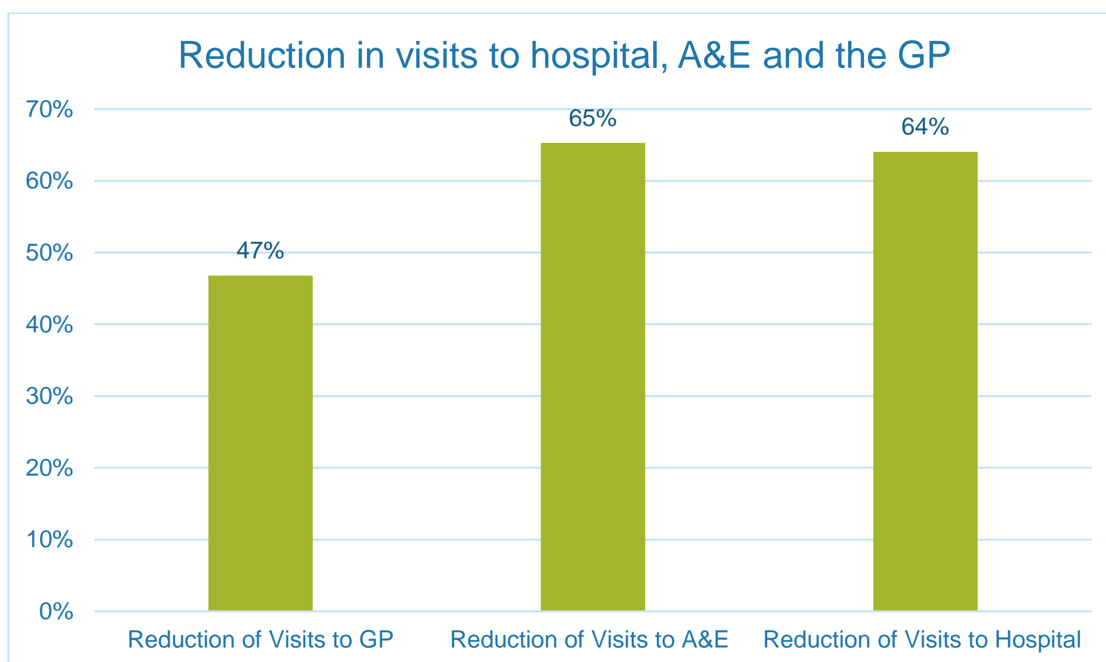
Attendances

4.17. When people first engage with a social prescriber, they are asked how many times they have attended their GP or made a visit to Accident and Emergency or hospital in the last 3 months. They are then asked these questions again after they have completed their social prescription and this information is recorded on the Elemental system.

"For some patients with loneliness, if you were able to engage that person in a programme that improved their wellbeing, often then the impact was reduced GP attendances" Dr Laura O'Donnell, GP, Enniskillen

4.18. This data has been extracted from the Elemental system for the period covered by this evaluation and is summarised in the table and chart below.

Location	Visits to GP		Visits to A&E		Visits to Hospital	
	No. of Reviews	% Reduction	No. of Reviews	% Reduction	No. of Reviews	% Reduction
NI	852	48%	851	72%	851	63%
Scotland	585	45%	585	58%	585	65%
Totals	1437	47%	1436	65%	1436	64%



4.19. It should be noted that the data is self-reported, has only been collected from some participants and is not available for all the NI delivery partners. Despite these caveats, it does make interesting reading, with those who participated reporting significant reductions in GP attendances (47%), visits to A&E (65%) and visits to hospital (64%).

"We found that a lot of the people that came here, referred by their GP or their healthcare professionals, actually opened up more once they had more support, about other issues that they didn't talk about in their 5 minutes with the GP, so it can highlight more issues." Julie Fox, Manager, Annexe Communities

Collaborative working

4.20. Whilst referrals to SPRING are primarily from GP practices, during the review period, SPRING has worked collaboratively with other parts of the Health and Social care system to further explore and develop social prescribing.

4.21. Some examples of this collaborative working are highlighted below:

Stroke Long Term Support – Social Prescribing Pilot

4.22. In the Western Trust area in NI, SPRING worked with the Western Integrated Care Partnership (ICP) to take a small number of referrals from Stroke services as a social prescription. This pilot was delivered in kind, from existing resources within SPRING, as a means of implementing post stroke referrals from Secondary Care at a locality level

4.23. The programme followed the SPRING referral pathway to connect post stroke patients to their wider community through interests that were important to them, including physical activity, cooking, gardening, craft, and historical or educational programmes.

4.24. Two Healthy Living Centres participated in the programme, Bogside and Brandywell Health Forum (BBHF) in Derry and ARC HLC in Irvinestown, Co Fermanagh. Eight clients were referred to the programme, five to BBHF and three clients to ARC HLC. Four clients were female and four were male. The clients' ages ranged from 68 to 81 years old, and the average age was 70 years old. A further two carers were supported by the pilot.

4.25. Those participating completed the monitoring tools used by SPRING before participating and after taking part in the 12-week programme.

4.26. Whilst it is important to note that this was a small pilot carried out over a short time frame, on an in-kind basis by the organisations involved, the evaluation of the pilot highlighted the following:

- There were clear benefits to both the clients and their carers (from participating in social prescribing).
- The process of implementing the pilot provided learning to all the professionals involved and aided the building of relationships between statutory and community sector.
- There continues to be a disparity in access to services between urban and rural areas, mainly linked to infrastructure and access to services.
- WHSCT felt by participating in this pilot, a working application of how an Integrated Care System of planning was fostered.
- Regular meetings with Trust and Social Prescribers uncovered two very different cultures and methods of working. These began to fuse somewhat and with a longer timeframe should improve service.
- Clients were referred to Chest Heart and Stoke (CHS(NI) services on most occasions. A potential pathway may be for CHS (NI) to refer patients to social prescribing following completion of their stroke specific services.

Case Study 6 – Stroke Long Term Support – Social Prescribing Pilot

I met client X and his wife, client Y in March 2022 in ARC Irvinestown. Client X had a stroke in October 2021 and was referred to social prescribing the following March. At this first meeting face to face, client X was noticeably quiet although his wife (also his carer) did talk about her husbands' history prior to stroke. Client X at this time was lacking in confidence and motivation and his wife was stressed and anxious regarding the slowness of her husbands' stroke recovery. They discussed a plan of action which was assessed by finding out client X's interests, hobbies, and capabilities.

The first step was to address concerns, discuss stroke recovery, check blood pressure and discuss the side effects of Client X's medication to provide reassurance and eased anxiety for the couple. Encouragement was given to the couple to pursue the issue of the side effects of the medicine Client X was taking with another GP in the same practice to air their concerns, this was resolved with beneficial effect the following week.

The next step was to provide information and encourage the client to attend ARC's Rethink/Resilience & Meditation programme to enable the client to prioritise and focus on his goals in his recovery. This was attended very diligently and as a result client was able to have clarity on his path and as well as the interaction socially, he learned how to meditate which has helped him to relax and to continue doing same at home.

Client X was now feeling more confident and talking to staff in ARC and he expressed an interest in joining the Weekly Horticulture Group in ARC beginning in May and ending in September 2022. He attended with great purpose and enthusiasm and his wife also benefitted from this respite, as transport was arranged via Fermanagh Rural Transport. There were a few issues with times around transport and collection of the client so that he was not waiting too long in ARC after project was concluded, Client Y had contacted Social Prescribing to intervene and get same sorted as this was stressful for her to attend to. It was resolved successfully by SP which in turn reduced stress for the carer.

Client X has made very noticeable progress in his confidence and mood this was observed by his wife and family and also by staff in ARC as he is now more motivated and interested in joining in with other musical and Christmas craft activities as planned in ARC currently and his wife also joins in some of the activities, this has been a positive journey post stroke for this client. He has had most success of the referrals within Post stroke Recovery as he received ongoing and consistent encouragement by his wife combined with his individual assessment (by ARC Social Prescriber) which demonstrated his interest, motivation, and his capability to join in with the interventions.

County Down Rural Network and Multidisciplinary Teams

4.27. In September 2018, the Department of Health in NI announced a pilot scheme to develop multidisciplinary teams (MDTs) in Primary care settings. The Down and Derry GP Federations were chosen as the first stage of the roll out of MDTs and first contact Physiotherapists, Social Workers and Mental Health Practitioners were allocated to GP Surgeries with many teams in place by September 2019.

4.28. County Down Rural Network (CDRN), one of the SPRING delivery partners, has been working in partnership with MDTs in the Down area to develop a referral pathway from MDTs to community and voluntary organisations. This pathway is based on the SPRING referral pathway.

Bogside and Brandywell Health Forum (BBHF) and Aberfoyle Medical Practice

4.29. BBHF was approached by a senior social worker within the Primary care multidisciplinary team (MDT) in Aberfoyle Medical Practice in Derry who was seeking to establish a small pilot project to tackle health inequality by improving the health outcomes for 'complex' patients (frequent attenders at health services).

4.30. Five patients agreed to participate in the project which was delivered through the SPRING social prescribing service between October and December 2021.

4.31. The senior social worker found that while participants initially appeared different in their profiles and presentations, it became clear that they had many similarities and shared needs. A key need for all participants, consistent with the research literature, was building confidence, self-esteem and learning to like/love yourself, as well as building self-efficacy around managing their own health.

4.32. Following the pilot, the senior social worker also concluded:

> *'Crucially, the presence within Social Prescribing allowed individual patient needs to be met via referrals to additional services. As well as the core groupwork element, participants were connected individually to community-based exercise services, addiction supports, further education and training and community volunteering opportunities. Social Prescribing also played a crucial role in endings and transitions for the group/project with the programme culminating in all participants migrating from the Wellbeing Group into Social Prescribing's new Right Time, Right Place community mental health project wherein they will continue to receive a range of group-based and individual supports.'*

4.33. Although the sample was small (2), the project also tracked attendance rates for patients identified as 'frequent attenders', noting participants showed reductions in attendance rates across a range of health services (e.g., GP, A&E, Out of Hours, NI Ambulance Service, hospital admissions). The project specifically reported the following:

- one participant had a clear pattern of increased A&E attendance during winter with 6 and 10 attendances respectively in the previous 2 winters. Whilst participating in social prescribing, there were zero A&E attendances during the 2021-2022 winter period with the participant achieving their goal of avoiding drug relapse by maintaining their wellbeing.

- a further participant had a long-standing pattern of frequent attendances at different health services. This participant had an average attendance rate at A&E of just over 1 attendance per month (1.3 attendances per month in 2021), average of 5.2 attendances per month at GP, average of 3.8 attendances per month at Out of Hours (OOH) and self-reported to have used NI Ambulance Service (NIAS) over 213 times in 2021. Whilst attending social prescribing there were indications of some reduction in levels of usage of health services with the number of presentations at GP having reduced in the period Dec 2021- Feb 2022. The participant self-reports that she has only utilised NIAS once in that period. OOH contacts reduced in frequency in 2022. The participant's A&E attendances may remain somewhat stable at approx. 1 per month with no attendances in Feb 2022.

For Communities and Delivery Partners

> *"I couldn't keep up to date with what was available, whereas the social prescriber knew exactly what was available in the community…essentially I was referring them to a specialist on what is going on in the community." Dr Laura O'Donnell, GP, Enniskillen*

4.34. The impact SPRING has had on communities and delivery partners is demonstrated by the following examples.

Project Echo

4.35. During the review period, SPRING and the HLC Alliance continued to play an important role in the Project Echo shared learning network for social prescribing. Project ECHO was originally developed in New Mexico and is a model for learning and sharing good practice which brings people with a shared interest together in structured way within a virtual community using video conferencing technology. The shared learning network in N. Ireland includes link workers from five other social prescribing initiatives.

Scottish Social Prescribing Network (SSPN)

4.36. The previous evaluation report noted that SPRING and Scottish Communities for Health and Wellbeing (SCHW) were instrumental in establishing the Scottish Social Prescribing Network (SSPN) in June 2020. This network brings together the key players in social prescribing in Scotland and aims to share learning on social prescribing practice, policy, and strategy.

4.37. In the current evaluation period, the SSPN continued to evolve and through the network, SPRING and SCHW have developed relationships with Members of the Scottish Parliament (MSP) and other organisations undertaking social prescribing. The impact of SSPN on Government Policy is further discussed in the section below. Other relevant activities undertaken by SSPN include:

4.38. NHS Education for Scotland (NES) – working with NES to discuss accessing training for social prescribers. In the short-term, NES has made the online training system for NHS staff accessible to social prescribers in third sector organisations.

4.39. Movement for Health - Movement for Health (MfH) is a coalition of 19 organisations that advocate for people with long-term conditions to move more. SSPN presented to and sat on a panel session at an event organised by MfH is November 2022 to discuss social prescribing in Scotland.

4.40. Global Social Prescribing Alliance – This alliance has representation from Spain, Finland, Canada, Austria, Australia, Germany, England and USA. Representatives from SSPN, including the SPRING Project Manager attended a meeting of the Alliance in October 2022 and presented on developments in social prescribing in Scotland. Through the Alliance, SSPN has also contributed to research by the University of Ontario which is trying to find a global definition of social prescribing.

4.41. Social Prescribing Research Hub – SSPN is part of a funding proposal submitted by University of West of Scotland to create a social prescribing research hub for Scotland.

All Ireland Social Prescribing Network

4.42. The previous evaluation report highlighted the role played by the HLC Alliance and SPRING in the All-Ireland Social Prescribing Network. During the current review period, the network continued to evolve, with the HLC Alliance NI Co-Ordinator as Co-Chair. In June 2022, the network organised a very successful All Ireland Conference on social prescribing in Derry. This was attended by over 200 delegates from Ireland and N. Ireland. These included social prescribers, representatives from community-based organisations, politicians (including 2 government ministers), academics and officials from government departments. SPRING and HLC Alliance played key roles in organising and facilitating the conference.

For Government policy

4.43. The previous evaluation report noted that *"SPRING should continue to share learning from the project with policy makers, through working on national steering groups and building on existing relationships with Government departments."*

4.44. Influencing policy makers has been a significant area of focus for SPRING, Scottish Communities for Health and Wellbeing (SCHW) and HLC Alliance in the period covered by this evaluation. Because SPRING operates in two different jurisdictions separate approaches have been taken in Scotland and N. Ireland. These are summarised below.

Scotland

SSPN

4.45. As noted previously SPRING and SCHW are important members of the Scottish Social Prescribing Network (SSPN). During the current evaluation period, SSPN, SCHW and SPRING have developed relationships with Members of the Scottish Parliament (MSP), including Maree Todd (currently Minister for Social Care, Mental Wellbeing and Sport), and Paul McLennan (MSP for (currently Minister for Housing) and through these relationships, have highlighted the difference social prescribing can make. As a result, these MSPs have become important advocates for social prescribing.

> *"The Scottish Government are currently looking at ways to bring together the diverse interests in social prescribing across portfolios and considering how to co-ordinate our approach at the national level. Thank-you for the important work that you and Scottish Communities for Health and Wellbeing continue to support regarding social prescribing." (Extract from a letter to SCHW from Maree Todd MSP, January 2023)*

Through this relationship, a Parliamentary reception was held in June 2022 at the Scottish Parliament sponsored by MSP Paul McLennan. The purpose of this event was to showcase the work of the SSPN and the impact social prescribing has on individuals, communities and healthcare.

4.46. Follow up round table discussions were held in November 2022 and February 2023 hosted by Paul McLennan and involving key stakeholders to further discuss social prescribing and these discussions are ongoing.

Health, Sports and Social Care Committee

4.47. During 2022, the Health, Sports and Social Care Committee of the Scottish Parliament reviewed health inequalities. The SPRING Project manager provided evidence on social prescribing and its impact on helping to address health inequalities to the committee on several occasions during 2022. The committee's report was issued in September 2022 and recognised the important role social prescribing can play in helping to address health inequalities. It also highlighted the lack of ownership of social prescribing within the Scottish Government.

> *"Many members raised the issue of social prescribing and I give an absolutely assurance that we are looking at the recommendations of the report. Maree Todd and I have asked officials to consider the point about a national lead for social prescribing. There is, understandably, a wide portfolio interest in social prescribing, but I am not opposed in principle of the idea of potentially examining and exploring the option of a national lead." – Humza Yousaf former Cabinet Secretary for Health (and current First Minister of Scotland) speaking at the Health, Social Care and Sport Committee Debate: Inquiry into Alternative Pathways to Primary Care 10 November 2022.*

Place and Wellbeing Programme

4.48. The Place and Wellbeing Programme is one of four programmes being taken forward as part of the Scottish Government's Care and Wellbeing Portfolio.

4.49. Representatives from Scottish Communities for Health and Wellbeing play a key role in the Place and Wellbeing: Communities workstream, working closely with the programme development team and targeted community-based approaches, including social prescribing.

> *"Working with communities and local service providers we will prioritise targeted, prevention-led and early intervention approaches. We will join up various programmes and policies to ensure our success. This includes linking to areas such as social prescribing and community link workers." Extract from briefing notes to partners including SCHW from the Scottish Government's "Place and Wellbeing: Communities" programme Development Workstream.*

N. Ireland

Department of Agriculture, Environment and Rural Affairs (DAERA)

4.50. The HLC Alliance has continued to work with DAERA to deliver social prescribing to rural areas in N. Ireland. During the review period, DAERA continued to fund 8 rural Healthy Living Centres to deliver social prescribing following a model based on SPRING.

"Many of these conversations are new. We need more time and more honest conversations to build equal partnerships with government and with the health sector to help us find a balance in social prescribing."
Nicholas McCrickard, Manager, Country Down Rural Community Network

Heritage and Museums

4.51. As demonstrated elsewhere in this report, there is clear evidence that social prescribing services such as SPRING help people experiencing mental health and wellbeing issues. The Melbourne Charter (2008), on mental wellbeing identified that mental health and wellbeing are increased when the arts and heritage are valued within society.

4.52. Some SPRING participants have benefitted from taking part in cultural activities and recognising this link, HLCA, SPRING and Museums NI (part of the Department for Communities) are keen to further develop dynamic partnership opportunities at a regional level. Museums NI have recently corresponded with HLC Alliance with a view to joint working in furtherance of some of the organisation's key social inclusion and wellbeing objectives.

Case Study 7 – County Down Rural Community Network

In October 2022, B was referred to Spring Social Prescribing by the social work team in the GP surgery. He is a 51-year-old gentleman who suffers from anxiety and depression and lives with his 17-year-old son (who has Aspergers). He didn't feel up to coming along on his own to his initial meeting with the social prescriber, so the social work assistant joined him for his initial meeting.

After chatting with B about what he would like to do, he agreed to try and go along to the men's group that met each Tuesday afternoon in the wellbeing hub. He joined in with them as coincidently they were starting a 4-week copper craft session that same week and he embraced learning a new skill. He also got to know a few of the others and now attends weekly where he has also done mindful art classes, photography sessions and went along on his own to a Christmas movie and lunch in the local cinema organised by the Social Prescribing team. He is presently taking part in a 6-week building resilience programme.

A new nature walk had been started up in conjunction with Mourne Heritage Trust's countryside officer and B is also attending these walks and enjoying learning about nature and plants as well as chatting to the people in the group. He engages well with men and women in this group. He recently said that he cannot believe the difference linking into social prescribing has made to his wellbeing. He hasn't had any alcohol in over 6 months and is out walking his dog twice a day. He now chats away to any newcomers to the groups and makes them feel welcome and is happy to tell them about his positive journey into good mental health through social prescribing.

Housing

4.53. In January 2020, the NI Housing Executive (NIHE) (part of Department for Communities) teamed up with SPRING to pilot a social prescribing service to support vulnerable tenants with their health and wellbeing. The pilot was run in the Derry City and Strabane District Council area by Bogside and Brandywell Health Forum and was funded through the Housing Executive Homelessness Prevention Fund. The pilot ran until March 2023 and total funding provided was £60,000.

4.54. Referrals to the service were made by Housing Officers, Patch Managers, Housing Associations and though First Housing, a charitable organisation offering advice, support and accommodation to people that are homeless and in acute housing need.

4.55. As the funding source was time limited and the funding cycle had exceeded contract time, NIHE felt unable to sustain the pilot with the absence of an Executive in NI.

"Social Prescribing has been a welcome boost for our tenants in the Derry City and Strabane council area….As a landlord, we recognise that many different services help tenants maintain their tenancies and enable them to enjoy their homes.
SPRING Social Prescribing supports vulnerable tenants, helping them to be aware of their personal situation and avoid unnecessary stressful situations that could impact their health or their home."
Caroline Connor, Assistant Director Housing Services, NIHE.

Sustaining SPRING in N. Ireland

4.56. During the review period, representatives from SPRING and HLC Alliance have met with politicians and government officials from several government departments to explore ways of sustaining SPRING when The National Lottery Community Fund funding ends.

4.57. This has included presenting to an inter-governmental group convened by the (then) Department for Communities (DfC) Minister and attended by representatives from DfC, Department of Health and DAERA, together with attending subsequent meetings with representatives from these Departments.

"[The health service] is under extreme strain and are looking to the community sector to relieve some of this pressure…they still see us as having untapped potential…this pressure has increased significantly [over the past few years] on both the Health and Third Sectors." Nicholas McCrickard – County Down Rural Community Network Manager

5. Conclusions, Learnings and Observations

This section sets out the overall conclusions from this evaluation and summarises some key learnings and observations from SPRING gathered over the last 5 years, based on this and previous evaluations.

Conclusions

5.1. This evaluation covers the period November 2020 to December 2023. During this period, 4250 people were referred to SPRING. Over 70% of the people referred were female and the majority (64%) were aged 45 or over.

5.2. As with the previous evaluation, the main reasons for referral were for people experiencing low level mental health issues and social isolation. 19 community partners participated in SPRING and the main referrals came from GPs with 169 GP practices engaged in SPRING during the review period.

5.3. There can be little doubt that SPRING has continued to help people to improve their health and wellbeing. During the review period, 87% of SPRING participants who completed Warwick Edinburgh monitoring tools showed an improvement, with an average improvement of 26%. 89% of people who completed Outcome Star monitoring tools showed an improvement in their health and wellbeing, with an average improvement of 32%. The main areas of improvement were lifestyle and feeling positive.

5.4. Some participants provided information on GP attendances pre and post attending SPRING. This shows a 47% reduction in GP appointments. In addition to GPs, SPRING has also worked in collaboration to introduce social prescribing to other parts of the health and social care system, including Stroke Services and Social Care.

5.5. SPRING, Scottish Communities for Health and Wellbeing and HLC Alliance have continued to play lead roles in sharing learning from social prescribing and social prescribing networks in Scotland and Ireland.

5.6. During the current review period, learning from SPRING was shared with policy makers in Scotland and N. Ireland.

5.7. In light of the above, in our view for the period covered by this evaluation, there is clear evidence that SPRING has achieved the anticipate impacts set out in the original business plan as it has helped:

i) People to improve their health and well-being.

ii) Health professionals to deal more effectively with their patients.

iii) Delivery partners to respond to the needs of their communities, and

iv) Government to understand the benefits of social prescribing and community led health provision.

Key Learnings and Observations

5.8. Some key learnings and observations from the SPRING social prescribing project based on this and previous evaluations are summarised below. It is anticipated that these may help inform the development of future social prescribing services and models:

Social prescribers

5.9. Social prescribers employed through the project have operated in a mixture of full-time and part-time roles – the social prescribers employed by delivery organisations in Scotland were mostly full-time, whilst those employed by delivery organisations in NI were often on a part-time basis. Evidence gained from social prescribers and delivery organisations shows that social prescribers are much more effective when working on a full-time basis.

5.10. The social prescriber's role is multifaceted and requires a wide range of skills and competencies, including having face to face conversations, and demonstrating negotiation and organisational skills. Perhaps the most important task fulfilled by the social prescriber is building rapport and trust with people referred to them and as SPRING has evolved, social prescribers have found that having meaningful conversations takes time, and those in part-time roles have often struggled to balance seeing people referred to them with other duties such as organising meetings, completing monitoring tools and taking part in training and development activities. The reality is that delivery partners with part-time social prescribers often found that they were unable to satisfy the demand for their services in their areas.

> *"I think when designing policies, especially for healthcare, one size does not fit all. I think to tackle the huge complexity of people's health, there has to be different approaches that can be effective, including community-led approaches" Julie Fox, Manager, Annexe Communities*

5.11. Evidence from SPRING also shows that to attract and retain quality people into social prescribing roles, the roles themselves have to be adequately remunerated and offer job security, a career pathway, and opportunities for progression. The work of social prescribers was key to the success of the project. Many social prescribers find their roles personally rewarding and go above and beyond to help people whilst working on temporary or short-term contracts. As social prescribing continues to evolve, it is important to adequately remunerate social prescribers on a consistent and permanent basis and provide these key workers with a career pathway and opportunities for progression.

5.12. It is also important to provide training and development opportunities for social prescribers. SPRING has developed resources in this regard and evidence shows that networking with peers can provide invaluable learning opportunities. An ethos of continuous development should be prevalent in any social prescribing service and adequate resources for training and development should be built into the delivery model.

5.13. Experience from SPRING demonstrates that social prescribers often find themselves working on their own, addressing difficult, complex, and emotional issues. In these circumstances, it is important to build appropriate support mechanisms for social prescribers into the delivery model to help protect their wellbeing and support their development. Support can come from HLC managers and peer social prescribers. Time and resources to provide this support should be factored into the delivery model for social prescribing services.

Project co-ordination

5.14. The SPRING project had a central team charged with co-ordinating approx. 20 delivery partners across NI and Scotland. This team was led by an overall project co-ordinator, and there were individual leads for NI and Scotland together with a central administrative resource. Subsequently the central team was augmented by data officer and a communications officer. The project's Finance function was provided by the lead partner.

5.15. Experience from SPRING shows that central co-ordination is vital for large multi-partner projects covering several jurisdictions and operating over extended timeframes. Evidence from SPRING shows that a central team, working closely with the lead partner and the management board can play an important role in

- gathering learning and seeking development opportunities for the project and delivery partners.
- providing support to help evidence and demonstrate the impact of the project and to influence government and other decision makers.
- providing learning opportunities for delivery partners and social prescribers; and
- helping the project to adapt and change as external circumstances change.

Delivery partners

5.16. SPRING has demonstrated the benefits of delivering social prescribing through community-based organisations and in doing this it is important to acknowledge that social prescribing is not a 'one size fits all approach'. The diversity of delivery partners has been key to the success of SPRING. SPRING delivery partners have demonstrated that community-based approaches are flexible and responsive.

5.17. Although limited programme delivery resources were sourced from underspends during the life of the project, SPRING was unable to provide substantive resources for programme delivery and delivery partners have pointed out that that resources for this area should be a component of social prescribing delivery models. Adopting the principle that 'money should follow the person' would provide a level of funding to help delivery partners develop programmes to meet social prescriptions.

5.18. Learning from SPRING demonstrates that rural delivery partners face different challenges from their urban counterparts, particularly regarding travel, transport, and the time necessary to deliver social prescriptions in rural areas. Therefore, when developing a social prescribing service, it is important to consider the geography in which it operates.

Importance of Governance arrangements

5.19. SPRING had a management board comprising representatives from BBHF, the lead partner, HLC Alliance, and Scottish Communities for Health. Experience from the project demonstrates that it is important to have clear governance arrangements in place to provide oversight of the social prescribing service.

5.20. The oversight board should include representatives from key stakeholders and the roles and responsibilities of members should be discussed, agreed, and documented when the service is established. The board should meet regularly, and its role should be to provide strategic direction to the social prescribing service, set the learning, development and continuous improvement ethos for the service and monitor the accountability arrangements.

Outcomes and targets

5.21. Measuring the success of social prescribing is important to those who provide the resources to enable the service to be delivered.

5.22. SPRING has demonstrated that is extremely challenging to measure work that is being carried out on the ground because it is nuanced and varied, holistic and person-centred. As noted elsewhere, the monitoring arrangements used by SPRING included Warwick-Edinburgh (SWEMWBS) and Outcome Star (Wellbeing Star). Whilst these tools provided important evidence of impact, especially at the beginning of a social prescribing journey, it is important

to strike a balance between building rapport and trust between the participant and the social prescribers and completing monitoring questionnaires.

5.23. For future social prescribing services, consideration should be given to the number of monitoring tools in place. Warwick- Edinburgh is used by several social prescribing services and this enables inter-service comparability. There could be debate over whether multiple tools like the Outcome Star and Warwick-Edinburgh tools are needed.

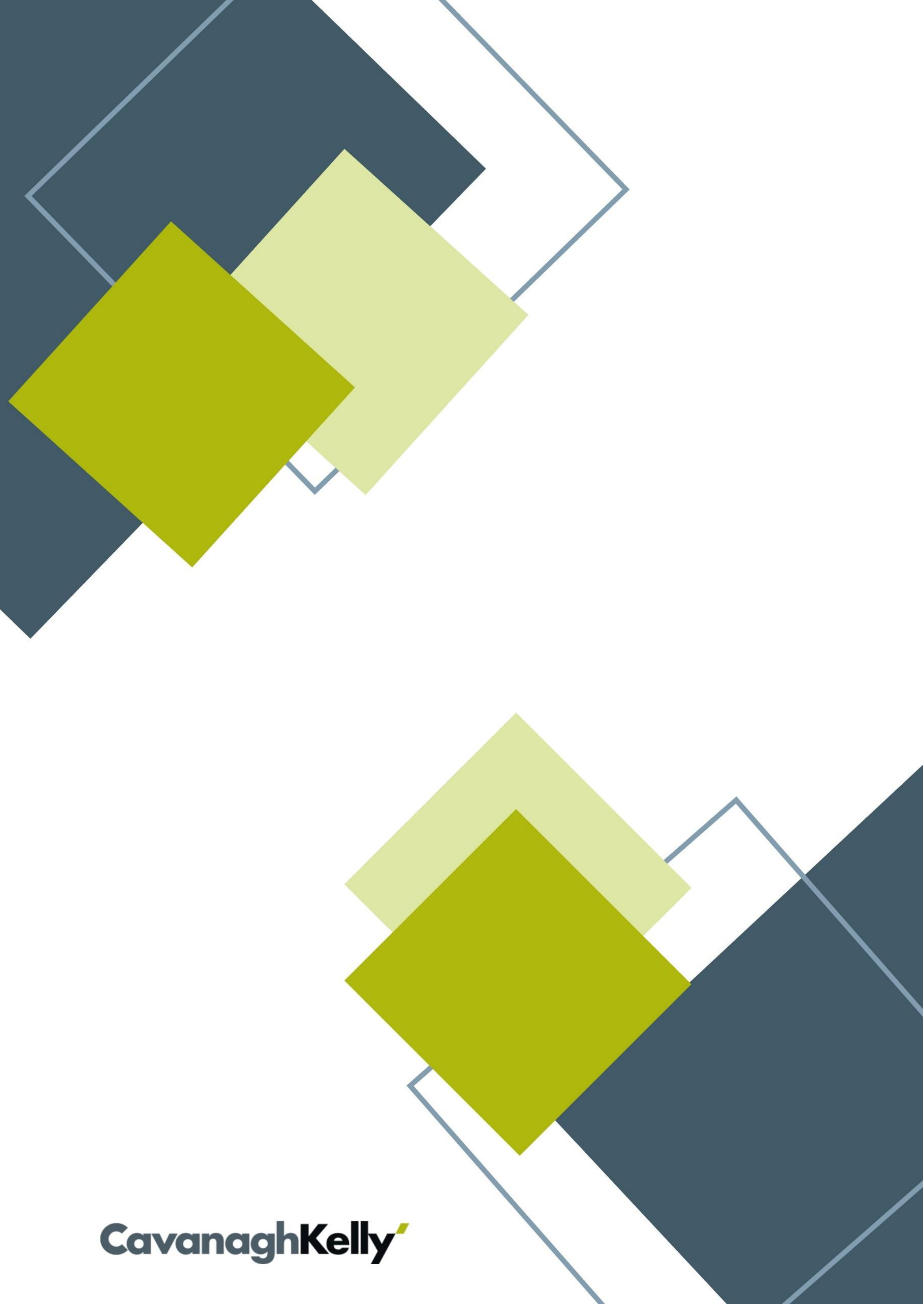
5.24. Learning from SPRING shows that data collection methods and approaches should be person centred and co-produced. Given the holistic nature of social prescribing, it is important not to become overly focused on activity targets. This was recognised by SPRING and representatives from The National Lottery Community Fund after year 1 of the project and as noted previous unlike other similar programmes, SPRING placed less emphasis on counting numbers of interventions and tried to focus on the impact of the project on the needs of individuals. When considering data collection, clarity is needed on why, and for what purpose, information is required. This should be discussed and agreed between funders, delivery partners and participants.

Evaluation

5.25. As social prescribing continues to evolve, it is important to have an evidence base to demonstrate its impact to learn what works and also what does not. SPRING has demonstrated that social prescribing provides a valid, valued alternative to the medical model. Based on learning from SPRING, it is important not to try to evaluate social prescribing using the medical model and there is a need for an alternative evaluation model which should be developed with input from all parties and will take time to develop.

5.26. Given the importance of evaluation, adequate ring-fenced finance and time should be provided for this when developing social prescribing services. Consideration could also be given to involving university-based academics in the evaluation process. Evaluation training is required for social prescribers to enable them to contribute to this efficiently and effectively. Furthermore, multiple methods of data collection are needed for evaluation, and these could include interviews, focus groups and narrative case studies.

> *"SPRING has been better than a previous funder, because SPRING is about quality and less about quantity" Marie Kelly, Social Prescriber, ARC*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