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Title: Evaluability Assessments as an Approach to Examining Social Prescribing

Kate Hamilton-West, PhD., C.Psychol., AFBPsS., FHEA. Centre for Health Services Studies,
University of Kent, Canterbury, Kent CT2 7NF

Erica Gadsby, PhD., PGDipPH., FRSPH. Centre for Health Services Studies, University of
Kent, Canterbury, Kent CT2 7NF

Natalie Zaremba, MSc. King's College London, Weston Education Centre, 10 Cutcombe
Road, London SE5 9RJ

Sabrina Jaswal, MA. Centre for Health Services Studies, University of Kent, Canterbury,
Kent CT2 7NF

Correspondence to Dr Kate Hamilton-West.

Email: k.e.hamilton-west@kent.ac.uk

Tel: +44 1227 823872

Abstract

We report on two evaluability assessments (EAs) of social prescribing (SP) services in South East England conducted in 2016/7. We aimed to demonstrate how EA can be used to assess whether a programme is ready to be evaluated for outcomes, what changes would be needed to do so and whether the evaluation would contribute to improved programme performance. We also aimed to draw out the lessons learned through the EA process and consider how these can inform the design and evaluation of SP schemes.

EAs followed the steps described by Wholey (1987) and Leviton et al. (2010), including collaboration with stakeholders, elaboration, testing and refinement of an agreed programme theory, understanding the programme reality, identification and review of existing data sources and assessment against key criteria. As a result, evaluation of the services was not recommended. Necessary changes to allow for future evaluation included gaining access to electronic patient records, establishing procedures for collection of baseline and outcome data and linking to data on use of other healthcare services.

Lessons learned included ensuring that: (i) SP schemes are developed with involvement (and buy in) of relevant stakeholders; (ii) information governance and data sharing agreements are in place from the start; (iii) staffing levels are sufficient to cover the range of activities involved in service delivery, data monitoring, reporting, evaluation and communication with stakeholders; (iv) SP schemes are co-located with primary care services and (v) referral pathways and linkage to health service data systems are established as part of the programme design.

We conclude that EA provides a valuable tool for informing the design and evaluation of SP schemes. EA can help commissioners to make best use of limited evaluation resources and prioritise which programmes need to be evaluated, as well as how, why and when.

Key words

Social prescribing

Community referral

Linking schemes

Evaluability assessment

Evaluation

Commissioning

What is known about this topic?

Social prescribing (SP) schemes are a means of linking patients with community-based resources

Despite widespread enthusiasm for SP, there is little high quality evidence to inform commissioning

SP schemes have proven difficult to evaluate and researchers have suggested adopting alternative methodologies

What this paper adds

We demonstrate how evaluability assessment (EA) can be used to inform the design and evaluation of SP services

EA can help commissioners make best use of limited evaluation resources and prioritise which programmes need to be evaluated, as well as how, why and when.

Background

Social prescribing (SP) schemes, also referred to as community referral or linking schemes, are a means of enabling healthcare professionals to refer patients with social, emotional or practical needs to a range of community-based resources. In the UK National Health Service (NHS), such schemes are being widely promoted as a way to help people manage long-term mental and physical health conditions (Mossabir et al., 2015, White et al., 2017, Thomson et al., 2015), with consequent benefits in terms of reduced primary care attendance and health service costs (Kimberlee, 2013). It has also been suggested that SP schemes represent an ‘innovative approach to engaging with health inequalities’ (Friedli et al., 2009, p25) and that benefits ‘have been particularly pronounced for marginalised groups such as mental health service-users and older adults at risk of social isolation’ (Thomson et al., 2015, p5).

However, a recent systematic review (Bickerdike et al., 2017) revealed that most evaluations of SP activity are small scale and limited by poor design and reporting. Furthermore, missing information made it difficult to assess who received what, for what duration, with what effect and at what cost. SP schemes are highly heterogeneous in terms of the range of needs represented in the patient group, the services offered (which often include small voluntary, or community groups operating at a local level) and outcomes assessed. Staff employed within these schemes as coordinators, link workers, or facilitators of social prescribing also vary considerably in terms of skills, training and knowledge (Bickerdike et al., 2017; Thomson et al., 2015).

Bickerdike et al. (2017) highlight that one reason for the lack of high-quality evidence is that SP schemes have typically ‘emerged’ rather than being systematically planned with evaluation built in at the outset. Hence, as yet, there is little high-quality evidence to inform the commissioning of SP schemes. The authors go on to argue that, if SP is to realise its

potential, ‘there is an urgent need to improve the ways by which schemes are evaluated’ (Bickerdike et al., 2017, p15).

The need for systematic evaluation planning

To make best use of limited evaluation resources, it is important to identify the most appropriate evaluation questions, approach and methods for each specific purpose. The usefulness of any proposed evaluation should be carefully assessed to make sure it addresses ‘the objectives, expectations, and information needs of program [sic] managers and policy makers; explores program reality; assesses the likelihood that program activities will reach measurable progress toward program objectives; and assess the extent to which evaluation information is likely to be used by program management’ (Wholey, 1979, p xiii, cited in Leviton et al., 2010). Researchers also have a duty to identify what each evaluation can add to existing knowledge. For example, thorough and systematic evaluation planning might ensure consistency and clarity within and between evaluations of SP schemes to enable better comparisons and systematic reviews, and/or contribute to the building of evaluation capacity, increasing the number of evaluations that are appropriately tailored and likely to yield valuable and usable information (Leviton et al. 2010).

Evaluability assessment

Evaluability assessment (EA) is a systematic approach to planning evaluation projects, which enables informed and strategic decisions to be made about whether and how to evaluate programmes and policies. To assess a programme’s evaluability is to assess the extent to which it can be evaluated in a reliable and credible fashion (Wholey, 1979). EAs consider three related dimensions: evaluability ‘in principle’, as seen in the quality of the programme design; evaluability ‘in practice’, as seen in the availability of data; and the utility and practicality of an evaluation, as seen in the institutional context (Davies, 2013). While EA

methods vary, Craig and Campbell (2015) identify core elements as systematic engagement with stakeholders from the outset; elaboration, testing and refinement of an agreed theory of change; identification and review of existing data sources; and making recommendations for, or against, evaluation.

EAs have been used in a wide range of policy areas and settings (Davies, 2013). When used in the field of public health, they can provide programme staff with rapid, constructive feedback about programme operations, thereby helping with programme planning, assurance and implementation (Leviton et al., 2010). EAs can also help to translate research into practice (e.g. by ensuring that stakeholders are involved in developing and appraising evaluation options, by testing assumptions about a programme's operation in new settings, or by guiding adaptation to real-world considerations) and practice into research (e.g. by identifying promising practices that are ready for evaluation) (Leviton et al., 2010). Spencer et al. (2016) demonstrated the value of conducting EAs on a selection of related Council health improvement programmes in England. The assessments enabled the Council to prioritise which programmes should be fully evaluated, as well as how, why and when. They also gave Council staff rapid, constructive feedback on the design and operation of their programmes (to increase the likelihood that they can be evaluated), and identified areas for programme improvement, data improvements, capacity strengthening and further research. The researchers concluded that EA is a low-cost pre-evaluation activity that can help to ensure best use of evaluation resources (Spencer et al., 2016).

Aims and Overview

We report on EAs of two SP services conducted in 2016/7. The aim of this article is to demonstrate how EA was used to assess whether the programme was ready to be evaluated for outcomes, what changes would be needed to do so and whether the evaluation would

contribute to improved programme performance. We also aim to draw out the lessons learned through the EA process and consider how these can inform the design and evaluation of SP schemes. We provide a brief overview of the two services below.

The Community Wellbeing Service

The Community Wellbeing Service (CWS) delivered by Southdown Housing Association, was commissioned by NHS Hastings and Rother Clinical Commissioning Group (CCG) to deliver support for people with low-level mental health problems through social prescribing embedded within GP surgeries (primary care medical practices). The service was developed in response to: national policy highlighting that poor mental health is associated with poorer physical health and reduced quality of life (Department of Health, 2010); local primary mental health data showing that people with early mental health issues are likely to have other contributory factors, such as debt, housing, employment, or social isolation; research evidence indicating that social prescribing can strengthen provision of, and access to services that influence public mental health (Friedli, 2009); and a local emphasis on developing services to help individuals take a pro-active approach to managing their health and wellbeing.

Encompass Social Prescribing Service

Encompass Multispecialty Community Provider (MCP) is one of 14 'vanguards' established following publication of the NHS Five Year Forward View (NHS England, 2014) to improve integration of health and social care and move specialist care from the hospital to the community. The Social Prescribing Service was developed to support the work of the vanguard by enabling patients registered with participating practices to be referred and/or signposted to non-medical support services in the community. The service was delivered by

Red Zebra Community Solutions, a Council for Voluntary Services (CVS), providing advice, training and support to local voluntary and community organisations.

Methods

The EAs were conducted using a systematic, iterative process, as outlined by Wholey (1987) and Leviton et al. (2010). The key steps (described below) were carried out in a cyclical, non-linear manner.

Collaboration with stakeholders

During meetings with the researchers and health service commissioners, SP services were identified as a key priority for evaluation. However, since these services were in the early stages of implementation, with limited outcome data available, it was important to determine whether they were ready to be evaluated and what sort of evaluation would be most useful and feasible. The group decided that a pre-evaluation exercise using EA was the most appropriate approach.

Subsequent discussions with commissioners and service managers were used to develop rapport and engagement with the programme teams, further define the aims of the EAs and outline next steps.

Commissioners and service managers provided a wealth of information on each programme, including written goals and objectives, progress reports, staff job descriptions, workbooks and training documents. These were catalogued and reviewed.

Each EA was conducted over a five-month period (on a part-time basis) by two independent academic researchers. Each EA took approximately 12 person days.

Elaboration, testing and refinement of an agreed programme theory

For the Encompass SP programme, a logic model (developed by the programme commissioners) was also provided. This was reviewed and discussed to develop a clear understanding of the programme theory. For the CWS programme, a draft logic model was developed by the researchers, in discussion with commissioners and service managers.

Understanding the programme reality

Interviews were conducted with the programme teams (including commissioners, managers and operatives) to test, refine and further develop the logic models and to understand the programme reality. For each EA, a total of six interviews were conducted. Following these interviews, the logic models were amended as appropriate, and key staff members continued to be involved to help clarify programme details/ supply outstanding information. Final versions, agreed with the programme teams, described each programme with respect to *aims and assumptions, inputs* (staff and resources), *outputs* (activities and participants) and *outcomes* (short, medium and long-term).

Identification and review of existing data sources

The different types of data collected on each programme (including process and outcome data) were identified and reviewed with key members of the team. This information was considered in relation to the logic models and any gaps or limitations in data collection were noted.

Making assessments against key criteria

EA reports were developed for each programme, which addressed methodological issues around data and its analysis, the plausibility of the expected outcomes, the quality of evidence and potential usefulness of findings. Evaluation and subject matter expertise were employed to form opinions regarding evaluability and the feasibility of alternative evaluation designs,

based on key criteria (questions) adapted from an existing evaluability assessment template (United Nations Office on Drugs and Crime, n.d.). These questions were then expanded to create a checklist (set of performance criteria) and scorecard (see Table 2).

Scoring was conducted by the researchers on the basis of information provided by (and discussed with) stakeholders. This was a useful, systematic way of generating an explicit assessment of likely challenges facing an evaluation and not a final judgement on evaluability (Davies, 2013). Written drafts and summaries of stakeholder discussions were shared with programme teams prior to submission of the final EA report, to check on the researchers' understanding of the programme theory, reality and data availability.

Ethical considerations

EAs are conducted to enable decisions to be made about whether and how to evaluate programmes and as such are a precursor to research/service evaluation, rather than a research study. Since the EAs did not meet the NHS Health Research Authority definition of research, full ethical review by a Research Ethics Committee was not required. EAs were conducted in accordance with the University's code for ethical practice.

Results

Programme theory

Logic models for the two programmes are shown in Figures 1 and 2.

Insert Figures 1 and 2 about here.

Information derived from EA indicated that CWS was conceived as a programme to reduce health inequalities by improving awareness of factors influencing mental and physical health, increasing uptake of support services and (consequently) enhancing self-efficacy, coping

skills, empowerment and confidence. Uptake of support services was also expected to lead to increased social networks and reduced social isolation. Anticipated long-term outcomes included improvements in mental and physical health and reductions in use of primary care services.

The Encompass programme was intended to transform local services, enabling a shift from provision of care and support that is reactive to ill health, towards proactive care and support focused on promoting health and wellness, thereby enabling people to stay well and live independently for as long as possible. Short to medium-term outcomes included improvements in social isolation, resilience and self-care and reductions in use of services.

Both programmes sought to achieve their objectives by implementing a SP programme.

Programme operation

The EA process yielded information on inputs (staff and resources) and outputs (activities and participants), as illustrated in Figures 1 and 2 and described further below.

Inputs

CWS staff comprised a co-coordinator and four community wellbeing advisors (CWAs). The service also received input from the Southdown Housing training team (which provided a programme of induction and CPD training for CWS staff) and the Southdown Housing data quality monitoring team (support with data analysis and compiling quarterly reports).

At the time of the EA, the service was embedded into nine GP practices – six provided a consultation room and resources (e.g. desk, computer, telephone), while three were not able to provide a consultation space – these were referred to as ‘satellite surgeries’. CWS also had access to display space in foyers/reception areas of GP surgeries (to raise awareness of the

service) and CWAs were able to access electronic patient records via the EMIS system (for data collection and entry) for four of the nine participating practices.

The Encompass Social Prescribing team comprised a manager and two part-time co-ordinators. The service had access to administration support for 20 hours per week (provided by a project officer) as well as office space, laptops, telephones and meeting rooms. There was a small budget for hiring outreach spaces (e.g. rooms in community centres) and staff training (e.g. information governance, safeguarding and mental health). It was intended that co-ordinators would have access to a private room/space in GP surgeries to meet with patients, but at the time of the EA, this had not been fully established (due to pressures on room availability in GP surgeries).

Outputs

The CWS team worked with GP practices and local community support services to raise awareness of the service. Referrals were received from GPs (family doctors), practice nurses, other practice staff and the local primary care mental health team. Patients could be referred to CWS if it was felt that their mental health would benefit from support from voluntary and community support services. Patients could also self-refer by telephone, email or referral form (available from the practice reception).

Daily walk-in clinics were offered to increase CWA availability to patients either by appointment or straight from their GP consultation. Patients registered with satellite surgeries were able to meet with CWAs at the alternative walk-in clinics, in community spaces (e.g. community centres or cafes), or in their home.

CWAs conducted an initial needs assessment and then used coaching techniques to encourage patients to engage with resources and specialist agencies relevant to their areas of concern

(e.g. carer support, financial, housing, or benefits advice). Three levels of service were provided according to the client's needs (see Figure 1).

Programme operation for the Encompass SP service centred around an online referral database ('Connect Well') developed by Red Zebra in consultation with Encompass, which could be accessed by members of the public or by health and social care professionals (HSCPs) to search for relevant services and activities (e.g. support groups, weight management services). Users could self-refer or be referred by their GP/ other HSCP. SP co-ordinators also offered face-to-face support to help users engage with a community activity or service.

It was also intended that co-ordinators would identify potential referrals by attending weekly Encompass multidisciplinary team (MDT) meetings. However, at the time of the EA, this was not in place due to concerns regarding data sharing and information governance.

Availability of process and outcome data

Process and outcome data collected by the two services are shown in Table 1.

Insert Table 1 about here.

For CWS, data were collected via referral forms, client assessment and exit interviews and via electronic patient records (EMIS systems). The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007) was completed at both assessment and exit by clients assessed as suitable for level 3 - i.e. those with multiple/complex needs requiring a more intensive level of support. Clients assessed as suitable for level 1 and 2 were not asked to complete the WEMWBS, since this provides a measure of wellbeing over the past two weeks, which may be longer than the period from assessment to exit interview. At the time of the EA, data were available for the first quarter (October-December 2015).

For the Encompass SP service, data were collected via the Connect Well database and feedback forms. WEMWBS had been considered as an outcome measure but was not adopted due to concerns that the questions could raise issues that activity providers were not trained to respond to (e.g. mental health needs). At the time of the EA, data were available for December 2016 to February 2017.

Quality assessment

Scores for each of the EA criteria are shown in Table 2 and described further below.

Insert Table 2 about here.

1. Does the quality of the design of the project allow for evaluation (in principle)?

All criteria in this section were met at least partly (score = 2) and some were met in full (score = 3).

The CWS programme theory is consistent with previous research on social prescribing (although, as noted in the introduction, there is limited high quality evidence to inform commissioning of SP services). CWS staff induction training, together with work to embed the service in GP practices and establish referral pathways via MDT and mental health teams ensured that programme objectives were understood by key stakeholders. Support from the data and quality monitoring team also ensured that performance indicators were monitored adequately.

The Encompass programme theory is also consistent with existing evidence on SP outcomes, although the service rested on an assumption that patients would be more likely to access support via an online SP database, as opposed to other routes (e.g. personal recommendation, internet search), which was not possible to verify (discussed further below).

Encompass SP service objectives were understood by key stakeholders, facilitated by positive working relationships with GPs, other HSCPs and support services. Lack of access to MDT meetings and consultation space in surgeries were limiting factors, although action was being taken to identify solutions to these challenges. The service was able to routinely collect process data, although outcome data were more limited (discussed further below).

2. Are the outcomes of the project plausible, given the way in which it has been/is being implemented?

For both programmes, criteria in this section were considered to be partly met and could be subject to further improvements (score = 2).

For CWS, short and medium-term outcomes seem plausible given the project design and implementation, although long-term outcomes (such as improvements in physical health and mental wellbeing) are likely to depend on the individual's areas of support need, the type of service accessed and other intervening factors (e.g. major life events, change in circumstances, pre-existing or newly diagnosed conditions). Outcomes also rest on a number of key assumptions (see Figure 1).

Short to medium-term outcomes for Encompass SP Service also seem plausible, with some (e.g. reduction in demand on crisis services) dependent on the individual's areas of support need and type of service accessed. However, staffing and resources may not be sufficient to achieve the anticipated outcomes and impacts, given the range of activities in the logic model, as well as activities needed to raise awareness of the service, resolve data sharing and information governance issues, maintain relationships with external partners, update the database, monitor process and outcome data and produce reports.

The use of a web-based platform is likely to be a limiting factor, for several reasons: i. clients with more complex needs may need help to access services, prioritise support needs and co-ordinate inputs from multiple services; ii. potential clients without internet access (or low levels of computer literacy) may be less likely to access the service; iii. those more accustomed to searching for services online may not perceive added benefit of the SP database (compared to use of internet search engines); iv. it is likely that considerable work will be needed to ensure the data base is up to date and represents the full range of support services available in the local area; v. while it was possible to collect data on referrals via the online form, it was not possible to collect data on clients accessing services listed in the database without using the online form (e.g. calling the service directly).

The long-term impacts of the programme are ambitious and require transformation of local services; these are likely to be beyond the scope of the SP service.

3. Are the results of the projects verifiable based on the data collected?

Scores in this section range from 0 (non-identification of the criteria) to 3 (criteria are fully met), with low scores indicating lack of available baseline data for Encompass and the early stage of implementation of the SP programmes. CWS did routinely collect baseline and follow-up data, as well as monitoring data against performance indicators. However, the service had faced difficulties accessing data on GP appointments. Although number of appointments in the past 3 months was requested on referral forms, this was not always provided and five of the nine participating practices had not provided access to EMIS systems (electronic patient records). It had not been possible to obtain WEMWBS data for all eligible patients; impacts on physical health and changes in proposed mediators (e.g. self-efficacy and coping) were not assessed.

For Encompass SP Service, service user feedback forms assessed perceived benefits arising from the service or activity they had been referred to. No data were available on perceived (or actual) benefits of the SP service itself.

Hence, project outcomes would not be verifiable based on data collected at the time of EA.

4. Would the evaluation be feasible, credible and useful?

Scores in this section also range from 0 to 3, with low scores indicating concerns about the timing of evaluation, budget available for evaluation and feasibility of collecting additional data. Both services were in the early stages of implementation, with further activities planned to develop referral pathways and collect outcome data. Hence, evaluation was not recommended at the time of the EA.

Recommendations

The EAs identified a number of changes necessary to enable future evaluation of and improve the SP services. These focused on criteria that were deemed to be either unmet or partially met in the scorecard and included:

- Improving the design of the project, for example, by testing (and where necessary amending) key assumptions and ensuring outcomes are measurable and realistic.
- Improving plausibility of outcomes by improving fidelity to implementation plans, for example, by:
 - identifying access to consultation space within participating GP practices
 - addressing issues relating to data sharing and information governance, in order to enable identification of potential referrals via MDT meetings.
- Improving potential to verify results, for example by:
 - gaining access to EMIS systems

- establishing procedures for collection of baseline data for self-referring patients, as well as short and long-term outcome data for all patients accessing the service
- obtaining data on acute admissions and use of other NHS services.
- Improving the feasibility, credibility and usefulness of an evaluation, for example by working with programme managers and operatives to:
 - identify the most appropriate point in the project cycle to evaluate outcomes
 - identify/access resources needed to collect, monitor and analyse outcome data.

For Encompass SP Service, use of the WEMWBS could be reconsidered. While questions may raise issues that service users wish to discuss with others, there are tools available to support discussing mental wellbeing with individuals and groups. For example, the Champs Guide to Action Planning could be used alongside the WEMWBS to guide discussions around any issues arising (Stansfield, Collins, Timpson & Whelan, 2013). Changes to user feedback forms were also recommended to ensure that these captured satisfaction with the SP service (not just satisfaction with onward referral services).

Recommendations were made in relation to possible evaluation designs and questions of priority interest. For both services, it was recommended that future evaluation should aim to analyse both quantitative data (e.g. change in WEMWBS scores and GP appointments) and qualitative data (on patients' experience of the service). Evaluation could also incorporate data on use of other NHS services. However, procedures for collection and analysis of data should be realistic and proportionate taking into account resources available and the need to minimise burden on patients.

It was further recommended that future evaluation of the service should ideally incorporate a process evaluation, in order to assess intervention fidelity (with respect to the underlying

logic model), quality of implementation, causal mechanisms (e.g. changes in self-efficacy and coping) and contextual factors associated with variation in outcomes (e.g. access to a consultation space, support services available in the local area).

Questions of priority interest for future evaluation of the SP services were identified as follows:

- Do patients accessing the service show meaningful improvements in health and wellbeing?
- Are improvements maintained over the long-term?
- Do improvements in health and wellbeing impact on use of NHS services?
- To what extent are improvements attributable to the intervention?
- What are the lessons learned in developing and implementing the service?
- How do patients experience the service and are there benefits beyond those captured by assessment measures?
- How do GPs and other HSCPs experience the service?

Discussion

Evaluability assessment can assist in the planning of evaluation projects, by systematically analysing key criteria related to the programme's design, implementation and monitoring, and by addressing pertinent questions related to the potential feasibility, credibility and usefulness of any evaluation. In doing so, EAs also highlight opportunities to strengthen programmes prior to evaluation, helping to make best use of limited evaluation resources and increasing the likelihood that evaluations will yield information that is helpful for guiding commissioning decisions.

Reporting on two recent EAs of SP schemes, we aimed to demonstrate how EA was used to assess whether the programmes were ready to be evaluated for outcomes, what changes would be needed to do so and whether the evaluation would contribute to improved programme performance. Each EA involved around 12 days' input from university researchers, working closely with health service commissioners and programme teams. While individual EAs vary, this is consistent with the average amount of time required and demonstrates that EAs can offer good value for money when used to influence the timing and design of subsequent (more resource intensive) evaluations (Davies, 2013). Full evaluation was not recommended at the time of the EAs, due to the early stage of implementation of the SP programmes and limitations in data availability. EA reports highlighted recommended changes to enable future evaluation together with questions of priority interest. Commissioner feedback indicated that these were helpful for informing improvements to programme design, monitoring and evaluation. For example, Encompass SP service subsequently implemented a user questionnaire based on the WEMWBS, resolved data sharing and information governance issues and re-established SP co-ordinator presence at MDT meetings. A formal evaluation of the service (including questions identified from EA) is planned for the future, subject to resources being available.

We also aimed to draw out the lessons learned through the EA process and consider how these can inform the design and evaluation of SP schemes. These are discussed further below.

Designing SP schemes

In terms of programme design, it seems likely that a number of preconditions are necessary for SP schemes to succeed in meeting their objectives. Firstly, it is likely that significant 'buy in' from stakeholders is needed for SP services to identify potential referrals, raise awareness of the service and access patient data. Future schemes should ideally be designed with input

from relevant stakeholders and ensure that SP teams are supported in developing and maintaining these relationships over the long term. Second, it is likely that information governance and data sharing agreements will need to be in place from the beginning. Third, staffing levels will need to be considered carefully to ensure these are sufficient to cover the range of activities involved in service delivery, data monitoring, reporting, evaluation and communication with stakeholders. A fourth lesson learned from the EA process is that SP services may benefit from being co-located with primary care services, since this has the potential to minimise delays in accessing help following a GP appointment (for patients presenting with psychosocial support needs) and raise the profile of SP services with patients and practice staff. Finally, linkage with other NHS data systems (e.g. hospital admissions data) or data collected is important to consider at the design stage in order to measure impacts of SP on use of healthcare services.

Evaluating SP schemes

In terms of programme evaluation, it seems likely that researchers will need to move beyond the question ‘does it work’ and seek to understand factors associated with variation in outcomes. The MRC has published useful guidance for evaluation of complex interventions (Craig et al., 2008) including guidance on process evaluation (Moore et al., 2015). However, Lamont et al. (2016) recently highlighted that this is often focused on rigorous evaluation of single services and may be more difficult to apply to complex, emerging services spanning organisational boundaries. A range of approaches and study designs have been developed to take account of the complexities of changing services and systems, including for example, mixed methods approaches, realist evaluation and natural experiments (discussed further in Raine et al., 2016). Lamont et al. (2016) highlight that it will be increasingly important for researchers to work closely with service leaders, helping them to articulate the goals and describe the components of planned change and selecting evaluation approaches that are

appropriate to resources, need and purpose. They further argue that ‘whatever the resources and timescale, careful thought at the start of a project will pay dividends’ (Lamont et al., 2016, p3). EA provides a structured approach to guide such careful thought enabling researchers and stakeholders to learn from each other.

Conclusions

EA provides a valuable tool for informing the design and evaluation of SP schemes, helping commissioners to make best use of limited evaluation resources. Conducting EA prior to evaluation of SP services may help to address methodological limitations identified via systematic review and begin to build a more robust evidence base to guide commissioning decisions.

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Figure 1. Community Wellbeing Service Logic Model

AIM: To contribute to reducing inequalities in health by enabling those with low level mental health problems to address their physical and mental health needs.

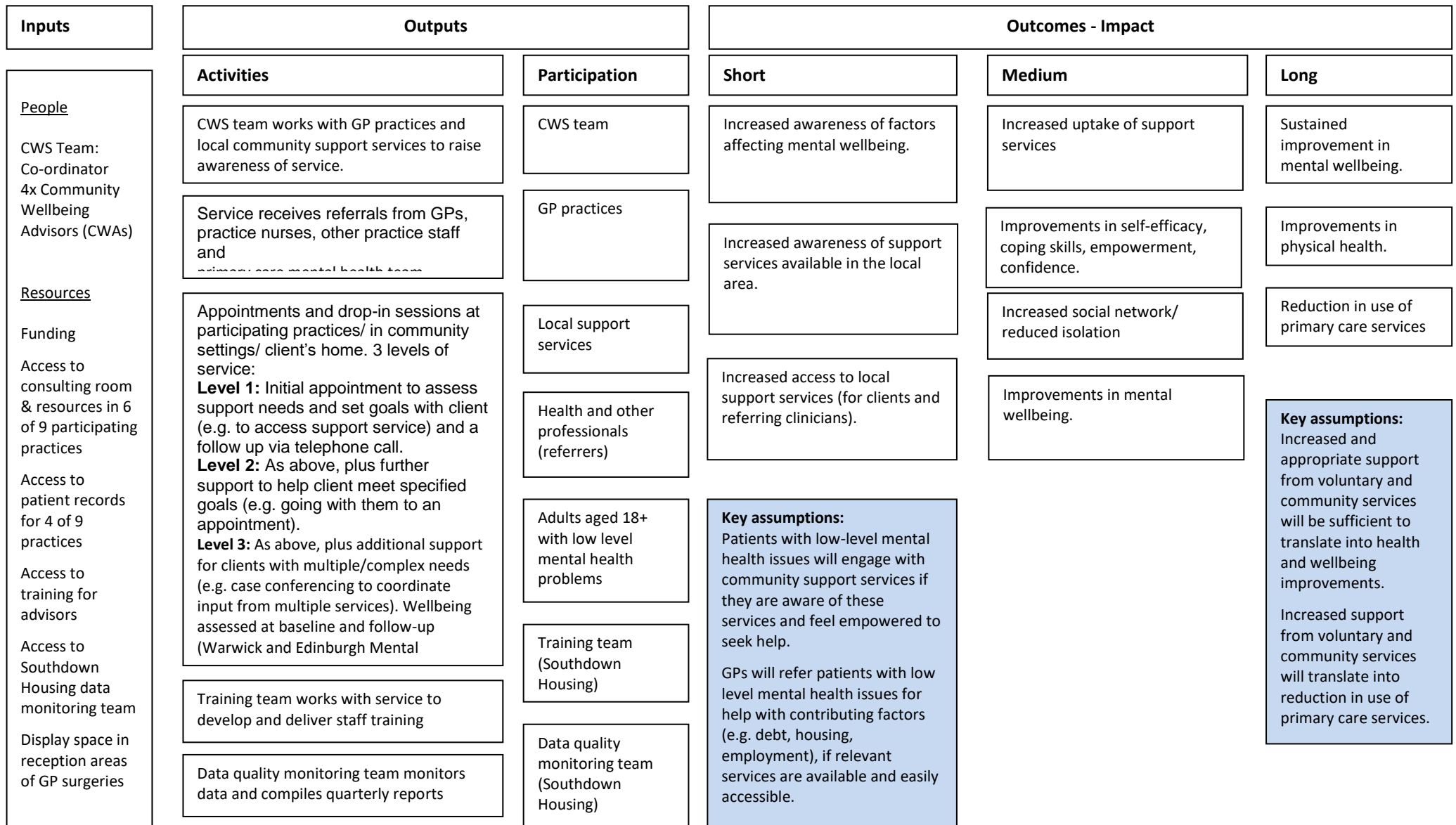


Figure 2. Encompass Social Prescribing Logic Model

AIM: To transform local services so that we deliver proactive care and support focused on promoting health and wellness, rather than care and support that is solely reactive to ill-health.

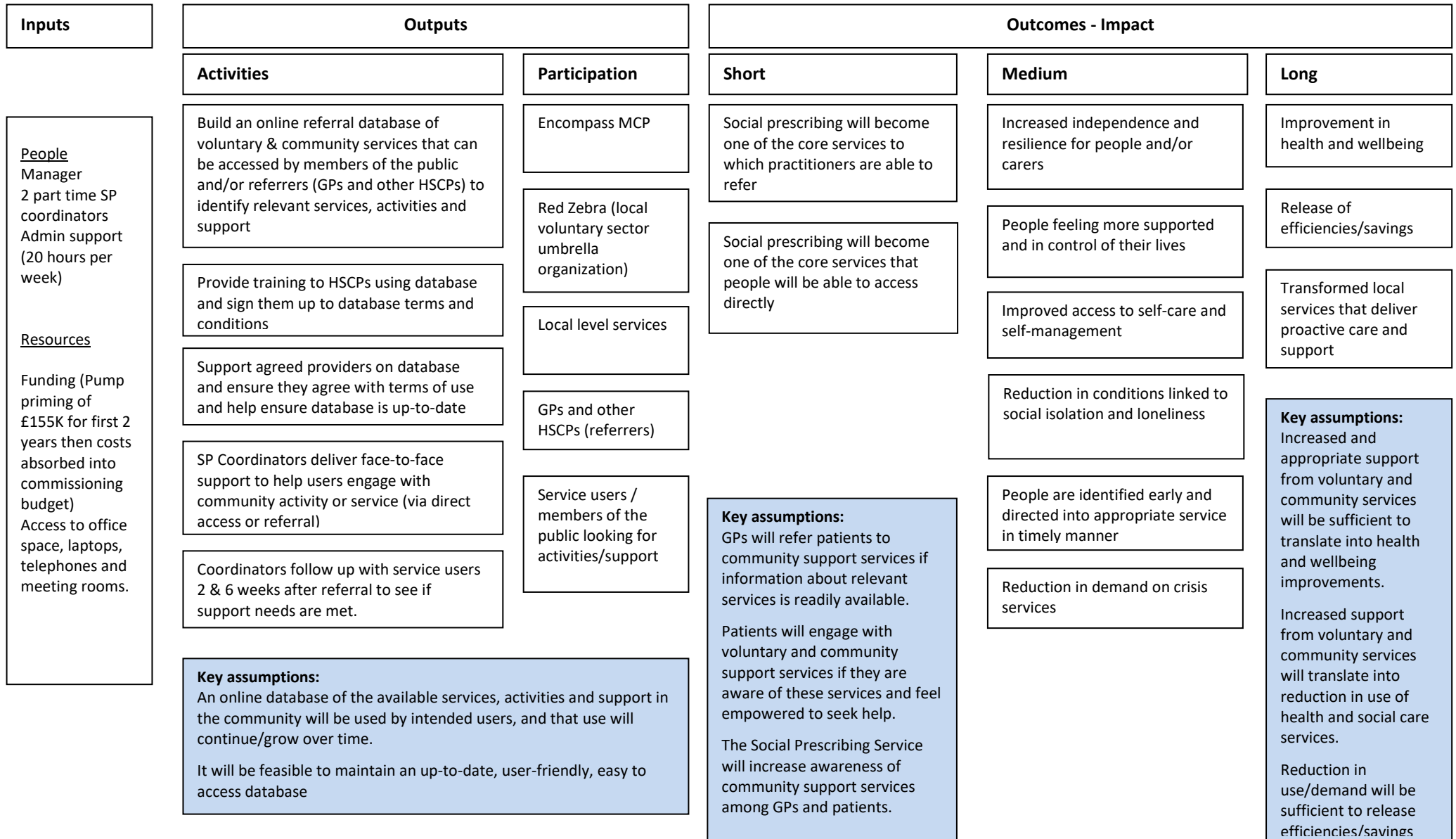


Table 1. Process and Outcome Data Collected

CWS	Encompass
<p>Client assessment covered:</p> <ul style="list-style-type: none"> • Level of support need (Level 1, 2, or 3) • Area of primary support need • Area of secondary support need • Action plan • WEMWBS (for clients assessed as suitable for Level 3) <p>Follow-up interviews gathered data on:</p> <ul style="list-style-type: none"> • Areas of support accessed • Specialist agencies engaged with • Satisfaction with the service provided • WEMWBS (for clients assessed as suitable for Level 3) <p>Data accessed via electronic patient records:</p> <ul style="list-style-type: none"> • Number of GP appointments 12 months prior to accessing CWS • Number of GP appointments 12 months prior to accessing CWS • Number of GP appointments 3 months post accessing CWS 	<p>Connect Well recorded:</p> <ul style="list-style-type: none"> • When a referral was made to an activity provider using the online form • Whether the activity provider had responded • Referral type (e.g. Self/HSCP referral) • Reason for referral (e.g. Anxiety, housing) • Type of activity/service (e.g. Befriending, carers' support) • Client age <p>Feedback forms recorded:</p> <ul style="list-style-type: none"> • Satisfaction with the activity/service client was referred to

Table 2. Evaluability Assessment Criteria Scores for the Community Wellbeing Service (CWS) and Encompass SP Service

	CWS	Encompass
A. Does the quality of the design of the project allow for evaluation (in principle)		
Is the justification of the intervention realistic, and based on a sound understanding of the situation?	2	2
Are the objectives of the project clear, realistic and commonly understood by stakeholders?	3	3
Are the objectives measurable, either quantitatively or qualitatively? (Are there SMART performance indicators?)	2	2
Are the performance indicators monitored adequately?	3	2
Is the logic model clear, sound, flexible and responsive to external factors? Have assumptions been explored/verified? Do the outputs, outcomes and impact follow results chain logic?	2	2
B. Are the outcomes of the project plausible, given the way in which it has been / is being implemented?		
Are outcomes likely to be achievable given the timeframe and resources that are available?	2	2
Are outcomes likely to be achievable given how the resources are allocated to the activities	2	2
Are outcomes likely to be achievable given how the activities are implemented (i.e. with what degree of consistency and fidelity to the original plans, and across program sites if there are multiple sites)	2	2
Are outcomes likely to be achievable given the context within which the project is operating?	2	2
C. Are the results of the project verifiable based on the data collected?		
Is baseline data available to track change?	2	0
Has monitoring data been collected on a regular basis against performance indicators?	3	2
Does the present stage of the implementation of the project allow for evaluation? (If so, what type of evaluation?)	1	0
Has the project been implemented as intended / planned?	2	2
D. Would the evaluation be feasible, credible and useful?		
Does the timing of the evaluation fit into the project cycle?	1	0
Have the building blocks of the project, if any, been previously evaluated?	3	2
Can external factors hamper the evaluation?	2	2
Is the budget sufficient for the evaluation exercise envisaged?	0	1
Can any additional data be realistically collected?	1	1

Scoring key:

4 = 'very good content' – criteria are fully met with a degree of detail that outmatches the criteria requirements.

3 = 'good content' – criteria are fully met.

2 = 'relatively good content' – corresponding criteria are partly met and can be subject to further improvements.

1 = 'poor content' – corresponds to an insufficient identification of a criteria

0 = 'no content' – corresponds to the non-identification of the criteria assessed.