An Evaluation of Get Well … Connected

South Dublin County Partnership
Social Prescribing pilot project

August 2018 to February 2020

By Jacqui Gage, Partners Training for Transformation
March 2020

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Acknowledgements

My thanks to João Esteves, Social Prescribing Coordinator for Get Well … Connected (August 2018 - October 2019), for his time in speaking with me and arranging contacts with other stakeholders, and especially for his generosity in continuing to support the evaluation after leaving the post. His thoughtful reflections on his experience were invaluable in gaining an insight into the project.

My thanks also to Marjo Moonen (SDCP) for her valuable input at different stages of the evaluation. And to Deirdre Ruane and to Clare McKevitt for their support in completing the work after João's departure.

Many stakeholders gave generously of their time in meeting with me, from community group representatives, the Social Prescribing Advisory Group, and GPs and practice staff. Thank you all.

My particular thanks to Mary Farrelly of Glenview Clinic and to Eimir Molloy of Parkhouse Family Practice for coordinating meetings with practice staff and participants, for sourcing data for the quantitative analysis, and for their generosity with the time they took to share their perspectives on the project. And especially for their warmth and support of myself and the whole evaluation project.

And finally, my thanks to the participants on this social prescribing project who completed measures at the start and finish of their engagement, and to the seven participants who were able to meet me to give such thoughtful insight into their individual experiences of the project.

Jacqui Gage
On behalf of Partners Training for Transformation

Executive Summary

Social prescribing connects people with supports and activities in the community to strengthen their health, wellbeing and quality of life. It is a formal way of enabling healthcare services to support self-management by referring people aged 18 or over to a variety of local, non-clinical projects, programmes and activities in the community through a link worker. It is a system which focuses on health and wellbeing more than on illness. It recognises that people's health is determined by a range of social, economic and environmental factors, (the social determinants of health) and the need to address these health and wellbeing needs in a holistic way. It aims to support people to manage their own health.

Social Prescribing is in its early days of development in Ireland. A number of projects have begun in recent years. Each project develops its own model to respond to the local context, learning from other projects and initiatives in Ireland and the UK, and depending on the resources available. It can be shown to have a contribution to make to the implementation of Slaintecare and Healthy Ireland initiatives.

Get Well … Connected is a pilot project based in South Dublin County Partnership (SDCP), funded by Health Service Executive (HSE), Healthy Ireland and the Social Inclusion and Activation Programme (SICAP). The work is supported by an advisory group with considerable experience and expertise in health promotion, community development, and specifically in social prescribing. This group meets approximately bi-monthly. Implementation and record keeping are facilitated by use of an online platform developed by Elemental.

The early development of the project involved researching the community services, facilities and resources available in the local area of Tallaght, as well as building an extensive network of relationships with service providers and healthcare professionals. 108 referrals were made between January 2019 and October 2019.

An evaluation of the project began in June 2019 and was completed in February 2020. Approximately 80 of those initially referred completed baseline measures using MYCAW (Measure Yourself Concerns and Wellbeing), SWEMWBS (Short Warwick-Edinburgh Mental Wellbeing Scale) and SDCP Community Involvement scale. A sample group of 25 participants took part in the evaluation, completing the follow-up measures. 7 of this group met one-to-one with the evaluator to give their feedback on their experience of the social prescribing project. Their stories are included in brief in this report, to give a broader understanding of the experience and impact of the service from the perspective of participants.

In addition the evaluator met with other stakeholders, using a combination of one-to-one interviews and focus groups.

The findings from the quantitative data showed significant positive changes over the time of engagement with the social prescribing project. Self-reported wellbeing measures improved, and the impact of causes for concern in the lives of participants diminished. Community involvement and knowledge of services in the community increased substantially over the same time.

The findings from the qualitative research supported these findings, and provided further insights into a number of aspects of the project, such as the role of the social prescribing coordinator, the value of the model used for the project, the location of the service and the achievements and challenges of the project.

Recommendations are made in relation to the continuation of the project, and its continued development and growth in the months and years ahead.

1. Introduction

This report describes the evaluation of Get Well…Connected, a pilot project to explore the feasibility and effectiveness of a model of social prescribing designed for an area of Tallaght in South Dublin County. It looks at the development of the project, and its effectiveness in achieving its aims during the first fifteen months of its development.

In order to do this, a number of quantitative measures were used, as well as gathering qualitative information through case studies and semi-structured interviews and focus groups with a number of key stakeholders.

The pilot project saw the employment of a social prescribing coordinator / link worker by South Dublin County Partnership (SDCP), supported by HSE and Healthy Ireland. The project is funded by Health Service Executive (HSE), Healthy Ireland and the Social Inclusion and Activation Programme (SICAP). This shared funding model reflects investment in the project from both the health sector and the community development sector.

The Social Prescribing Coordinator (SPC) began work on 1st August 2018. He was based in the Partnership, and when he began taking referrals in January 2019 he worked for one session a week in each of two general practices in the Tallaght area: Glenview Clinic, Glenview, and Parkhouse Family Practitioners, Brookfield. A key part of the project's success seems to be rooted in this combination of strong connections with healthcare professionals as well as strong connections with the community and voluntary sector. The SPC came to be seen as part of the team in each situation.

This report gives a background to social prescribing and the national context. It describes the quantitative and qualitative research, and reports on the findings of these. It identifies some of the challenges facing the project, what has been learned from the first fifteen months, and makes some recommendations.

2. Background

2.1 What is Social Prescribing?

Social Prescribing connects people with supports and activities in the community to strengthen their health, wellbeing and quality of life. It is a formal way of enabling healthcare services to support self-management by referring people to a variety of local, non-clinical projects, programmes and activities in the community through a link worker. It is a system which focuses on health and wellbeing more than on illness. It recognises that people's health is determined by a range of social, economic and environmental factors, (the social determinants of health) and the need to address these health and wellbeing needs in a holistic way. It aims to support people to manage their own health.

2.2 Aims of Social Prescribing

- The primary aim of social prescribing is to help people live their lives as well as possible.
- A secondary aim of social prescribing might be to have an impact on system outcomes, e.g. reduce demand for medical services.

This hierarchy of aims is reflected in the ethos of this project, in the way stakeholders talk about the project, and in the reported experience of participants interviewed.

2.3 The National Context

Social prescribing is at an early stage of development in Ireland, with one of the earliest projects being in Donegal dating back to 2013. There are now a number of projects developing around the country. Social Prescribing Network Ireland has formed to mainstream social prescribing through lobbying and establishing a learning network across Ireland. It is not clear exactly how many projects now exist in Ireland. What is clear is that each project is developing its own model to fit its particular circumstances, and that these projects vary widely. They vary in terms of the model of social prescribing which they work out of, and also in terms of the resources available to them.

"Sláintecare is the ten-year programme to transform our health and social care services. It is the roadmap for building a world-class health and social care service for the Irish people."[1]

Slaintecare includes an Integration Fund to support projects from across the country which

- "demonstrate innovative ways in which citizens can engage in their own health
- represent best practice in the management of chronic diseases and caring for older people
- encourage innovations in shift of care to the community or promote hospital avoidance"[2]

At the launch of the fund Minister of State for Health Promotion Catherine Byrne said,

> **"I am pleased to see so many successful projects with a focus on prevention and on empowering people and communities to be more engaged in their own health and wellbeing."**

Four community based social prescribing projects and one hospital based SP project were funded in the 2020 round of Integration Fund grants. Social prescribing is a good fit with the themes and goals of Slaintecare and of Healthy Ireland.

"The Healthy Ireland Framework 2013-2025 supports Government's response to Ireland's changing health and wellbeing profile."[3]

Two key themes of the Healthy Ireland Framework are most closely connected with the work of social prescribing:

- "Theme 2: Partnerships and Cross-sectoral Work …

  2.13 Combine mental health promotion programmes with interventions that address broader determinants and social problems as part of a multi-agency approach, particularly in areas with high levels of socio-economic deprivation and fragmentation. …

- Theme 3: Empowering People and Communities …

  The impact of positive social interaction cannot be underestimated. Social interaction and supporting social connectedness and involvement in community life are a keystone to empowering people at the individual level and building strong communities for health and wellbeing. …

  3.6 Support, link with and further improve existing partnerships, strategies and initiatives that aim to remove barriers to participation and to provide more opportunities for the involvement of older people in all aspects of cultural, economic and social life in their communities. …

  3.11 Develop strategies to enhance social connectedness across the life course and to connect people most in need to resources, services, education and healthcare."[4]

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[1] https://www.gov.ie/en/campaigns/slaintecare-implementation-strategy/

[2] https://www.gov.ie/en/press-release/a98320-minister-for-health-announces-20-million-funding-for-122-slaintecare/

[3] https://www.hse.ie/eng/about/who/healthwellbeing/healthy-ireland/

[4] https://www.hse.ie/eng/about/who/healthwellbeing/healthy-ireland/hidocs/healthyirelandframework.pdf

3. Get Well … Connected

3.1 The project

The project is based in South Dublin County Partnership, as part of their Health and Wellbeing strategy. It grew out of a collaboration between HSE, SDCP, South Dublin County Council (SDCC) and local community and health interests.

It is for people over 18 years of age, living in South Dublin, who may need additional support to mind wider health and wellbeing needs previously identified by General Practitioners. This project is mainly beneficial to people who may feel lonely, socially isolated, anxious, depressed or in need of different kinds of social supports. It provides an additional and different resource for health care professionals, often valuable when there is no obvious clinical need, or alongside a clinical need.

The pilot project seeks to achieve the following outcomes:

- "Increased acceptability and uptake of the social prescribing service, among patients and health care practitioners
- Improved patient self-reported wellbeing
- Reduced pressure on clinical workload
- Improved connections between medical and community sectors"[5]

The project is funded by Health Executive Ireland (HSE), Healthy Ireland and the Social Inclusion and Activation Programme (SICAP). This shared funding model reflects investment in the project from both the health sector and the community development sector.

3.2 The name: Get Well … Connected

A decision was made early in the development of the project that a unique name for the project would convey more clearly the intention and nature of the project. 'Get Well … Connected' was chosen and approved by the advisory group. In practice, it is not widely used or recognised, despite being used in literature to promote the service. The project is widely referred to as 'Social Prescribing' or else by the name of the link worker, which is the way participants mostly refer to the project. An online search for 'Get Well … Connected' shows a reference to this project several pages down the list of results (It comes after Ryan and Matthew, "on a lightyears long journey to return home with sounds from across the galaxy").

Social Prescribing is a term which has significant meaning for many healthcare professionals and community workers.

[5] https://sdcpartnership.ie/strengthen-your-health-wellbeing/social-prescribing/

3.3 Project Structure

The Social Prescribing Coordinator is employed by South Dublin County Partnership, and reports to the Manager of Health and Wellbeing (also Deputy CEO of SDCP)

For a short period of 2 months a temporary administrator was employed to support the populating and updating of the database of mapped local services.

The Social Prescribing Advisory Group meets approximately every two months and provides expertise, advice and support to the project.

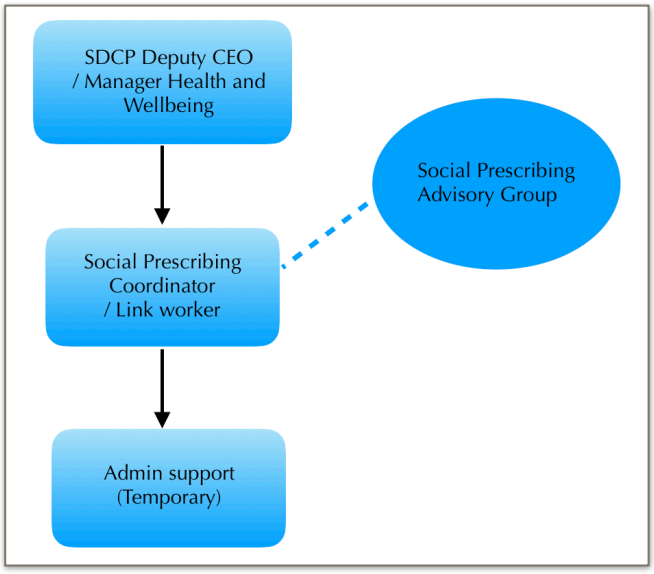


Figure 3.1 : Structure of Get Well … Connected project

3.4 Location of work

The Social Prescribing Coordinator is based in SDCP offices, and also has regular times when he works in the general practice clinics in Glenview and Brookfield to meet with clients. Other meetings with clients are arranged, by negotiation, in local community centres, projects, and programme venues.

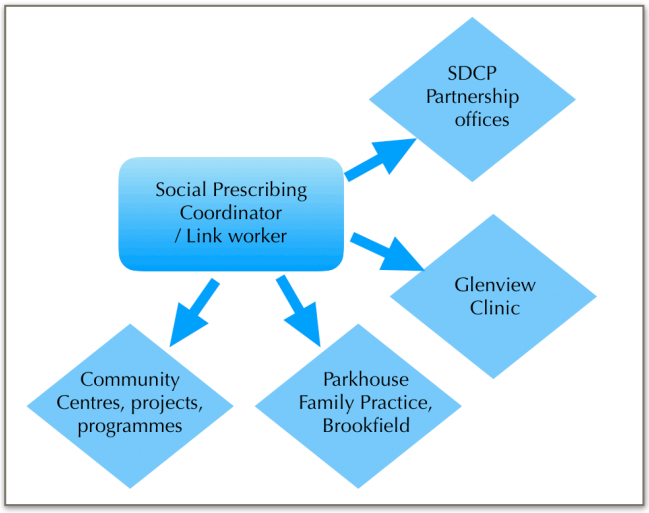
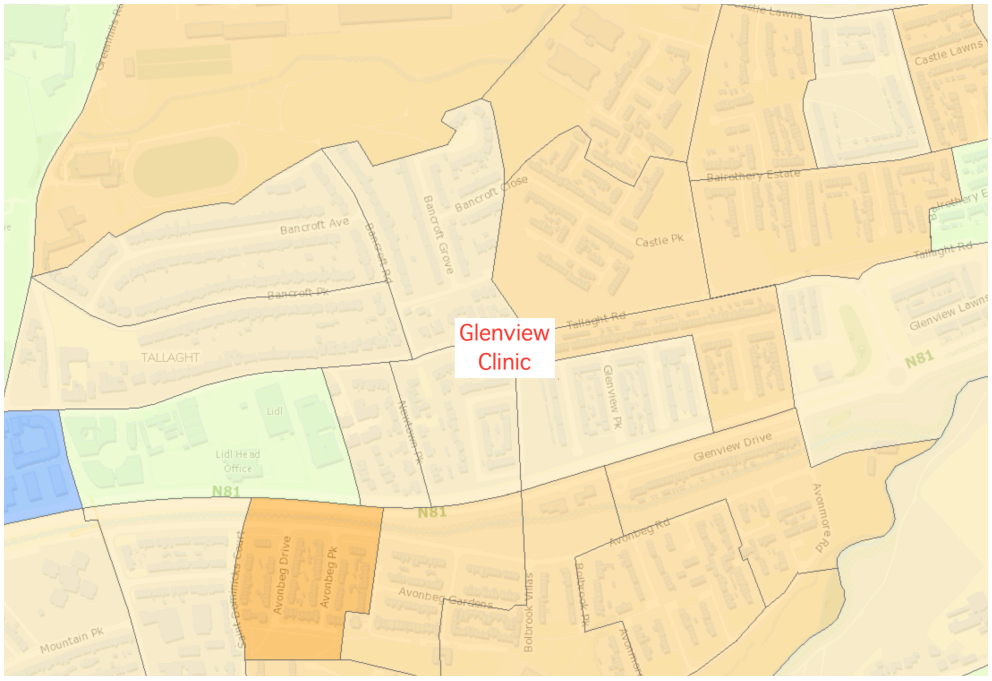


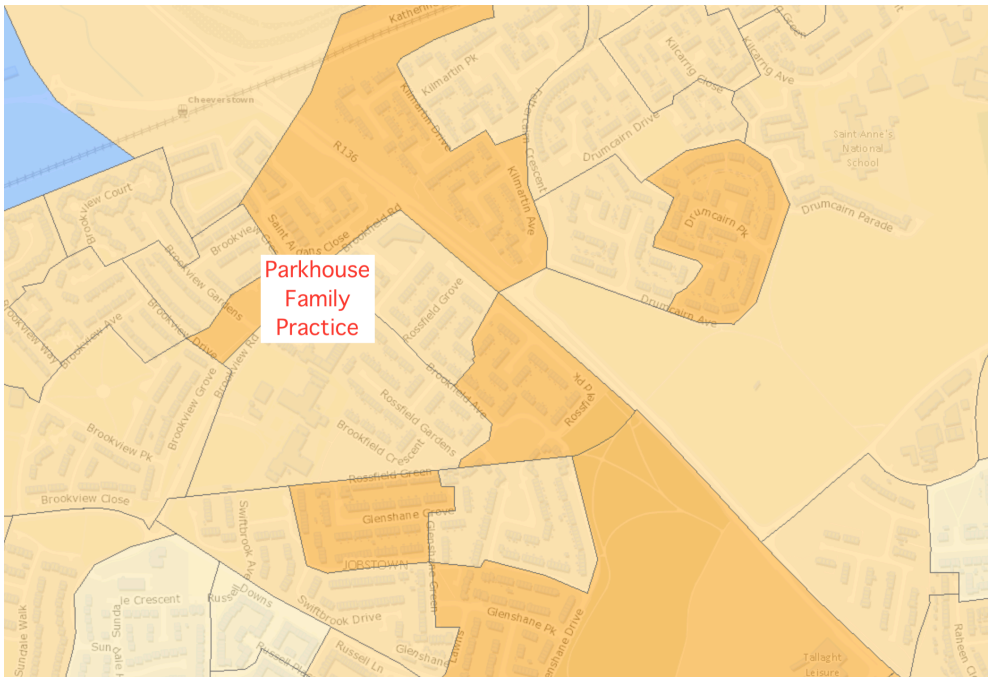
Figure 3.2: Regular places of work for S.P.C. / link worker

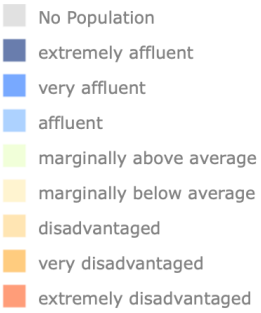
3.5 Glenview Clinic and Parkhouse Family Practice

This model of social prescribing forges a close link between the Social Prescribing Coordinator / Link Worker and GP practices. In this pilot phase, referrals are being made from Glenview Clinic, Glenview and Parkhouse Family Practice, Brookfield.

These two practices were approached for inclusion in this pilot project because of their interest in social prescribing, and because of the demographic differences between the areas served by the two practices.







As can be seen from the Pobal index of deprivation small area maps, the area around Glenview is predominantly made up of areas which are marginally above average, marginally below average and disadvantaged. The area around Parkhouse Family Practice is predominantly disadvantaged and very disadvantaged.

The Pobal HP Index and description are derived from a number of measures drawn from the CSO 2016 census data. These measures include: age dependency ratio, lone parent ratio, proportion with primary education only, proportion with 3rd level education, proportion in local authority rented properties, and unemployment rates for men and for women.

A comparable relationship with Gerontological Emergency Department Intervention team in Tallaght University Hospital is in advanced planning stages.

3.6 Referral Pathway

Referrals to SP are made through Elemental software which healthcare professionals have easy access to. Through the platform they can also see what social prescriptions have been made with reference to their patient, as well as meeting SP coordinator for feedback and discussion of issues emerging.

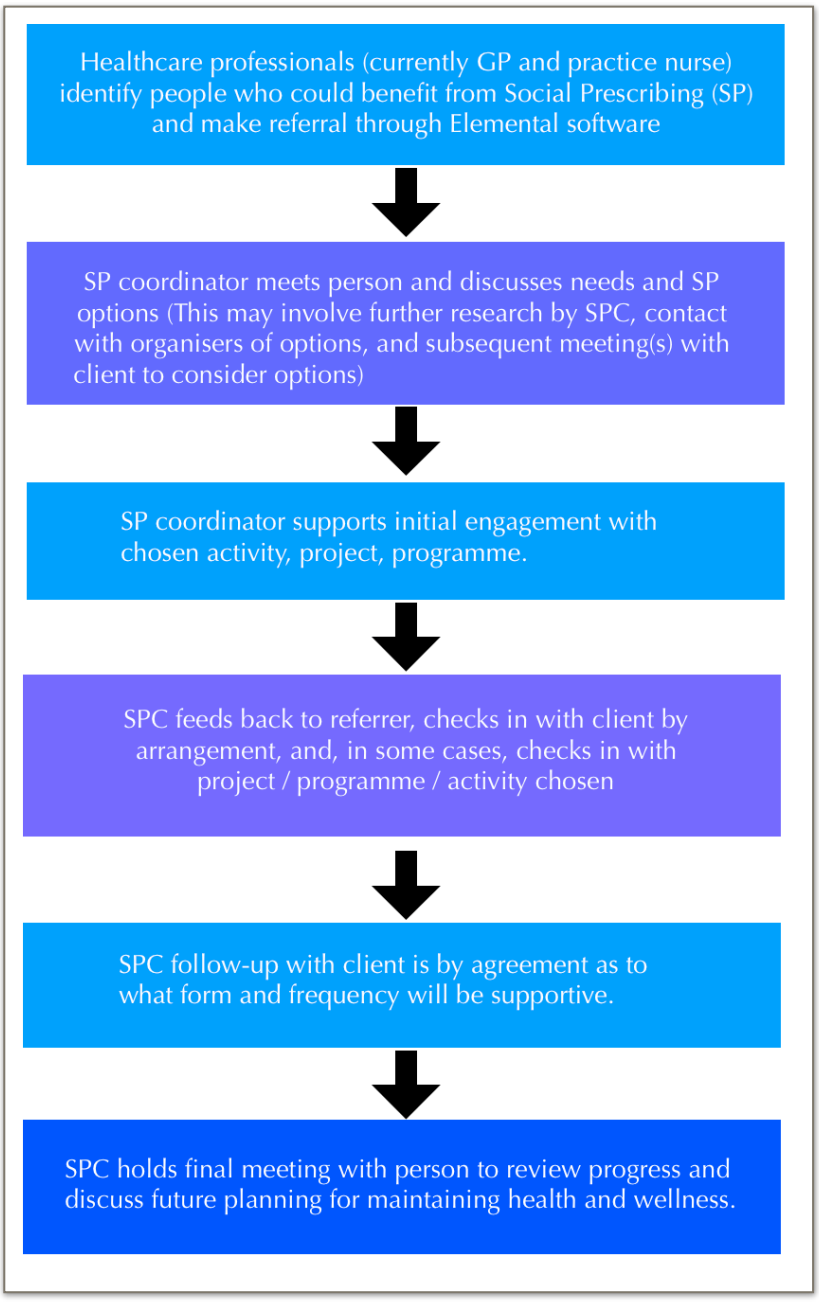


Figure 3.3: Social prescribing referral pathway

The referral pathway is indicative, and flexible. This facilitates the sensitive and appropriate response to each individual referred to Get Well … Connected.

The need to check in with community projects, programmes and activities following referral to them depends on the nature of the option chosen. This checking in was appreciated and experienced as supportive of community programme organisers, and also served to strengthen trust and relationships.

The referral pathway reflects the fact that while there is clarity, there is also the scope to tailor each intervention to the individual, so that no two cases have exactly the same pattern. The judgement of the SPC and the negotiation with the participant each play a role.

3.7 Role of Social Prescribing Coordinator in Get Well … Connected.

The role of the social prescribing coordinator / link worker in this project is to:

- Lead the design, delivery and development of the pilot Social Prescribing project in South Dublin County
- Develop effective referral and feedback protocols with (healthcare) practitioners;
- Gather data on local and community projects and activities and populate database / social prescribing software;

- Take referrals for individuals, arrange and meet with them, identify options and support initial engagement with options chosen
- Agree referral and support mechanisms with local activities, projects and programmes
- Develop and maintain relationships with health care professionals, community workers, SDCP colleagues and others.
- Research, collate and maintain / update a directory of services available in the local area that will be a resource to SPC and to healthcare professionals. (Maintaining / updating may be delegated to admin support where available)
- Support active links between health care professionals and community and voluntary sector in local area
- Raise awareness of Social Prescribing and the Get Well … Connected project among healthcare professionals and community sector.
- Develop and implement appropriate referral and feedback mechanisms
- Review progress of each person referred to SP and agree feedback to referrer
- Maintain confidential records of all people referred to SP
- Implement evaluation processes

3.8 Social prescribing options:

An extensive database has been researched and collated, with numerous services and activities. Examples of signposting or referrals include:

- Glenview practice monthly walking group
- Women Together Tallaght Network
- Local community centres e.g. Dominic's, Ballyroan
- South Dublin Volunteer Centre
- SWAN (Holistic therapies)
- Job Club (SDCP)
- Seniors Social clubs
- Threshold Training Network (Route 24)
- Grow Your Own Community Garden
- Wellbeing Cafe
- 1 to 1 bereavement counselling
- Park walks and park runs
- Walking and hiking groups
- Fettercairn Community Health Project
- Annual Tallaght Health Fair
- St Catherine's Counselling service
- Breakthrough Programme (in partnership with FAI and Shamrock Rovers academy)

3.9 Social Prescribing Advisory Group

The advisory group consists of representatives of South Dublin County Partnership (SDCP), Health Service Executive (HSE), South Dublin County Council (SDCC), Healthy South Dublin, South Dublin Volunteer Centre, Glenview Clinic, Parkhouse Family Practice, Fettercairn Community Health Project, Dublin South, Kildare & West Wicklow Community Healthcare, Representative of local Social Prescribing project based in a GP surgery, Tallaght University Hospital.

The group meets approximately bimonthly. The Social Prescribing Advisory Group (SPAG) is advisory, not a steering nor management group. In this capacity they contribute by:

- Hearing about the progress of the project
- Hearing about concerns and challenges during the development fo the project
- Giving advice and support, both theoretical and practical
- Contributing from their experience and expertise to inform decisions about the project
- Giving input on the project evaluation
- Facilitating access to resources and contacts

3.10 Elemental Online Platform

An online platform designed specifically to monitor social prescribing was developed and provided by Elemental Development. Work on the software continued throughout the early phase of the project, and is ongoing. The software allows GPs to refer through it, and has provision for recording and monitoring all interventions and interactions with SP clients. It also includes the mapped services and resources, including a geographic map that allows SPC to identify how accessible services are to individual clients.

Healthcare providers in Ireland use a number of different software packages, and that used in Glenview is different from that used in Parkhouse. This has caused extra challenges in integrating the platform with the surgeries' own software systems. In practice, this has not been a very significant source of difficulty to the GPs using the system. They have a window to Elemental's platform open on their desktops, and it is relatively quick and easy to use.

4. This Research

This research was designed to evaluate numerous aspects of this pilot project, including

- the implementation process;
- feasibility;
- acceptability and uptake of the service from healthcare professionals as well as patients;
- impact on patients' self-reported health and wellbeing;
- impact on the use of health care services, and
- healthcare practitioners satisfaction with the service.

Work on the evaluation began in June 2019. There was an unanticipated interruption to the project in October 2019 when the Social Prescribing Coordinator left his post earlier than originally planned, for personal reasons. The post was filled in early February 2020.

4.1 Methodology

The evaluation consisted of a longitudinal mixed methods study. Quantitative methods were used with participants at baseline and follow-up, and qualitative methods were used at follow-up assessment.

The aims of the evaluation were:

- To understand the effectiveness and impact of this pilot project in this context
- To identify learnings from the development and early implementation phase of the project
- To make recommendations for the future development of the project

4.2 Quantitative Data Collection

Three measures of wellbeing and connection to the community were built into the project from the start of engagement with patients. These were selected by the project with the support and advice of the advisory group, and were:

1. MYCAW, Measure Yourself Concerns and Wellbeing, is an individualised questionnaire that requires participants to nominate one or two concerns and, using a seven-point scale, to score these concerns and their general feeling of wellbeing. Higher scores indicate that the concerns 'bother me a lot' and that wellbeing is 'as bad as it can be'.
2. Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS): 7 statements, 5-point scale. Measures current mental wellbeing (time frame of the previous two weeks). This was completed at start of engagement with social prescribing, and on completion or at final session with outgoing SPC.
3. SDCP measure of Community Involvement, Knowledge of Community Services, and Likelihood of Engaging with Community Services: Three questions, 4 point scale from 1 (not at all) to 4 (very much)

Participants were invited at initial engagement to participate in research for the pilot project. They were informed of the nature of the research and offered a consent form to complete.

Baseline measures were collected from approximately 80 participants.

Baseline and follow-up measures were collected for a sample of 21 participants (MYCAW) and an additional 4 participants, totalling 25 participants (SWEMWBS and Community Involvement measure). In most cases these were completed at end of engagement with social prescribing. These

were collected by SPC and entered into Elemental platform. This data was then communicated to the evaluator.

Additional information was gathered in relation to this sample group for GP attendance. This took the form of gathering from practice records the number of GP visits in the three months prior to the start date and prior to the finish date for each individual.

In addition, data on age profile and gender of referred patients was gathered. This related to 108 patients referred between January 2019 and October 2020.

The evaluation tools chosen reflect a congruence with the emphasis on the needs of the individual participants, as the MYCAW in particular is a valuable tool in working with a client to identify priority concerns to address. The measures were used sensitively, and in a small number of cases where it was not in the best interest of the individual participant, they were not used.

4.3 Qualitative data collection

A series of semi-structured interview schedules were developed to explore the experience and perceptions of participants and other stakeholders of the social prescribing project. These included exploring:

- The needs that the Social Prescribing project is addressing
- The challenges and achievements of the different aspects of the project's work
- The effectiveness of the project's structures and procedures (decision-making, administration, referral systems, feedback pathways, record-keeping, etc.) in serving the work of the project.
- The relationship between the project, its funders and stakeholders.
- The ease of use and effectiveness of the 'Elemental' online platform being used in this project.
- Benefits to participants
- Benefits to stakeholders
- Thoughts on future development of the project

The following stakeholders were interviewed and / or participated in focus groups:

- Social Prescribing Co-Ordinator / Link Worker.
- Members of Social Prescribing Advisory Group of the pilot project (SPAG)
- 7 Participants (5 from Glenview clinic, 2 from Parkhouse Family Practice)
- Practice managers of 2 GP practices
- 8 Doctors and one practice nurse (4 from Glenview, 5 from Parkhouse)
- 10 Representatives of community / voluntary groups connected with the social prescribing work in Tallaght

The evaluator also met informally with participants on the Glenview Practice Walk in December 2019.

4.4 Project Participant Information

Overall there were 108 referrals from 11 doctors and one nurse in 2 GP practices to Get Well … Connected between January 2019 and October 2019. (Referrals were suspended from end October 2019)

Of these, 25 took part in the evaluation. The evaluation measures were decided early in the development phase of the project, and were integrated into the Elemental online platform being used for the project.

Details of the people referred are given below:

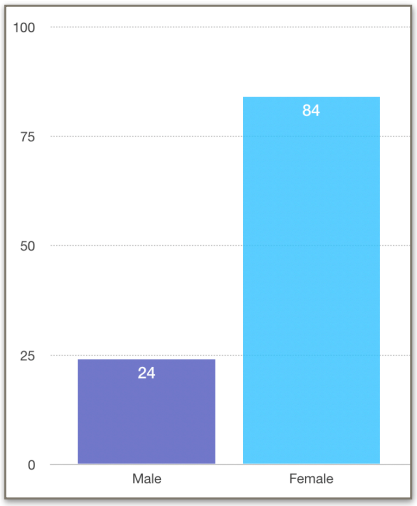


Figure 4.1: Gender of people referred to Get Well … Connected

(78% female; 22% male)

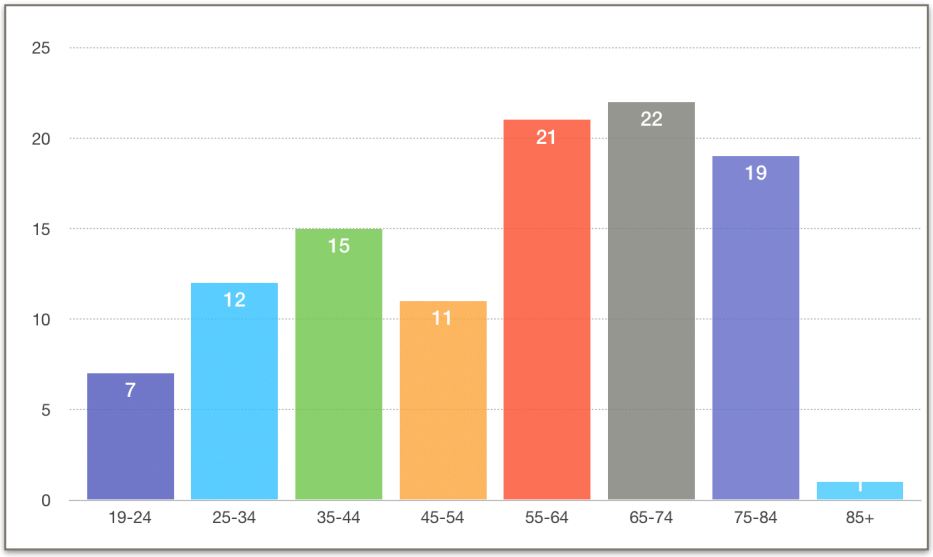


Figure 4.2 Age profile of people referred to Get Well … Connected

58% of referrals were for people aged 55 or over

There were significant numbers of younger people referred to the project: 19 were under the age of 35 (17.5%); 34 under 45 (31.5%).

Of these 108 referrals:

19 did not progress because of being unable to contact them

9 were assessed to be inappropriate referrals, for a variety of reasons, e.g. severity of mental health issues which only became apparent during initial consultation with SPC; doctor more invested in SP than the client; client not motivated to make change at that time

5 declined the referral

2 said that referral was no longer required

1 had moved out of area

Work involved in responding to these 38 referrals ranged from single contact, repeated unsuccessful attempts to contact, to initial meetings with follow-up to referrer in the case of inappropriate referrals.

A further 15 disengaged after initially engaging with Social Prescribing. No further data is available on these 15 at time of writing.

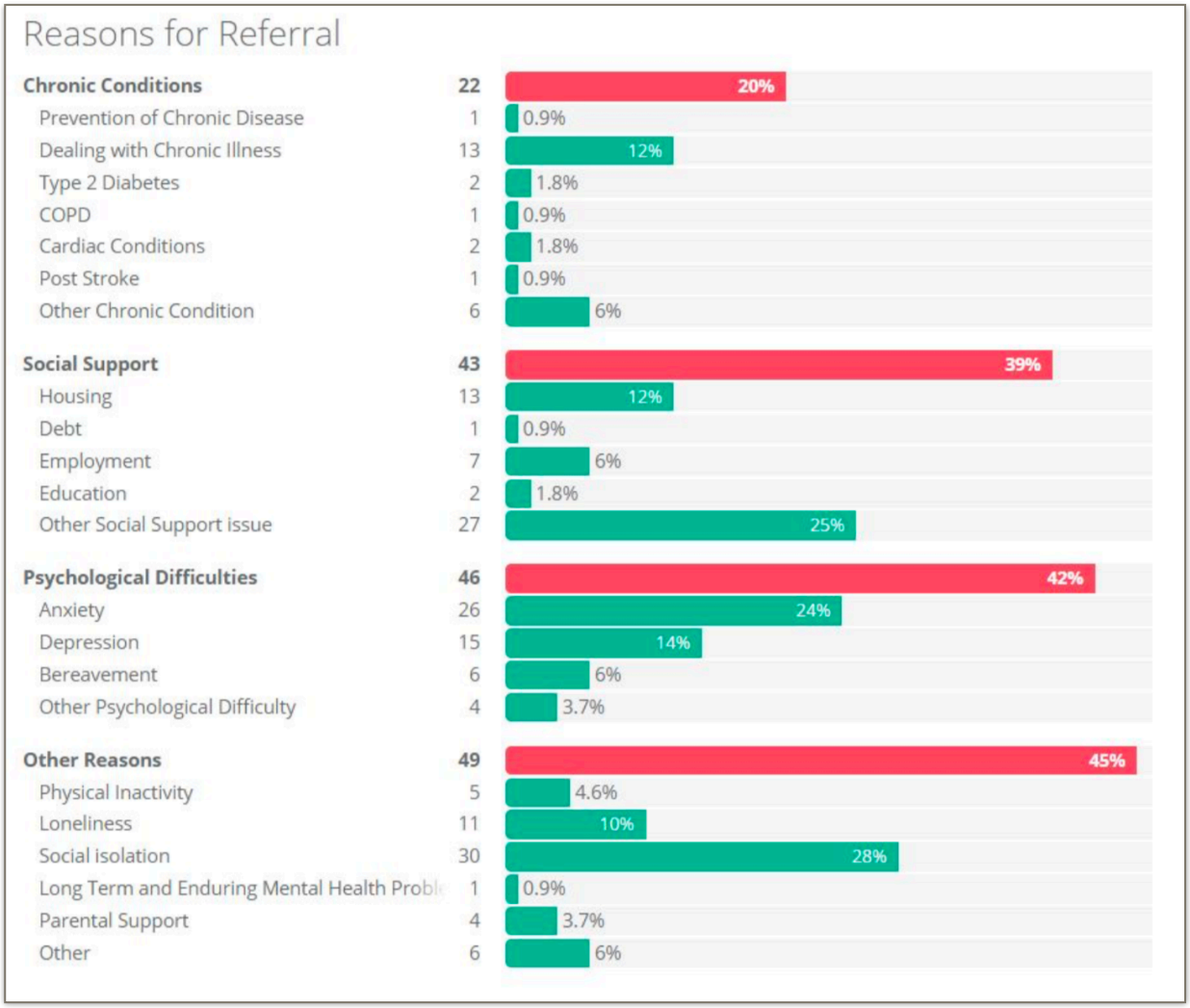
The remaining 57 cases, at time of reviewing data (Feb 2020) included 8 waiting or on hold; 21 active, engaging in services, and 28 complete. 25 of these formed a sample of participants for the

evaluation. These 25 had completed baseline and follow-up measures, and consented to be part of the research. 7 of these were interviewed individually, and case studies were written for these 7.

4.5 Reasons for Referral : 57 Waiting, Active and Complete Cases

A look at the reasons for referral for the 57 cases including those Waiting, Active and Complete revealed a few significant clusters. The online platform allows for referral for multiple reasons, so the totals are more than 100%

Figure 4.3: Reasons for referrals from 1st January 2019 to 1st January 2020.



- Social Isolation (16) and Loneliness (6) Together 38.6%
- Housing (7) and Other social support(15) Together 38.6%
- Anxiety (11) and Depression(6) Together 29.8%
- Dealing with Chronic Illness (12) 21.1%
- Employment (6) 10.5%
- Bereavement(3)
- Parental Support (2)
- Education (2)
- Post stroke (1)
- Other (5)

4.6 Evaluation participant information

Total 25 clients participated in the evaluation sample.

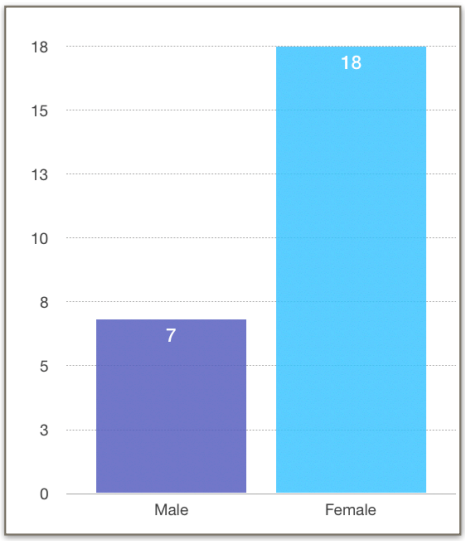


Figure 4.4: Gender profile of evaluation participants: 18 women, 7 men

(72% women)

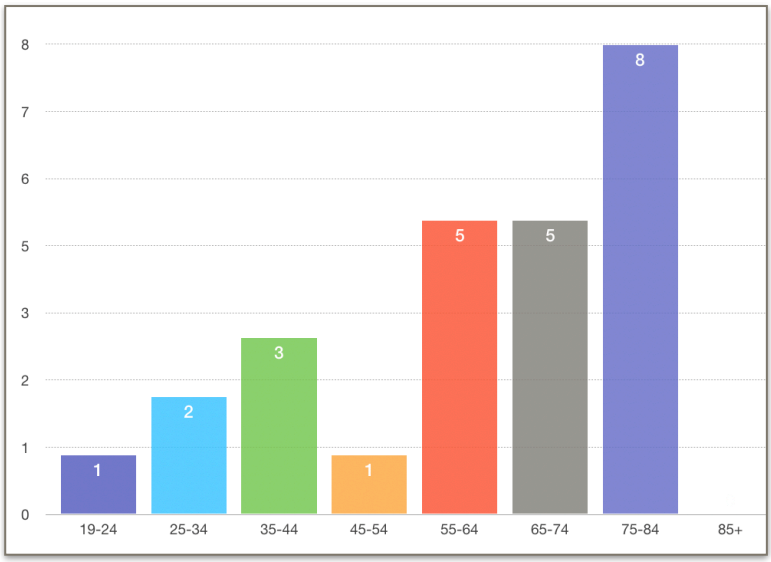


Figure 4.5: Age profile of evaluation participants

72% 55 or over, including 32% 75 or over.

5. Findings From the Quantitative Research

The length of time between the first contact of SP and client and the final meeting / contact varied from 11 weeks to 38 weeks, with the average being 28 weeks. Some of these may have been concluded earlier than planned because of the suspension of the service from end of October 2019.

5.1 MYCAW, Measure Yourself Concerns and Wellbeing

MYCAW is an individualised questionnaire that was designed for evaluating complementary therapies in cancer support care, and has been widely used for social prescribing. MYCAW requires participants to nominate one or two concerns and, using a seven-point scale, to score these concerns as well as their general feeling of wellbeing.

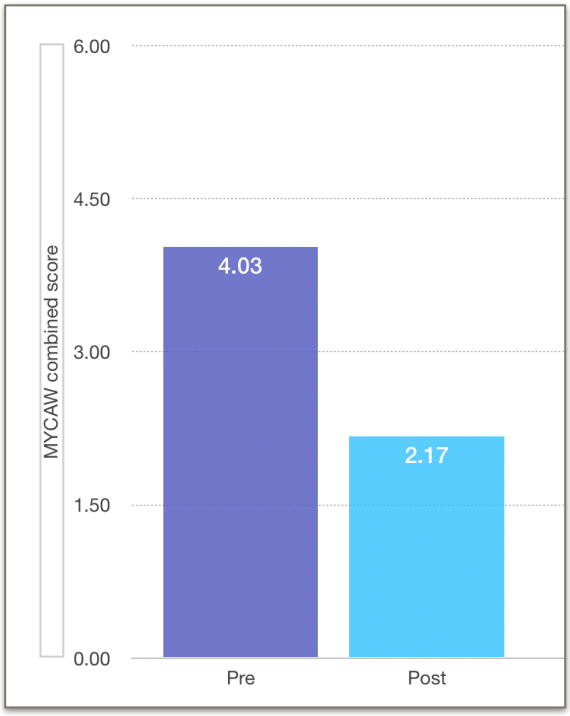


Figure 5.1: MYCAW scores for sample group of 21 participants:

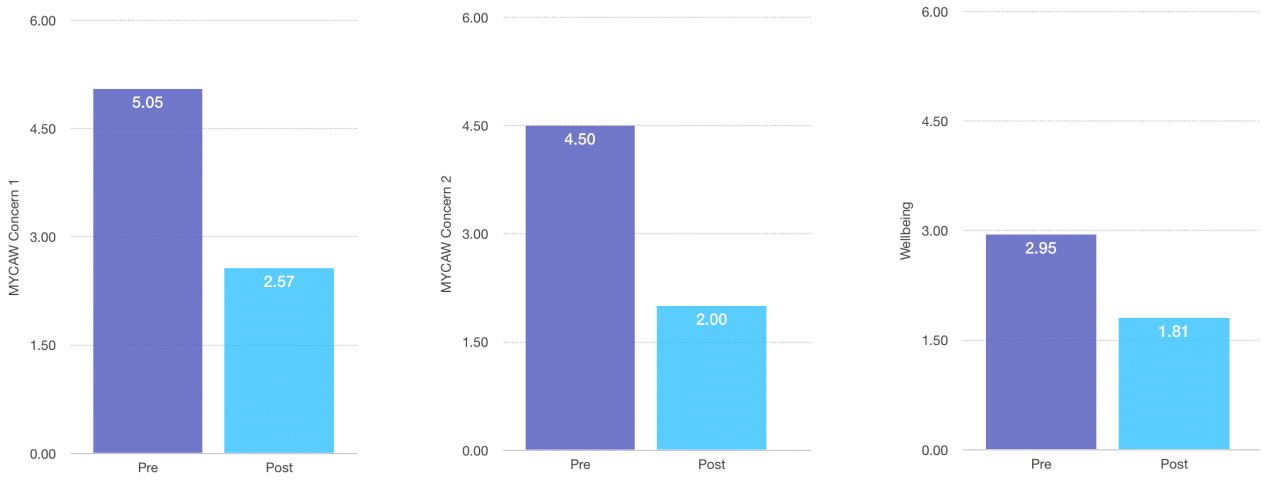
A decrease in the overall MYCAW score indicates that participants are less bothered by the cause of concern, and that wellbeing has moved closer to 'As good as it can be'. Taken for the sample group of 21 who completed baseline and follow-up measures, the average combined score decreased from 4.03 to 2.17.

The average change across 21 participants was a decrease of 1.87, (SD 1.35). This is an average decrease of 46%.

When looking at the scores for Concern 1, for Concern 2, and for Wellbeing, it can be seen that there was a decrease in the average for each measure. Only 8 participants identified a 2nd Concern.

Average Wellbeing measure improved by 39%.

Figure 5.2 Details of MYCAW averages of 21 participants



In addition to this, it is worth noting that the score for Concern 1 decreased for 16 participants (76.2%), stayed the same for 5 (23.8%), and didn't increase for any.

Similarly Concern 2 decreased for 7 participants (87.5%) who named a 2nd concern, and stayed the same for the other participant (12.5%).

Wellbeing score reducing indicates a move towards wellbeing being 'As good as it can be'. This score reduced for 17 participants (81%), showed no change for 1 (4.8%), and increased for 3 (14.3%)

5.2 SWEMWBS Short Warwick-Edinburgh Mental Wellbeing Scale

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS): asks participants to rate 7 positively worded statements, on a 5-point scale. It is designed to measure current mental wellbeing (time frame of the previous two weeks). This measure was completed by 25 evaluation participants.

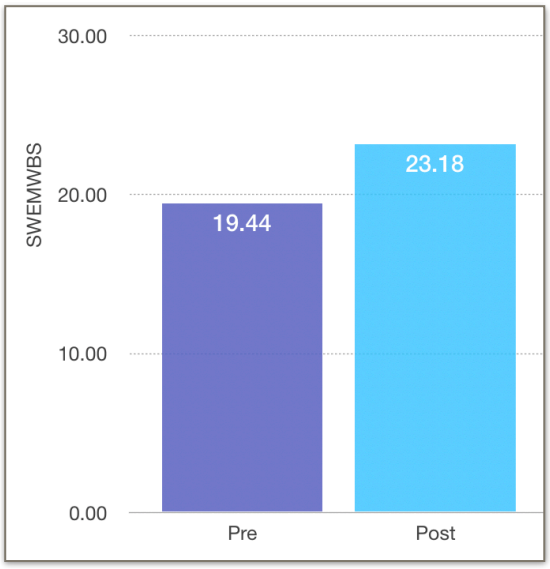


Figure 5.3: SWEMWBS for 25 evaluation participants

For this measure, an increase in the metric score suggests an improvement in mental wellbeing.

23 participants self-reported an increase in this measure (92%), 1 reported a decrease, and 1 reported no change.

The average score increased from 19.44 to 23.18, an increase of 19%.

5.3 SDCP Community Involvement Scale

This was developed for this project, and asks participants to respond to three questions relating to how involved they are in their community, how much they know about services in their community, and how likely they would be to use them, on a scale from 1 (not very much) to 4(very)

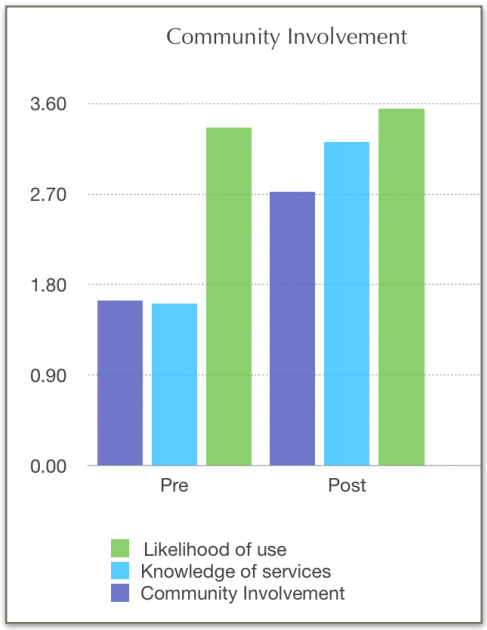


Figure 5.4: SDCP Community Involvement

Each of these measures showed an increase from pre to post social prescribing engagement. The biggest increase was for knowledge of services in the community, with the average score increasing from 1.61 to 3.22.

Community Involvement showed a similar though slightly smaller, increase, from 1.64 to 2.72

The smallest increase was in reported likelihood to use the services. In a few cases the likelihood of using services decreased. On inquiring into this, the suggestion was that with greater knowledge about a service or activity came greater clarity about which services they might engage with. Thus they were clearer that there were some which were not for them. Knowing simply that something existed might lead them to think, 'Yes, I might do that.'

5.4 GP visits

For this sample of 25 participants, the number of GP visits in the 3 months prior to starting SP, and in the 3 months prior to finishing, was looked at and compared. This data was drawn from GP practice records. (In a few cases these periods overlapped slightly).

Concern was expressed by some health professionals that the time period was too short to show any change to frequency of GP visits. Looking at the average number of visits, this is perhaps borne out, though possibly more significant in terms of drawing any conclusions is the small sample size.

The average number of GP visits in the three months prior to SP was 2.2, and in fact increased to 2.52 in the three months prior to the finish date. It is however worth noting that for 11 participants there was a decrease in the number of visits, for 7 there was no change, and for 7 there was an increase.

In the case of one patient there was an increase from 1 to 10 visits, which was due to beginning a programme of treatment which required frequent monitoring. Anecdotally health professionals reported that they were seeing a difference in the *type* of visit from some patients participating in social prescribing, with more emphasis on medical than social needs.

As there was a wide variation in the length of time between start and finish of engagement with the SP project the choice of these dates for comparison may not have been the most appropriate. An alternative might be to look for differences at a fixed time after beginning with SP, e.g. six months. This was not possible for this evaluation, as there were not enough participants who had finished for more than six months.

Participant Story

P (69) is a widow, bereaved following the sudden death of her son in recent years. She is kept busy during the week, but is depressed. Following her first meeting with SPC, when she identified giving up smoking as her top priority, she met him at Fettercairn Health Fair, and there signed up to 'We Can Quit' course. She enjoyed being in the group on the course, and succeeded in giving up smoking. She tried a few clubs from the 55+directory, but wasn't able to find one that suited her. Her successful completion of the We Can Quit course fell during the time when there was a suspension of the SP service, and while that felt like progress and a huge achievement, she was feeling like she had since gone backwards in terms of her depression. A follow-up appointment would probably have identified this, and also the fact that she was ready to move on to addressing her second priority, which is to access some form of bereavement counselling or support.

5.5 Evaluator access to quantitative data

The current form of the online platform for record-keeping and implementation of the project poses significant challenges to an evaluator in terms of access to data. The process used in the course of this project was cumbersome and not entirely satisfactory in that data was not easily accessible to interrogate. The possibility of an anonymised version of the platform might perhaps go a long way to resolve these issues for future evaluations.

5.6 Comment on the tools used

Significant research was done on the various measures and tools in use for social prescribing before deciding on the MYCAW, SWEMWBS and the Community Involvement measure developed for this project. The evaluation tools chosen reflect a congruence with the emphasis on the needs of the individual participants, as the MYCAW in particular is a valuable tool in working with a client to identify priority concerns to address. They also serve the purpose of evaluation of the project. One concern expressed, which would apply whichever tools or measures were used, was the difficulty and time involved in re-connecting with participants to complete the follow-up measures.

5.7 Main findings from quantitative evaluation

In summary, the findings from the quantitative evaluation are:

- Social Prescribing appears to have had a significant positive impact on self-reported wellbeing of participants
- The impact of causes of concerns on the lives of participants reduced significantly.
- Community involvement and knowledge of community services and activities increased
- The average frequency of GP visits increased slightly between first and last engagement with Social Prescribing. There were some reasons why this information may not be a significant cause for concern.

6. Findings From Qualitative Research

The material from the interviews and focus groups was reviewed and a number of themes were identified. In addition, the stories of seven participants were summarised, to give a clearer picture of the nature of the work of Social Prescribing, and its range.

6.1 Model of Social Prescribing

A number of models of social prescribing are operational in Ireland. Some (e.g. Donegal and Sligo) describe a clear process with a defined term of a 6-8 week programme, and a specified number of contacts. A project in Fatima Resource Centre, Dublin 8, connects people primarily with programmes and activities based in their resource centre. Others (e.g. Older Voices Kildare) create programmes to respond to needs identified through social prescribing referrals, as well as creating a directory of services. The model used in Get Well … Connected is built on extensive research into community resources and services available, and strong relationships with GP practices. Flexibility is built into the model. Some patients will be seen once, signposted to the specific thing they are looking for, and contacted by phone or text at a later stage. Others might be met more often, and more or less regularly.

6.2 Project Structure

The structure of the project is relatively simple, and clear, and allows for quick and effective decision-making. A one person team with a line manager and advisory group has a lot of autonomy, and the scope to be flexible in carrying out the role. It can also be an isolated role, connected with multiple teams, but ultimately a solitary position.

6.3 Role of Social Prescribing Coordinator / Link Worker.

The role of the Social Prescribing Coordinator combines the coordination and project management role with the essential link worker role of working directly with patients, healthcare staff and community workers. The link worker title captures the nature of the work linking participants to their communities, and the medical and community sectors with each other. This post is in effect a combination of the two roles.

Every stakeholder who contributed to this evaluation spoke very positively about their experience of the person in the role of the Social Prescribing Coordinator. Some of the key qualities and characteristics which were mentioned most frequently were

- His obvious concern for and interest in each individual participant who he engaged with. This was apparent to the individuals themselves as well as to health care professionals and community workers he engaged with.
- His ability to get to know people as individuals and to see them as more than their problems and issues.
- His ability to listen. A number of participants on the project talked about how they began to think differently, or to see things differently about their lives.
- His extensive knowledge of the area and the wide range of services that he knew about, combined with his willingness to research resources as the need arose. Numerous stakeholders expressed their amazement and admiration for the breadth of his knowledge.
- His generosity in sharing what he knew and in connecting contacts with each other where it was to their mutual benefit.
- His ability to give the impression that he had time. (even though it was recognised that he was very busy with many aspects to his role). This combined with the experience that he respected other people's time and the demands on them.

- Facilitating other links, for example:
  - Linking medical and community sector, e.g. Tallaght Drug and Alcohol Task Force and Tallaght Travellers Community Development Project meeting with Parkhouse Family Practitioners practice manager
  - Connecting doctors and geriatricians from Loughlinstown Hospital with Social Prescribing Coordinators form other areas.
  - Social Care Department from Connolly Hospital Blanchardstown making contact to ask for information about community services available for their clients
  - ARC Cancer Support Services inquiring about services available in Dublin North.
- The fact that he followed up on contacts.
  - For individual participants he agreed with them what form that would take and the frequency that they would experience as supportive.
  - For organisers of community programmes and activities, the fact that following referral he contacted them to inquire about the person he had referred gave them confidence in him and helped to build trust.
  - For referrers the feedback on individuals at a time and place convenient to them (including through Elemental online platform) allowed them to develop increasing understanding of the potential for social prescribing, and facilitated them to carry out their role effectively.

Participant Story

L (80) is a widow who was suffering with a bad back, stopped going out and was feeling isolated. The practice nurse referred her to SPC, and it was easy for her to meet him, as he was available to meet in the clinic. It was a familiar place, and she knew where to go. He introduced her to yoga and Tai chi, and a walking group that met weekly, in addition to the practice walk. She now knows more people than she did a year ago, has more people to say hello to, is more connected in her community. One really good thing about the project for her was meeting people.

- As the Social Prescribing Coordinator put it, a big part of the job is to know:
  - What services can do
  - What kind of support they can provide
  - What is the best way to put people in contact with them
  - Who participants will meet and what they can expect.

"It's not enough to read about services. You need to see them, to meet the people involved and know what the client can expect so that you can easily facilitate a connection."

In addition the job involves

- Raising awareness of the service
- Building trust: which takes time.

This role was supported on a short term basis by a temporary administrator post to update information on Community Providers activities / programmes and upload them to the platform. There is a need for this post on an ongoing basis.

One feature of the role is that while there is good support from the line manager and Advisory Group, the role is essentially one person working on their own, although in collaboration with many. It can be a lonely, even isolated position being currently essentially a one-person team. There were echoes

in this of the loneliness and isolation being experienced by a number of patients referred to social prescribing.

This isolation in the role has been recognised and addressed by supporting collaboration with other organisations and their link workers, in particular the Dun Laoghaire social prescribing co-ordinator of Southside Partnership.

> **"We had regular meetings and discussions (which) I believe were very helpful to reflect about the way I was developing the pilot project. On the other hand I guess it also helped Lisa from Southside Partnership to set up her own project. Following up on the meetings and discussions we had I believe it has also contributed to "launch"/"activate" an informal social prescribing coordinators network which was very helpful to share experiences with other SPC from other geographical areas (Listowel, Offaly, Wicklow, Bray, DLR)."**

6.4 Role of GP practice managers

The practice managers of the two practices involved in this pilot project had crucial roles to play in its successful development. Collaborative work with Practice Managers has been key. This took a number of forms through the different phases of the project.

- From the start they supported the introduction of the service, often in conjunction with a key GP in the practice.
- It was through the practice managers that time was made available for SPC to speak to GP practice staff about social prescribing, and to outline the proposal for the project.
- Practice managers took on a lot of the set-up work for the project in the practices, liaising about room availability, software issues, and times to meet with practice staff.
- They took a role in reminding GPs to refer to SP in the early days of the project.
- As the project continued, there was good communication with SPC which allowed the practice manager to help to regulate the flow of referrals. When there was high demand GPs could be made aware to refer highest priorities, and when referrals slowed they could be reminded of the facility.
- On an ongoing basis, practice managers support the project by managing the logistics of time and space availability for the work of SPC in the surgeries.
- The participation of practice managers on the Social Prescribing Advisory Group has been key to the development of the project.

6.5 Role of Social Prescribing Advisory Group (S.P.A.G.)

The advisory group consists of deputy CEO of South Dublin County Partnership (SDCP), representatives of Health Promotion Unit, Health Service Executive (HSE), Healthy South Dublin, South Dublin Volunteer Centre, Fettercairn Community Health Project, practice managers of Glenview Clinic and Parkhouse Family Practice, and a local GP with particular interest and expertise in Social Prescribing. Software developers Elemental attend as necessary.

The group plans to meet approximately bimonthly. The group met 5 times in 2019, the last of which was combined with a focus group meeting for this evaluation. There has been a fairly high rate of 'apologies' at many of the meetings. In practice it can be difficult to gather such a busy group of people, and care is taken to only call a meeting when there is something specific to discuss. This is a practical way to manage the challenge, though there may be some risks to it becoming more ad hoc in its culture. The project was in a suspended state following the departure of the project worker. Some members of SPAG were central to the recruitment, interviewing and appointment of the person to fill the post, but others may have begun to feel more distant from the project as some momentum was lost.

Having said that, the group, when it meets, brings considerable expertise and experience to the service of the project. Their input has contributed substantially to the success of the project to date.

6.6 Role of Community Groups, Organisations and Services

The work of social prescribing could not succeed without the existence of the rich resource of community groups, organisations and services. It in no way replaces any of these, but works to connect individuals and the health sector with what exists, and perhaps to identify any gaps in services across the geographic area. (An example of this is social groups for the 25 - 50 age group) These groups have grown out of the hard work of many people in many local communities, and it was clear that their role is vital to the project.

There is some overlap in the aims and values of some community groups and of social prescribing. Initially there was some resistance to SP on the basis that some groups felt it was work they were already doing. There was a growing recognition, however, that significant differences included the time available to work with individuals, and the access to and connection with general practitioners. In addition, many of the participants in social prescribing were individuals who had not found their way to community projects. Those referred by GPs were predominantly a different group to those who were already connecting with community projects; they were mostly people who wouldn't have or hadn't connected to community resources without social prescribing.

Participant Story

G (73) was referred by the practice nurse. She had discussed with PN the stresses in her life which were outside of her control. Because of travelling away a lot, she found it hard to embed regular activities. She felt very burdened looking after people.
Through two meetings and conversation with SPC she began to look at things differently. Together they focused on what would make her life good, as distinct from the focus being on her having or being a problem. She tried out some activities. The first didn't suit her, but she continued to explore others. She joined the practice walk, which she enjoyed much more than she expected, because she already walked a lot. What the monthly practice walk offered was more connection in her community, more people she might say hello to: people who she would have exchanged a nod with now became people who would exchange a smile and a greeting. She continues to look for activities that she can share in a group with others, and feels that her quality of life is now good, good enough. The sources of stress still remain, but she has learned to let the small positive things matter.

What she valued about her experience of SP was the respect for her own timing, and being recognised as someone who was well, and wanted to be better, in contrast to being seen as someone who was sick. She considers herself to be well able and resourceful, and still found SP a help in changing her perspective. It supported her to allow her life to be more significant than she had previously been allowing it to be.

6.7 Close Collaboration With Two General Practices.

In this project the social prescribing coordinator takes referrals from doctors and a nurse in two general practices, and works for one or two sessions a week in each practice. Seven doctors and practice manager in Parkhouse Family Practice made referrals, 4 doctors and practice nurse made referrals from Glenview Clinic. Part of the thinking in approaching these particular practices was the contrasting demographics of their patient groups, as outlined earlier (**3.5**).

Referral numbers differed between the two practices, with Glenview referring 70 patients, and Brookfield referring 37. The reason for this disparity is unclear, though some tentative observations can be made. Feedback from the two groups of doctors indicated that each group greatly valued the extra resource / referral pathway available to them through social prescribing.

Charts below show a comparison of the two practices, both for the number referrals and the reasons for referrals. The biggest differences show in the proportion of referrals which are for chronic conditions, with a markedly higher percentage of Parkhouse referrals as compared with Glenview.

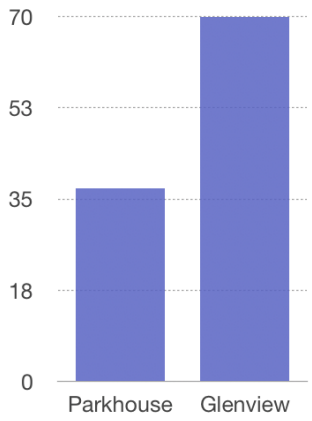


Figure 6.1 Comparison Number of referrals from two practices

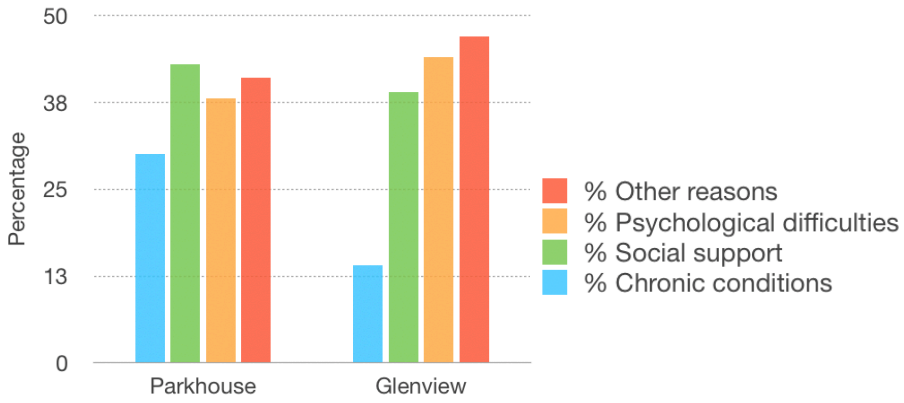


Figure 6.2 Comparison reasons for referrals from two practices

One doctor, in wanting to practically demonstrate support for the project, made numerous referrals early in the project. Some of these were not best suited to social prescribing, but the numbers and the communication between the doctor and SPC facilitated the learning around refining what constituted a good referral. The most appropriate referrals were often made by doctors who knew their patients well. In broad terms this is somewhat easier in Glenview practice where there is a fixed team of a small number of doctors. Parkhouse Family Practice is part of a group of practices, and a larger team of doctors moves around these practices, so that in some cases it might take longer to see the same patients often enough to get to know them well.

There are also differences between the practices in how often they are able to meet as a team, both formally and informally over lunch breaks. The informal meetings allow for more sharing of experience, including about social prescribing, which facilitates individual GPs in recognising the range of patient needs and issues which can be supported through social prescribing.

One observation of the SPC was that the DNA (did not attend) rate in Brookfield was higher than in Glenview, and higher than he expected. In fact the DNA rate for Social Prescribing was lower in both practices than for GP appointments.

The regular presence of the SP Coordinator in the surgeries seems to be positive, as it:

- reminds doctors to refer patients to service;
- allows brief discussions about patients;
- allows sharing valuable information about service providers;
- allows introducing patients personally to SP Coordinator immediately after GP appointments.

All of these contribute to building positive working relationships between SPC and healthcare professionals. Participating in Glenview practice walk is another opportunity to build relationships with staff and patients of the practice.

6.8 Location of Work

This has already been referred to above. Other aspects of this include the use of venues such as community centres and other services to meet with participants. These serve similar purposes in building connections, between participants and services they might want to connect with, and between SPC and community groups and services. It takes an investment of time to negotiate the use of a space at a time that also suits participants.

An important aspect of the project is that it is located within community sector, and works in collaboration with GP practices, but is not tied to just one.

Participant Story

P (19) is a young man who had anxiety, struggled with anger, and wasn't getting along with his peers on his PLC course. His stress levels were very high. When he visited his GP to ask about increasing his anxiety medication, his doctor suggested that he talk with the SPC. As he was at the surgery at the time, SPC was able to have a quick chat with him and arrange to meet nearer to his home at a time to suit them both. Following the first consultation, where P's love of football became apparent, the SPC was able to identify and offer a number of possibilities for him to choose between, but the standout suggestion was the option to join a Breakthrough programme, which combined training at Shamrock Rovers (with FAI and SR coaches) with weekly counselling sessions at Beacon of Light. He developed personal and social skills through the football training. He learned techniques for managing his anger, and his anxiety.

His time on the Breakthrough programme was interrupted by an opportunity to work overseas in children's football camps. From his time on Breakthrough and with contacts he made there he has organised and run his own children's holiday football camps. He is exploring joining a football team, and looking forward to working overseas again. Now he still has good days and bad days, but he described his life before as just bad days. He now has methods that he uses. SPC's background in sports psychology was a valuable resource for this case.

He valued the ongoing support from SPC, including the fact that he took the trouble to ring him when overseas, and the effort he made to find a helpline for the place he had travelled to. He valued the time the SPC took to get to know him, not just saying "Tell me your problems". He also valued being able to meet in places where he was relaxed, including a local coffee shop.

6.9 Communication

Each focus group and stakeholder commented on the clear and open communication with SPC. Community groups appreciated his checking with them in following up on referrals, and also his openness to them making contact with him. Communication with healthcare professionals was appreciated, in particular that it was fitted around their busy schedules.

During the suspension of the service while the post was unfilled there was some uncertainty about who to contact, and which might be the best form of communication to use to contact them in order to be updated about progress on filling the post. People in community groups and surgeries were very keen to see the service resume. There was some concern that what was a good pilot project might be discontinued, as some other projects had been in the past. The unfilled post left something of a gap in communications. During the regular running of the project though, communication was generally described as excellent.

6.10 Elemental Online Platform

There was significant work on the development of the online platform provided by Elemental during the time between the start of the project (1 August 2018) and the time when the platform went online in March 2019. The development continues as issues arise and are worked on by Elemental.

GPs reported that they find the platform easy to use, and that it doesn't demand excessive time from them to make referrals. In addition they value the fact that they are able to access updates about the engagement of patients whom they refer through the platform, and also to see the resources available in their community.

Representatives of community groups varied in their awareness of the platform, and in their knowledge of how to input into it. They raised the question of whether they might have access to the database of resources about other groups and services in the area covered by the project.

While the platform suited the needs of GPs, there are some issues with extracting useful information from it. One community group which had attempted to use it to track their engagement with participants referred to them found the necessary information difficult to extract, and eventually developed their own system.

The value of the online platform in facilitating remote working has been highlighted during the Covid-19 epidemic.

Participant story

F (57) had been suffering from very severe anxiety for more than three years prior to engaging with social prescribing. He was virtually housebound, only going out to visit GP, and to get food every week or ten days. He slept 12 / 14 hours a day, and spent many of his waking hours on the internet. "It was just horrible, it's no existence." He felt he wasn't really progressing. He met SPC and they continued to meet about every 4 to 6 weeks. While they were meeting, he didn't feel a need to see the doctor. Family members offered support and encouraged him to go out with them to play golf. The conversations he began with SPC continued with family members. One goal he set himself with support from SPC was to give up smoking, which he has. Another was to increase the number of days he got out of the house. He now goes out three days a week, as well as joining the practice walk once a month. Over the past year he has lost two stone in weight.
He has new goals, including maintaining getting out the door and improving his fitness, with a longer term goal of getting back working.

He particularly valued not being pressured, experiencing respect for his judgement, while being supported to set and achieve goals for himself. While the family support was and continues to be important, in his view it wouldn't have been enough without the social prescribing.

For the evaluation purposes, it is not as straightforward to secure quantitative data from the platform as might be supposed. Anonymised access to patient records and case notes would make accessing quantitative information a more manageable task.

Some of the categories used are overlapping and unclear, so that the person entering the data has to make a choice between several categories that might equally apply, for example, between 'scheduled appointment' and 'face to face', 'telephone' or 'text'. In practice, the vast majority of appointments (190 /) were logged as 'scheduled appointment', with only 8 being logged as 'face to face'. In fact it is known that each of the participants had at least one 'face to face' meeting, so there is a significant discrepancy in the data available. It would be helpful to review the categories for 'appointments' and for 'visits' to ensure that they can be consistently and reliably logged. Some of the language might also be usefully reviewed.('visits', for example, is used to refer to any case notes, including records of

time spent researching, and time spent feeding back to referrers). Finally, some of the data generated is of uncertain usefulness.

6.11 Programme Promotion and Awareness Raising

A name was created and approved by the SPAG: 'Get Well … Connected', and materials were created to promote and explain the service to healthcare professionals and to patients in GP surgeries. The name was not widely used or recognised, with the service being known as 'Social Prescribing', or by the name of the SPC.

In addition to these materials, networking was a high priority in the development of the role. SPC attended a GP study group in Tallaght University Hospital. There he was introduced by GP and local Social Prescribing innovator Darach O'Ciardha, and he spoke to the group about the pilot project 'Get Well … Connected'. A number of GP surgeries made approaches following this to inquire about working with the project. SPC also spoke at conferences and events about social prescribing, and in his day to day work when he met with healthcare professionals.

Participant Story

K (54) is a mother of two adults, one who was diagnosed with autism in his late teens. She used to spend a lot of time on her own, felt really isolated, and felt she had no life. Her life existed only around her son's timetable. She felt they were both depressed. She needed support to parent him. She was on a waiting list for counselling.

At her first meeting with SPC she realised that for her the way life was wasn't right. She described that first meeting as brilliant, in that it woke her up. She connected with Women Together Tallaght Network and joined a cookery class. She began to take a bit of time for herself, and realised that she was important. At the same time she felt more able to encourage and support her son to move out of his bedroom.

Now she and her son go out walking together several times a week, and her son has re-engaged with sports which he loved, and lost weight. Their relationship has transformed, as she has come to recognise him as an adult, and gradually learned to give him the space to become his own person. K herself took part in a park run, and did a mini marathon.

Meeting with SPC completely changed her way of looking at things. At their last meeting she got a call to go to counselling. At time of interview she had had eight weeks of counselling and was able to make further progress. She felt that she was in a better place to engage with counselling as a result of her engagement with social prescribing.

She continues to have multiple medical issues. She said that "Meeting J. completely changed my way of looking at things, left me open, opened something inside me for me to be able to move on."

6.12 Glenview Practice Walk

To celebrate Social Prescribing Day on 14th March 2019, the SP coordinator challenged staff of Glenview Clinic to participate in a walking group organised during their lunch break. This was a positive experience which brought together Healthcare staff (Doctor, Nurse, Practice Manager), Patients, Social Prescribing Coordinator and a Walking Group Leader (Denise Lakes). Following this one off event, Glenview Clinic worked in collaboration with Denise to organise a regular walking group from the surgery at lunchtime on the first Friday of every month. This has continued every month since, and is now a valued feature of the practice. On occasion the walk has been postponed because of storms, but none have been cancelled.

The initiative has thrived with the support of the practice nurse and the practice manager. It has grown month by month, so that on the most recent walk there were 18 patients. The walk now regularly

ends in the cafe in the Enterprise centre with tea, coffee and more chat. The cafe is accessible for people in wheelchairs, using walkers etc, and some now join the group at the cafe stage. The emphasis is on social walking more than walking for fitness.

On the walks, patients and practice staff forge new relationships. As one participant remarked, "It's great to be seen in my wellbeing, as well as in my sickness". Patients tell each other about what they have learned through their social prescribing experience, and pass on the groups and activities they have discovered. And patients just chat with each other and enjoy the social interaction. For some, it is the encouragement they need to get out of the house. People appreciate that the walk happens with everyone going at their own pace. Those who like to walk fast can go on ahead, those who enjoy a slower space will have someone to walk with them too. Some who are anxious about the risk of falling are reassured by the presence of a doctor and a nurse.

This walk has further enhanced how the practice sees itself in its community. Participants on the walk make new connections with each other, some with near neighbours who they had never met. The practice manager puts a high value on it too, and undertakes to send out reminder texts to patients who have expressed an interest. This list is updated monthly. Its value is multi layered, including the physical benefits, the relationship benefits, and the smiles on people's faces.

The first walk came out of a suggestion from the social prescribing coordinator, but since then it has become fully an initiative of the practice. It is suggested to patients by GPs and practice nurse as well as by SPC. This feature of the practice reflects their team approach.

6.13 Time and trust

A theme which recurred repeatedly across interviews and focus groups was time.

Participants experienced someone listening to them for uninterrupted time of an hour or more. Some described this as one of the most valuable aspects of the service.

Participants felt that SPC took the time to get to know them as individuals, including their interests, not just their issues.

Participants experienced respect for their own timing in relation to engaging with activities prescribed. In fact they referred to this part of the process as having (at times multiple) options offered to them, and never saw them as 'prescribed'. As they experienced themselves being trusted, some said that they learned greater trust in their own judgement.

Health professionals experienced that the Social Prescribing Coordinator had time to liaise, communicate and collaborate with them.

The SPC respected the time of others, and their many commitments.

Significant investment of time was and is necessary to build and maintain relationships.

The development of the project itself from an idea to a functioning service required the investment of time in researching the local resources available, and in building relationships and systems.

> **"The concept is brilliant, and it needs time."**

A quote heard in another context seems relevant here: **"Change moves at the speed of trust."**

6.14 Resources

As well as the vast array of activities, projects, programmes and services identified and researched for the database, one resource which was mentioned again and again was the 55+ Daily Activity booklet updated annually by South Dublin County Council.

Comment was made on the number of different directories and partial directories which seem to be compiled by various organisations and departments, and how valuable it would be to create a directory available to all interested parties, which is reliably updated and maintained. The 55+ Activity directory goes some way to meeting this need (although being in print, or downloadable pdf.

it goes quickly out of date). Hard copies of this directory are an invaluable resource to community projects, and to the social prescribing service. There is concern that the project should be continued after the retirement of the individual currently responsible.

Participant Story

R (74) is a widow who was spending long days on her own doing nothing. Her life felt empty and she felt she had lost the knack of talking to people. She regretted leaving school early, and thought she might like to learn some more. At her first meeting with SPC, after they had talked, they went together to explore some adult education options. The adult education centre was more serious, and the courses and levels scared her. Then they went on to Threshold Training Network, which she described as 'magic'. She has since tried yoga, meditation, a course in speaking out, and some arty things, and goes to their Wellbeing cafe.

Because SPC went with her and looked with her at the options, and introduced her to staff there, she felt able to go back on her own at a later stage. She also joined the practice walk, which finishes in the cafe at the enterprise centre, and enjoys the chance to chat with people. She has told others about Threshold, and her family have told their neighbours about it too.

Now she feels like she has something to look forward to. She has an interest, and gets meeting people again. Her life is now a much brighter place.

6.15 Achievements

Before the appointment of Social Prescribing Coordinator on 1st August 2018 there had been a lot of research, thinking and planning for the project, with proposals for the service written, and funding secured for the pilot project. Following his appointment, the service still had to be created. In order to achieve this, the following work was completed by the Coordinator / link worker supported by his line manager (manager of Health and Wellbeing SDCP) and the Social Prescribing Advisory Group.

In the early stages of development of the project he:

- Developed strong working relationships with key stakeholders, including
  - GPs, practice staff and practice managers in 2 health care practices,
  - community groups, community project and activity organisers and providers,
  - colleagues in SDCP within Health and Wellbeing team and beyond (e.g. Jobs club and other partnership colleagues),
  - the SP Advisory Group
  - other healthcare professionals in preparation for expanding the service to Tallaght University Hospital
  - Elemental development support team
  - Other Social Prescribing Coordinators
- Worked effectively with male and female participants, across a wide age range (from 19 to 80+) and in distinct demographic contexts
- Developed effective referral and feedback protocols with (healthcare) practitioners, as well as negotiating use of space in the two pilot GP practices
- Gathered data on local and community projects and activities and populate database / social prescribing software; the information gathered reflects a really broad perspective of resources and activities valuable in the community. A number of contributors expressed how impressed they were by the quality and the breadth of the mapping
- Shared that data with healthcare practitioners

- Oversaw commissioning of Elemental software and customisation
- Organised training for healthcare professionals and community workers in using the Elemental online platform
- Developed a monitoring and evaluation plan, including identifying the measures to be used for this programme
- Talked with numerous groups, including GP group about social prescribing to raise awareness and understanding of social prescribing
- Created literature / brochures to publicise and explain the project to patients and healthcare professionals
- Began to take referrals from 2 GP practices and to see clients.
- Formed a bridging role between the medical sector and the community sector, facilitating communication and understanding of what each could contribute
- Documented and reported on the progress of the project
- Convened meetings of the S.P.A.G.
- Participated in the SDCP Health and wellbeing team.
- Identified the department in Tallaght University Hospital to begin referring to Get Well… Connected. This has involved considerable work over many months. The Gerontological Emergency Intervention Department was eventually identified, and is now ready to begin making referrals. An important feature of this department is the multidisciplinary team, and a named contact person.

An initial substantial task of the project was to gather information and understanding of the resources in the local area, and to map these, entering them into the Elemental database.

7. Future Development

It is clear from people's experience of and reflections on both the service when it was there, and its absence during its suspension, that this service has been greatly appreciated. General practitioners valued having another referral line, and an option available to them when they had done everything they could to support clinical needs, but knew there was something more which they couldn't help with. They valued learning about the wealth of community resources which exist which they had been unaware of. Community groups valued the opportunity to raise doctors' awareness and understanding of their existence and what they could offer. They also appreciated that people who would benefit from their service were facilitated to make contact with them.

Other GPs in Tallaght / Clondalkin area have made contact with SDCP's Social Prescribing service to inquire about working with them. Other healthcare professionals such as the Physiotherapy team and Occupational Therapy team based in Russell House have inquired about being able to refer to SP. Talllaght University Hospital Gerontological Emergency Intervention department is ready to begin making referrals.

Public Health Nurse requests to refer as well as some inquiries about self referral have been received.

It is clear that when there is the capacity to respond to these demands, it is likely that there is significant scope for the service to expand, both geographically to GP practices in other areas of Tallaght, and to other disciplines being able to make referrals.

At present the service still has room to grow in the two surgeries where it works. It is difficult to predict what referral rates might be in the coming months and years, in part because of the freeze on referrals because of the vacant post. There was a slowing of referrals in August and September, before it was known that the service would be suspended for a time. This may or may not have been due to the time of year. GPs and practice nurse, when asked about their experience of the project, were

enthusiastic about its continuing. The project has not been taking referrals for a full year yet. February and March saw the highest number of referrals, when the project was just beginning to take referrals. This might be accounted for by a stored up demand, but a contributory factor might also have been the early stages of learning what is an appropriate referral. Most of the cases of 'inappropriate referral' occurred early in the life of the project.

When asked about how they saw the project developing, healthcare professionals saw great potential for there to eventually be a team of link workers connecting with a number of GP surgeries and other healthcare professionals.

Such development would obviously req uire careful and detailed planning, with careful management of caseload as the project builds. The need for this caseload management has already become evident. One to one appointments plus follow up plus maintaining database of services plus feedback to doctors plus managing waiting list plus plus equals considerable pressures on the SPC time.

8. Challenges for the Project

A number of challenges have been successfully addressed in the course of the project so far, including

- getting the first GP practices on board. The practice managers were key to achieving this
- collaborating on the development of the online platform to get it ready for use for this project
- organising advisory group meetings at times to suit busy group members. This last is perhaps a work in progress.

8.1 Resuming the Service With a New Social Prescribing Coordinator

The newly appointed SPC has an active caseload to take on, as well as needing to do substantial groundwork in developing relationships with the many stakeholders connected to the service. There is likely to be a backlog of referrals which have been held ready for the time when referrals can resume. While significant groundwork has been completed by the outgoing SPC, the new SPC needs to quickly become familiar with the context of the geographic area, to build a network of relationships, and to become familiar with the range of resources available to refer participants to.

8.2 Database of Resources

Maintaining an updated database remains an ongoing challenge. A small number of community groups upload updates about their programmes and activities, but the majority do not. Training was provided early in 2019 to 15 workers with community projects and services. A number still have not received training, and some were unaware of the platform. Others felt that the time it required of them placed an added demand to populate yet another database, and were unclear of any benefit to themselves. That made it hard to justify dedicating significant resources. This was a view expressed by just some of those present at the community groups focus group.

What was more widely expressed was the value that groups would put on being able to access the information about all the services. It seems that this information is accessible to the SPC and to healthcare professionals, but not to those uploading data about their services.

The question of updating the database will be partially addressed when part time administrator support is recruited, as is intended. There is perhaps further scope for communicating with community groups about their needs in relation to their role in this task, and what might help to make it worthwhile for them.

8.2 Managing Caseload as the Project Grows

An important feature of this project has been the time that SPC has made available for initial meetings with participants and flexible tailored follow-up, as well as feeding back to referrers and checking in with groups referred to. As the caseload grows, this becomes more challenging. It is envisaged that referrals will be accepted from Tallaght University Hospital in the coming year. It is anticipated that the number of referrals from the hospital will remain small. It may be useful in the early months to have a cap on the number of referrals from the hospital, and to keep the demand under review.

It would be useful to have a protocol for managing the caseload which doesn't overly constrain the flexibility and ability to respond sensitively to individual SP cases. Decisions will need to be made about at what point further link workers are required, and research will be needed to identify how these might be funded.

In the assessment of the outgoing SPC, approximately 10 to 15 new referrals a month would be manageable, if the only focus is on the link-worker direct work with participants. If project development work is taken into account, this will be less.

This is an issue which will require the creative support of the advisory group.

8.3 Funding

Funding for this project has come from community sector as well as the health sector. This reflects a recognition of the value of social prescribing to both sectors.

Much of the funding available for Social Prescribing is on an annual basis. This poses an extra challenge to planning growth and development of the service. Securing multi-annual funding will be important to ensure the continuity of the service, and will be important for staff retention.

A question was raised about whether a model of subscription by GP practices might be developed, or a way for GP practices to contribute in some way to the costs. However, it was also noted that funding for GP practices has very little (if any) scope for absorbing additional costs.

There are differences in financial cultures between funders and between funders and South Dublin County Partnership which can cause some difficulties. These relate to timing of funding and accounting.

8.4 Planning Future Development and Growth

A significant challenge for the project and its advisory group will be the careful thinking through of plans for the future development of the project. There is clear demand for increasing the geographic area for taking referrals (including more General Practices) and also for increasing the disciplines and services who can refer to the project. There is also demand for a self-referral option. This will need to be carefully planned and managed, with a parallel process of monitoring and addressing the need for further resources, not least the recruitment of link workers to respond to demand. Similarly for administration support. There is a current need for part-time administration role for the project, and this will increase as the project expends. The project was designed to be one which could be scaled, and has succeeded in that. The main obstacle to further growth is the need for funding.

8.5 Reimagining and maintaining the project during Covid-19 epidemic.

At time of completing this report, what had been 'normal life' for many has changed drastically. During the epidemic, work is continuing remotely, and the resource of the Elemental online platform is proving invaluable. It is hard to predict at this time what additional challenges will be faced by the Social Prescribing service as the effects of the Covid-19 epidemic on daily life become clearer. It might be safe to assume that it will have an important role in contributing to re-building social connectedness after an extended period of social distancing.

9. Case Studies: Participant Stories

The stories of seven individuals can be seen through this report. Each of them reported that their lives had changed for the better, to varying degrees. Their experience of Social Prescribing was of being listened to, respected and supported to make positive changes in their lives. In some cases they felt that their lives were now transformed, that they had learned to think differently about their lives and circumstances and felt better able to manage their lives. In other cases their lives had improved, and they still had more work to do which would benefit from further support.

In addition to these face to face interviews with participants, other stories were referred to in interviews and focus groups with other stakeholders.

One was of an unemployed man, who was seen fairly frequently at the surgery, and seemed very down. Through SP he was connected with SDCP Heads Up Programme, which then led to employment which matched his interests. He is now fully employed in work he loves, and was too busy to return to complete follow-up measures.

A second was the story of a young mother of four, who presented with anxiety, maybe drinking a bit too much. During her initial SP meeting she revealed that she had been buying methadone for years. She hid her habit from her GP as she didn't want to disappoint her. She was then connected to a methadone programme, and is now supported by her GP, on a stable dose and receiving support. Her anxiety levels have dropped, as a major source of anxiety was that people would discover her habit. She has been able to tell family members and get their support.

A third story was of a migrant in her thirties, working long hours. She was referred for depression and social isolation. She had a complicated relationship with her husband. She was helped by being listened to, and connected with Women Together Tallaght Network, who provide secure, confidential support. She was only available to meet early in the morning. Exploring other options, she was considering moving her job, and was connected with one of SPC's SDCP colleagues in Enterprise and Employment. She started to run, and was also interested in volunteering, but was time-poor. She seemed to begin to think about things in different ways.

There was also a story of where social prescribing didn't lead to any immediate change in a person's life. She appeared very stressed, was overweight and working very long hours for a number of employers. Her housing situation was another source of stress. The SPC was able to identify a source of support very close to where she lived, which appeared to be a very good match to her needs. However, she didn't avail of it. Her priority appeared to be the need to work long hours to secure the income she needed to meet the demands on her.

10. Conclusions

10.1 In just 15 months this Social Prescribing project developed from project proposals resourced by an advisory group, and with funding secured for a full-time worker, to a functioning service. This service and the Social Prescribing Coordinator are widely respected and valued. The range and breadth of the knowledge of SPC, as well as his clear purpose of supporting people to improve their lives and wellbeing was commented on by each group of stakeholders.

10.2 Fifteen months after the appointment of the SPC and 9 months after the project began to take referrals there was an unplanned suspension of the service, due to personal circumstances of the person in post. The post was filled after a gap of three months. Perhaps remarkably for such a young service, it was missed in its absence. (At time of completing this report, Covid-19 has lead to another disruption to the service.)

10.3 The project achieved increased acceptability and uptake of the Social Prescribing service, among patients and health care practitioners.

10.4 Participants report that their lives and wellbeing have improved significantly as a result of their engagement with the Social Prescribing service.

10.5 Quantitative data suggests that for the sample group who participated in the evaluation, self-reported wellbeing improved, concerns causing anxiety and distress diminished, and community connectedness increased.

10.6 Frequency of GP visits rose slightly when comparing the three months prior to starting with social prescribing and the three months prior to the last appointment. It was observed by a number of stakeholders (before collection of data) that it felt too early to expect any significant change in this. The comparison itself may not have very strong validity. The small sample size meant that average results were significantly affected by a large increase in GP visits for two participants.

10.7 There is some anecdotal evidence that the nature of GP visits for Social Prescribing participants changed, in that they were more about medical issues, and less about social issues. GPs were supported in their work by the fact that they had another referral pathway which gave them a way of responding to social needs of their patients. This served to ease pressure on them.

10.8 Connections between the medical and community sectors improved, in terms of relationships as well as mutual knowledge and understanding.

10.9 The location of the service in the community sector, in combination with regular sessions based in GP practices, appears to have contributed significantly to the success of the project to date, and to the positive relationships which have been developed.

10.10 The role of SPC is key to the success of the project, both in the work undertaken and in the manner of engaging with participants and other professionals.

10.11 Caseload management is a significant challenge and will need the attention of the advisory group and newly appointed SPC and her line manager.

10.12 The project currently works closely with two GP practices and an agreement is in place to begin work with Gerontological Emergency Department Intervention team in Tallaght University Hospital. Other GPs and healthcare providers have inquired about the possibility of referring to the project.

10.13 The project and its implementation has quickly become a valued resource to healthcare practitioners and community service providers. It serves to bridge the two sectors with respect to mutual knowledge and understanding, and connectedness.

10.14 Healthcare professionals, community groups and service providers, members of the advisory group and patients all saw a need for this service to be made available more widely. Many saw significant potential for the project to grow.

10.15 Multi-annual funding will be needed to secure the continuity and future development of the project.

11. Recommendations

The following recommendations are made for the continuation and development of Social Prescribing in South Dublin:

11.1 Celebrate the significant achievements of the past eighteen months (and more).

11.2 Make the Social Prescribing service more widely available across the South Dublin area, both geographically and in collaboration with other disciplines.

11.3 Research and secure multi-annual funding. This will ensure the sustainability of the project and staff retention. It is consistent with the aims of the project for this to continue to be sourced from both the health and community sectors.

11.4 Protect the model for this social prescribing project in future planning. In particular, the principles of flexibility, responsiveness, and trust in participants should be retained. These were greatly valued by the participants and other stakeholders. This will involve recognition in any future developments of the project that it is essential that the SPC has enough time to work with individual participants.

11.5 Communicate the value of Social Prescribing for people with a wide range of issues, conditions, experiences and ages, to healthcare professionals, community workers, and the wider public. This may be demonstrated by the sharing of carefully anonymised participants' stories.

11.6 Continue to develop and maintain strong relationships with colleagues in community groups and organisations, and with a wide range of healthcare professionals.

11.7 Continue support for the Social Prescribing Coordinator to network with other social prescribing co-ordinators.

11.8 Plan for future expansion of the project to other geographic areas and further healthcare disciplines. This will require the securing of further funding as well as a timetable of recruitment, and engagement with other GPs and healthcare providers.

11.9 Develop a case management protocol, in consultation with SPC, practice managers, advisory group and other stakeholders. This needs to include the provision in the near future for taking referrals from Tallaght University Hospital. It also needs to take account of the need for the newly appointed SPC to develop the breadth and depth of local knowledge that will allow her to work effectively with the current caseload.

11.10 The Social Prescribing Advisory Group should continue to offer support and advice in a way which creates space and time for the project to develop.

11.11 Social Prescribing Advisory Group should keep a focus on maintaining regular contact with the project as it moves into a new phase. Consider creating a calendar of meeting dates for the next 6 / 12 months, including negotiating the frequency of meeting which is manageable and achievable.

11.12 Consider a sub-group structure for the SPAG. Three possible sub-groups could give their focused attention to:

- Researching and securing multi-annual funding
- Case management protocol (short-term)
- Planning for project expansion

11.13 Consider including a participant perspective in the SPAG.

11.14 The Elemental online platform provides a strong foundation for ongoing monitoring and evaluation of the project into the future. It is however cumbersome to access for an external evaluator. Consider how to develop access to anonymised data for future external evaluation and monitoring.

11.15 Engage with community groups on the questions of their access to the database of services, and what might make it valuable and feasible for them to upload updated information about their programmes and services on a continuing basis.

Appendix 1: Measures Used

SDCP Community Involvement

Baseline	Follow-up
How involved are you in your community? (e.g. groups, activities) *(Not involved at all) 1 2 3 4 (Very involved)*	How involved are you in your community? (e.g. groups, activities) *(Not involved at all) 1 2 3 4 (Very involved)*
How would you rate your level of knowledge of the services in the community? *(I have no knowledge at all) 1 2 3 4 (I know every service)*	How would you rate your level of knowledge of the services in the community? *(I have no knowledge at all) 1 2 3 4 (I know every service)*
How likely you think you would use them? (Less likely) 1 2 3 4 (most likely)	How likely you think you would use them? (Less likely) 1 2 3 4 (most likely)
Date:	Date:

SWEMWBS The Short Warwick-Edinburgh Mental Well-being Scale

The Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS)

Below are some statements about feelings and thoughts.
Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

MYCAW Measure Yourself Concerns and Wellbeing

Measure Yourself Concerns and Wellbeing (MYCAW)

First form

Full name..... Date of birth .....

Date first completed .....

.....

Please write down one or two concerns or problems which you would most like us to help you with.

1.

2.

MYCAW. Measure Yourself Concerns and Wellbeing (face-to fa

Please circle a number to show how severe each concern or problem is now:

This should be YOUR opinion, no-one else's!

Concern or problem 1:

	0	1	2	3	4	5	6	
☺	Not bothering me at all						bothers me greatly	☹

Concern or problem 2:

	0	1	2	3	4	5	6	
☺	Not bothering me at all						bothers me greatly	☹

Wellbeing:

How would you rate your general feeling of wellbeing now ? (How do you feel in yourself?)

	0	1	2	3	4	5	6	
☺	As good as it could be						As bad as it could be	☹

Thank you for completing this form.

MYCAW. Measure Yourself Concerns and Wellbeing (face-to face at follow-up version)

Appendix 2: Interview / Focus Group Schedules

Interview with Participants (5 - 8 case studies)

This began with an open invitation to tell me their story from before they participated in Get Well … Connected until now.

Following that, these unfinished sentences were used to fill in further details.

1. Before I was referred to João, …
2. At the beginning, when (GP) referred me to social prescribing, but before I met João, I thought it would mean…
3. Organising the first meeting with João was…
4. Then, when I met João, …
5. The first time I went along to (group / organisation / event)…
6. One really good thing about this project for me has been…
7. When I think back from the start to now, something that was difficult for me was…
   - What helped me then was…
   - OR What would have helped me then was…
8. The biggest change for me since my first meeting with João has been…
9. Other smaller changes were …
10. A suggestion I have about the social prescribing project is…

Through these prompts, the intention was to inquire into experience of and reflections on:

- The referral process
- Accessibility of the project
- Expectations of the project
- Communication / follow up
- Changes in lifestyle, habits, connection with the community, communication with others, general health

Interview with Social Prescribing co-ordinator

This explored interviewee's experience of and/ or reflections on:

1. The need(s) Get well … Connected is addressing / benefits to
   i. Individual participants
   ii. Healthcare practitioners / G.P. practices
   iii. The local community / community groups
2. Achievements of Get well … Connected since it began
3. Challenges faced by Get well … Connected
   i. Whether and how they have been overcome
   ii. How they have contributed to the development of the project
4. Effectiveness of structures and procedures (decision-making, admin., referral systems, record-keeping, feedback, advisory group, management, etc.) in serving the work of the project.
5. Elemental Software / Referral system
   i. Training provided
   ii. Using Elemental
   iii. Opportunities to feedback on experience of using Elemental
6. Resource issues
   i. What resources are required / available / used in Get well … Connected ?
   ii. What constraints exist to your capacity to take referrals? On number of community groups? On number of referrers?
7. Relationships between Get well … Connected and
   i. G.P. practices / individual G.P.s / referrers
   ii. Participants
   iii. ? Family members / carers of participants
   iv. Community groups / organisations referred to
8. Place of Get well … Connected in context of local area
9. Understanding of what is / is not social prescribing
10. Clarity about what is an appropriate referral
11. Perception of how Get well … Connected might develop into the future
12. What is one thing you have learned from your work with Get well … Connected that might be helpful to the project as you go forward?

Interview with G.P. practice managers

These explored interviewees' experience of and/ or reflections on:

1. The need(s) the social prescribing project is addressing / benefits to
   i. Individual participants
   ii. Healthcare practitioners / G.P. practices
   iii. The local community / community groups
2. Achievements of the social prescribing project since it began
3. Challenges faced by you in relation to the social prescribing project
   i. Whether and how they have been overcome
   ii. How these challenges have contributed to the development of the project
4. Experience of referral processes to and feedback (if any) from the social prescribing project
5. Elemental Software
   i. Training / how easy to learn to use?
   ii. Using Elemental to make referrals
   iii. Opportunities to feedback on experience of using Elemental
6. Resource issues
   i. What resources are required / available / used in practice in relation to the social prescribing project?
   ii. What constraints exist to your capacity to work with the social prescribing project?
   iii. What was / is your role in getting support for this project from G.P.s?
7. Relationship between the social prescribing project and
   i. G.P. practices / individual G.P.s / referrers
   ii. Participants
   iii. ? Family members / carers of participants
8. Place of the social prescribing project in context of local area
9. Effect / Impact of the social prescribing project on you / your practice
10. Understanding of what is / is not social prescribing
11. Clarity about what is an appropriate referral
12. As a practice, you have invested in this. What has been the return for you on this investment?
13. Perception of how the social prescribing project might develop into the future
14. What is one thing you have learned from your involvement with Get Well … Connected that might be helpful to them as they go forward?

Focus groups with G.P.s

These explored interviewees' experience of and/ or reflections on:

1. The need(s) the social prescribing project is addressing / benefits to
    i. Individual participants
    ii. Healthcare practitioners / G.P. practices
    iii. The local community / community groups
2. Achievements of the social prescribing project since it began
3. Challenges faced by you in relation to the social prescribing project
    i. Whether and how they have been overcome
    ii. How they have contributed to the development of the project
4. Experience of referral processes to and feedback (if any) from the social prescribing project
5. Elemental Software
    i. Training / how easy to learn to use?
    ii. Using Elemental to make referrals
    iii. Opportunities to feedback on experience of using Elemental
6. Resource issues
    i. What resources are required / available / used in practice in relation to the social prescribing project?
    ii. What constraints exist to your capacity to make referrals?
7. Relationship between the social prescribing project and
    i. G.P. practices / individual G.P.s / referrers
    ii. Participants
    iii. Family members / carers of participants
8. Place of the social prescribing project in context of local area
9. Effect / Impact of the social prescribing project on you / your practice. Is there any effect on your personal wellbeing?
10. Understanding of what is / is not social prescribing
11. Clarity about what is an appropriate referral
12. As a practice, you have invested in this. What has been the return for you on this investment?
13. Perception of how the social prescribing project might develop into the future
14. What is one thing you have learned from your involvement with the social prescribing project that might be helpful to them as they go forward?

Focus group with Community groups / organisations

This explored interviewees' experience of and / or reflections on (as far as aware):

1. The need(s) the project is addressing / benefits to
   i. Individual participants (what changed for the participant?)
   ii. The local community / community groups (what changed for you?)
   iii. Healthcare practitioners / G.P. practices
2. Achievements of Get Well … Connected since it began
3. Challenges faced by Get Well … Connected
   i. Whether and how they have been overcome
   ii. How the challenges have contributed to the development of the project
4. Experience of people being referred to your group (What's your sense of…?)
5. Resource issues
   i. Has your involvement in Get Well … Connected required any extra resources? ?
   ii. What constraints exist to capacity for number of referrals?
6. Elemental Software
   i. Training / how easy to learn to use?
   ii. Using Elemental
   iii. Opportunities to feedback on experience of
7. Relationship between Get Well … Connected and
   i. Community groups / organisations
   ii. Participants
8. Place of Get Well … Connected in context of local area
9. Effect / Impact of Get Well … Connected on you / your practice / organisation
10. Understanding of what is / is not social prescribing
11. Perception of how Get Well … Connected might develop into the future
12. As a group / organisation, you have invested in this. What has been the return for you on this investment? Or How have you gained from your involvement?
13. What is one thing you have learned from your involvement with Get Well … Connected that might be helpful to them as they go forward?

Group interview with Advisory Group

This explored the group's experience of and/ or reflections on:

1. The need(s) Get well … Connected is addressing / benefits to
   i. Individual participants
   ii. Healthcare practitioners / G.P. practices
   iii. The local community / community groups
2. Achievements of Get well … Connected since it began
3. Challenges faced by Get well … Connected
   i. Whether and how they have been overcome
   ii. How they have contributed to the development of the project
4. Effectiveness of structures and procedures (decision-making, admin., referral systems, record-keeping, feedback, advisory group, management, etc.) in serving the work of the project.
5. Elemental Software / Referral system
   i. Training provided
   ii. Using Elemental
   iii. Opportunities to feedback on experience of using Elemental
6. Resource issues
   i. What resources are required / available / used in Get well … Connected ?
   ii. What constraints exist to capacity to take referrals? On number of community groups? On number of referrers?
7. Relationships between Get well … Connected and
   i. G.P. practices / individual G.P.s / referrers
   ii. Participants
   iii. ? Family members / carers of participants
   iv. Community groups / organisations referred to
8. Place of Get well … Connected in context of local area
9. Understanding of what is / is not social prescribing
10. Clarity about what is an appropriate referral
11. Perception of how Get well … Connected might develop into the future
12. What is one thing you have learned from your involvement with Get well … Connected that might be helpful as you go forward?