HSE Social Prescribing Framework

Mainstreaming social prescribing in partnership with community & voluntary organisations.

This Framework was developed by the Mental Health and Wellbeing Programme within HSE Health and Wellbeing. It was led by Orla Walsh and Anne Sheridan and supported by a Social Prescribing Framework Steering Group that was established to oversee its development. Membership of the Steering Group is listed below.

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A&E	accident & emergency
ASPIRE	Adult Social Prescribing for Individual Resilience & Empowerment
CHN	Community Healthcare Network
CHO	Community Healthcare Organisation
CMHT	Community Mental Health Team
CYPSC	Children and Young People's Services Committee
DSGBV	domestic, sexual and gender-based violence
ED	Emergency Department
GP	general practitioner
HSCP	health and social care professional
HSE	Health Service Executive
H&W	Health and Wellbeing
ILDN	Irish Local Development Network
IPS	Irish Prison Service
IRPP	Irish Refugee Protection Programme
LCDC	Local Community Development Committee
MECC	Making Every Contact Count
MISA	Mercer's Institute for Successful Ageing
NGO	non-governmental organisation
NHS	National Health Service
NOSP	National Office for Suicide Prevention
OT	occupational therapist
PHN	public health nurse
RCSI	Royal College of Surgeons in Ireland
UK	United Kingdom

Foreword

The health and wellbeing of our population is influenced by numerous social, economic and environmental factors. Clinical healthcare services alone cannot meet the range of health needs of our population. Social prescribing is an effective means of engaging people in non-clinical activities and services in their communities in order to promote their health and wellbeing and reduce health inequalities. It generally involves healthcare and other professionals referring people to a social prescribing link worker, who supports them to access local services through discussion and joint decision-making. Evaluations have demonstrated that social prescribing can have a range of positive outcomes, including improvements in mental wellbeing, physical health and health behaviours, and reductions in social isolation and loneliness. Those who can benefit the most include people with one or more long-term conditions, who need support with their mental health, who are lonely or isolated, who are frequent health service users, and who have complex social needs which affect their health and wellbeing.

The development of social prescribing in Ireland has primarily been driven by the community and voluntary sector, in partnership with health services. Social prescribing services are now being delivered by 30 locations around the country by community-based organisations such as local development companies and family resource centres, supported by the HSE, Sláintecare and Healthy Ireland. The expansion of social prescribing is a commitment in the 2021 Programme for Government and is an action in many recent strategies and polices, including Sharing the Vision 2020-2030, the Sláintecare Implementation Strategy and Action Plan 2021-2023, and the Healthy Ireland Action Plan 2021-2025. As part of the newly established Healthy Communities Programme, an area-based approach to community health and wellbeing improvement targeting areas of disadvantage, social prescribing will be one a suite of health and wellbeing initiatives implemented. It is therefore an opportune time to explore how social prescribing can best be developed and integrated across the HSE to ensure services are effective and sustainable.

This framework has been developed to support the development of social prescribing within the HSE and sets out a common approach for its delivery across the organisation. It outlines the key elements of social prescribing services and provides guidance for how the HSE can work in partnership with the community and voluntary sector in order to best meet the needs of service users. Tailored guidance is offered for a range of HSE services, highlighting the roles we all play in realising a collective approach. The framework lays the foundations for the work that is required over the months and years ahead to develop and integrate social prescribing across the HSE, in close partnership with the community and voluntary sector. It complements the National Framework and Implementation Plan for Self-management Support for Chronic Conditions and the Model of Care for the Prevention and Management of Chronic Disease in Older People, along with numerous other strategies and action plans.

The publication of this framework is timely not only due to the current expansion of social prescribing services, but also due to the invaluable support social prescribing can offer to people most vulnerable to loneliness and social isolation, issues which have been accentuated during Covid-19. We would like to thank all the staff who contributed to its development, particularly the Social Prescribing Framework Steering Group, which included representatives from HSE Health and Wellbeing, Mental Health, Primary Care and Social Inclusion, as well as representatives from the community and voluntary sector and a service user. Key stakeholders also provided input and feedback and their participation and support have been critical. We look forward to partnership with the community and voluntary sector in the implementation of the framework, which will create a coherent and sustainable approach to the delivery of social prescribing services, leading to positive impacts on the health and wellbeing of people and communities.

Dr Philip Crowley
Dr Siobhán Ni Bhriain

SECTION 1
Background and Context

SECTION 1: Background and Context

Social prescribing is a means of enabling healthcare professionals and other professionals to refer people to a range of local, non-clinical services, primarily provided by the voluntary and community sector. The problems of social isolation, fear and loneliness and often associated inactivity have negative consequences for health and can particularly impact older age groups, those with chronic health problems, people with mental health difficulties and psychosocial needs, carers, single parents, migrant and immigrant and minority ethnic groups. Social prescribing began as a community-led movement that seeks to address these needs in a holistic way using an assets-based approach by empowering participants to improve their Health and Wellbeing.

This document was developed to support the development of social prescribing within the HSE. It sets out a common approach for the delivery of social prescribing across the organisation. It is primarily designed to support HSE staff and the community and voluntary sector involved in the delivery of HSE-funded social prescribing services. The document may also be of interest to a broader audience, including other funders of social prescribing beyond the HSE as well as any person or organisation with an interest in social prescribing.

A social prescribing service generally has a number of key components:

a) a referral from a healthcare professional/other professional or self-referral into the service

b) an intervention between the service user and a social prescribing link worker. The intervention can take up to eight sessions

c) supporting the service user to access local voluntary community and social enterprise organisations or services through discussion and joint decision making

d) measuring the impact of the social prescribing on the person, the wider community and the health service

Many different models of social prescribing exist. Social prescribing has been categorised as ranging from basic signposting through to what has been described as 'light', 'medium' and 'holistic' social prescribing (Kimerlee et al. (2016) cited in Polley, et al., 2017). These categories refer to the level of engagement that a social prescribing link worker has with a person. Most social prescribing services in Ireland fall into the category of 'holistic' whereby a social prescribing link worker spends a number of sessions with a person to assess their needs, support them and co-produce solutions to work towards an improvement in their health and wellbeing.

The core principles of social prescribing are that it:

- is a holistic approach focusing on individual needs and preferences
- recognises that people's health is determined primarily by a range of social, economic and environmental factors
- promotes health and wellbeing and reduces health inequalities in a community setting, using non-clinical methods (although may be alongside medical intervention)
- addresses barriers to engagement and enables people to play an active part in their health and wellbeing
- utilises and builds on the local community assets in developing and delivering the service or activity
- aims to increase people's control over their health and lives (Public Health England, 2019).

Evaluating social prescribing schemes can be challenging because of the complex and wide-ranging issues it seeks to address and the difference in social prescribing models and approaches (Drinkwater, Wildman, & Moffatt, 2019). A systematic review of non-clinical community interventions published in 2020 identified multiple benefits reported by participants and referrers directly engaged in social prescribing, including improvements in mental wellbeing, physical health and health behaviours and reductions in social isolation and loneliness (Chatterjee, Camic, & Lockyer, 2018). A number of evaluations have been conducted to date in Ireland demonstrating positive findings on participant health and wellbeing (South Dublin County Partnership, 2020; HSE, 2015).

In 2020, a randomised controlled trial took place in 13 GP practices in disadvantaged urban areas in Limerick, Cork, Waterford and Dublin run by the Royal College of Surgeons in Ireland (RCSI) and funded by the Sláintecare Integration Fund and the Health Research Board Ireland. The trial aimed to evaluate whether meeting a social prescribing link worker improved quality of life and mental health for people with multimorbidity. 240 people with multimorbidity participated in the trial. Due to the impact of COVID-19, the trial did not recruit as many participants as had been originally planned but there was a trend towards a positive impact. Interviewed participants were positive about the social prescribing link worker with 70% reporting a benefit and a further 20% finding it positive but limited due to Covid-19 (Kiely, et al., 2021).

Moreover, a review of the evidence assessing the impact of social prescribing on healthcare demand and cost implications was undertaken by the University of Westminster in 2017. This showed average reductions following referrals to social prescribing schemes of 28% in GP services, 24% in attendance at Emergency Departments (ED) and statistically significant drops in referrals to hospital (Polley & Pilkington, 2017). The publication of a Minimum Data Outcomes Framework for social prescribing by the HSE in 2020 will support and enable the development of a good quality evidence base for social prescribing in Ireland (HSE, 2020a).

Social Prescribing started in Ireland, like in most countries, as a ground up movement in partnership between the Health Service and the community and voluntary sector (Figure 1). Host organisations such as Family Resource Centres and Local Partnership companies have been instrumental in enabling the growth of social prescribing across the country. Social prescribing services are now available in over 30 locations around the country, supported by Sláintecare, Healthy Ireland and the HSE, always in partnership with community-based organisations such as

local development companies and family resource centres. In 2018, an All-Ireland Social Prescribing Network was established with the purpose of championing social prescribing so that it is valued, understood and sustained across the island of Ireland. The network includes representatives from the health service, academia and the community and voluntary sector North and South of the island of Ireland. (see Figure 1 social prescribing development in Ireland).

Most social prescribing services in Ireland are open to adults over the age of 18 years but social prescribing is evolving and growing at pace and in Ireland there is growing interest in social prescribing specifically for children and families. Similarly, in the UK, Public Health England recently launched a call for expressions of interest in relation to 'green social prescribing' geared towards linking people to nature-based interventions and activities (Public Health England, 2021). Finally, arts-based social prescribing is a growing area of interest in both the UK and Ireland.

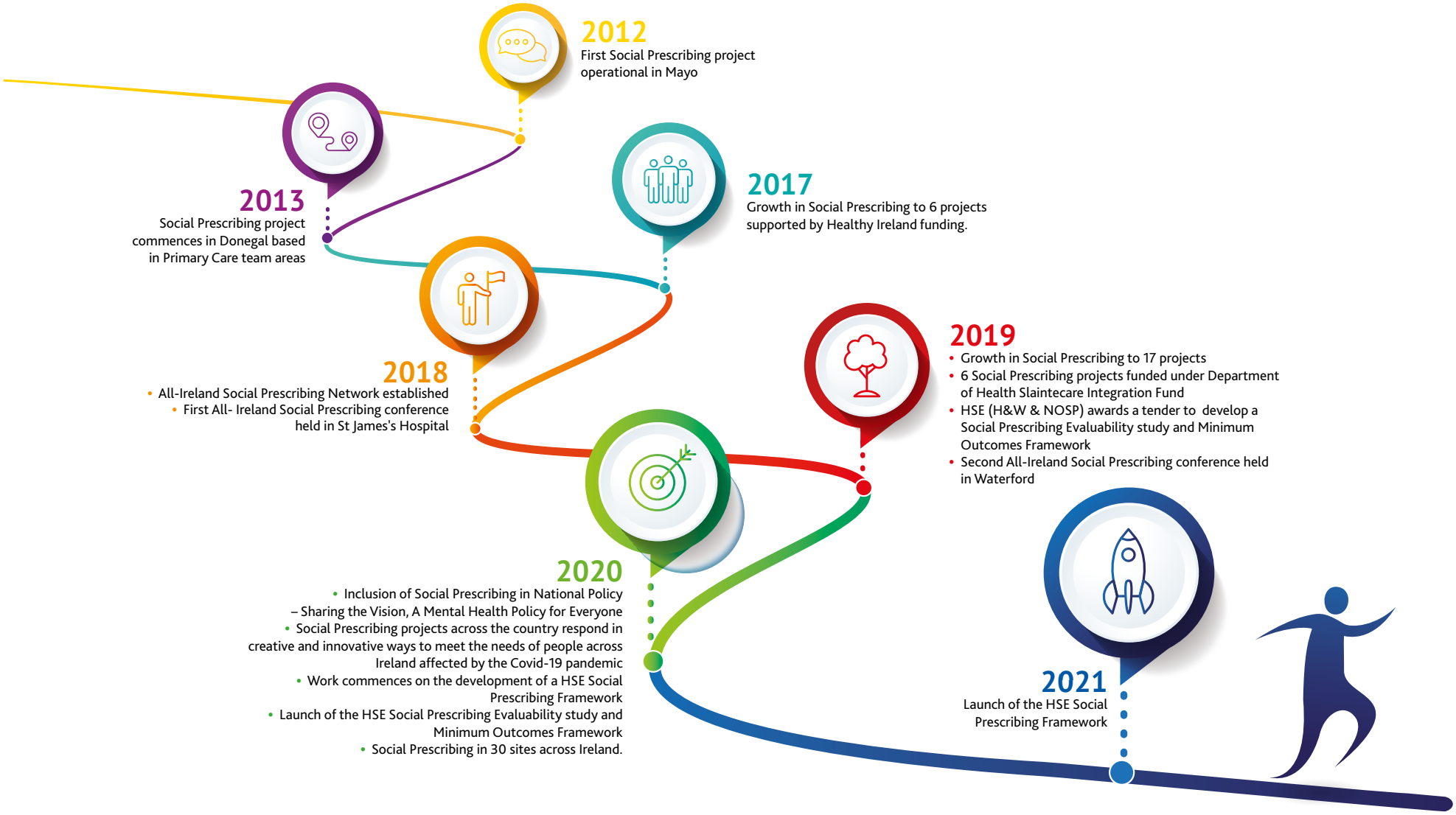


Figure 1: Social prescribing development in Ireland

Social prescribing has now gained a significant policy mandate. The 2020 Programme for Government includes an action to 'seek to expand social prescribing where patients are referred to non-clinical activities, as a means of positively influencing mental wellbeing' (Government of Ireland, 2020). Social prescribing is a key enabler emphasised in the revised mental health policy *Sharing the Vision 2020-2030* (Department of Health, 2020) as an effective means of linking those with mental health difficulties to community-based supports and interventions through the local voluntary and community sector.

In 2021, the HSE published the *HSE Psychosocial Response to the Covid-19 Pandemic* (HSE, 2020b) to address the need for a national health sector psychosocial plan in response to the pandemic. Social prescribing is particularly relevant to Level 1 of the framework focused on societal wellbeing, resilience and safety. Like many other services, social prescribing has had to adapt in order to quickly respond to the Covid-19 pandemic and provide an invaluable link to people most vulnerable to loneliness and social isolation or who have poor social supports. Although a relatively new service in many communities, social prescribing link workers have demonstrated important flexibility to respond differently to existing and new referrals.

Social prescribing is closely aligned with the HSE's transformation agenda in reorientation of the health service model of care towards a primary and community care approach of the 'Right Care, Right Place, Right Time' in line with the Sláintecare vision (Government of Ireland, 2017). The fact that six social prescribing projects nationally were funded as part of the Sláintecare Integration fund is evidence of the interest in social prescribing and the potential for it to support a cross-sectoral health and wellbeing reform agenda in line with the Sláintecare vision.

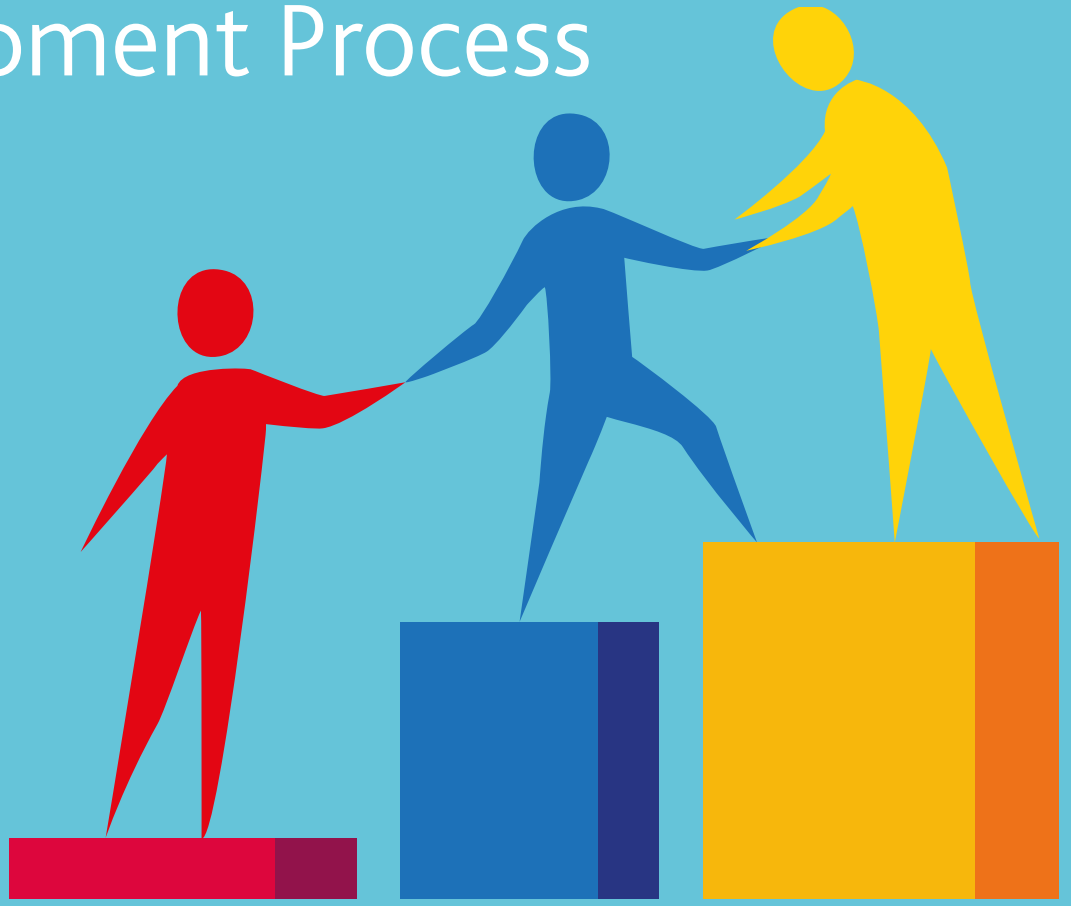
A firm indication of the HSE's commitment to the growth and development of social prescribing within the HSE was stated in the 2021 Service Plan (HSE, 2021), which includes the following priority: *Launch and implement the social prescribing framework for the sustainable development and integration of social prescribing across the HSE, in partnership with the community and voluntary sector*. In addition, in 2021, the Department of Health provided funding to HSE Health and Wellbeing to support the development of the Healthy Communities Programme – an area-based approach to community health and wellbeing improvement targeting areas of disadvantage. The roll-out of social prescribing will be one of a suite of Health and Wellbeing initiatives implemented across multiple sites as part of this programme.

Social prescribing can facilitate the achievement of a number of the high-level objectives in the *HSE Corporate Plan 2021–2024* (HSE, 2021) particularly following objectives 1, 2 and 4.[1]

The Healthy Ireland Strategic Action Plan 2021-2025 further strengthens the policy context for social prescribing (Department of Health, 2021).

1. Objective 1: Manage the COVID-19 pandemic while delivering health services safely to the public
   Objective 2: Enhance primary and community services and reduce the need for people to attend hospital
   Objective 4: Prioritise early interventions and improve access to person-centred mental health services

SECTION 2
Development Process



SECTION 2: Development Process

The development of the HSE Social Prescribing Framework commenced in 2020, led by the Mental Health and Wellbeing Programme within HSE Health and Wellbeing, Strategic Planning and Transformation. In September 2020, a Social Prescribing Framework Steering Group was established, whose role was to oversee the development of a Social Prescribing Framework for the sustainable development and integration of social prescribing across the HSE. Membership included representatives from HSE Health and Wellbeing, Mental Health, Primary Care and Social Inclusion as well as representatives from the community and voluntary sector including two social prescribing link workers and a service user.

The steering group guided all aspects of the framework development and met four times between September 2020 and May 2021. Between meetings, individual elements of the framework were advanced via virtual meetings and discussions between the Mental Health and Wellbeing Programme and individual steering group members. A wide range of stakeholders across the HSE and the community and voluntary sector were engaged to seek their views, input and feedback on particular sections of the document of relevance to their area of expertise. The broad range of stakeholder expertise and input was critically important in terms of informing the content of the document.

During the development of the framework, the HSE sought to learn from the NHS England experience, where social prescribing is now embedded in the primary care infrastructure across the country (NHS, 2019). To facilitate this shared learning, Craig Lister, who played a key role in advancing the development of social prescribing in England, was contracted to provide expert advice to the steering group during the development process.

SECTION 3
Delivery Model

SECTION 3: Delivery Model

Social prescribing services funded by the HSE will be delivered by community and voluntary organisations through grant aid agreements with the HSE. Variation in how social prescribing services operate locally is to be expected given that social prescribing builds on existing local assets unique to each community. Despite these local differences, there are essential elements that successful social prescribing services have in common (NHS England, 2020) (Polley, Fleming, Anfilogoff, & Carp, 2017) and therefore the key elements and guidance outlined in this framework are recommended as an essential part of grant aid agreements for all social prescribing services funded by the HSE.

The delivery model set out in this framework is based on a Community Healthcare Network (CHN)[2] structure that serves a population of 50,000 people. This is broadly in line with the population size many of the existing social prescribing schemes in the England serve (NHS England, 2020a). The delivery model outlined will also form the basis of how social prescribing will be implemented as part of the Healthy Communities Programme in areas of social and economic disadvantage across the country, due to commence in 2021. One full-time social prescribing link worker per CHN or Healthy Communities site is proposed as part of this delivery model.

Social prescribing link workers will be recruited, employed and hosted by community and voluntary organisations. They should ideally have a physical presence for 1-2 days a week in a local primary care centre or GP practice to facilitate relationship building and integration of the service within the primary care team.

2. A Community Healthcare Network will deliver Primary Health Care Services across an average population of 50,000. Each will consist of between 4-6 primary care teams involving GPs in the planning and delivery of services in a structured way. There will be 96 Community Healthcare Networks across Ireland.

SECTION 4
Referrals and Referral Pathway

SECTION 4: Referrals and Referral Pathway

The service user

Social prescribing is for adults over the aged of 18 years, including (but not exclusively) people:

- with one or more long-term conditions
- who need support with their mental health
- who are lonely or isolated
- who are frequent GP/ED attendees and may benefit from other social supports outside of clinical services
- who have complex social needs which affect their health and wellbeing.

Where a referrer is unsure of the appropriateness of a referral to social prescribing this can be discussed with the social prescribing link worker beforehand. Likewise the social prescribing link worker can revert to the referrer if the referral is considered inappropriate.

Referrals

Figure 2 illustrates the social prescribing referral pathway. Referrals to the social prescribing link worker come from various sources including for example GPs, nurses, community mental health teams, health and social care professionals, older people services, the community and voluntary sector as well as self-referral. A more detailed description of the alignment between HSE services and programmes is in section 5. The sample referral form is shown in Appendix 3. A system will be in place for feedback to the referrer and the GP of the service user with the consent of the service user.

Referral pathway

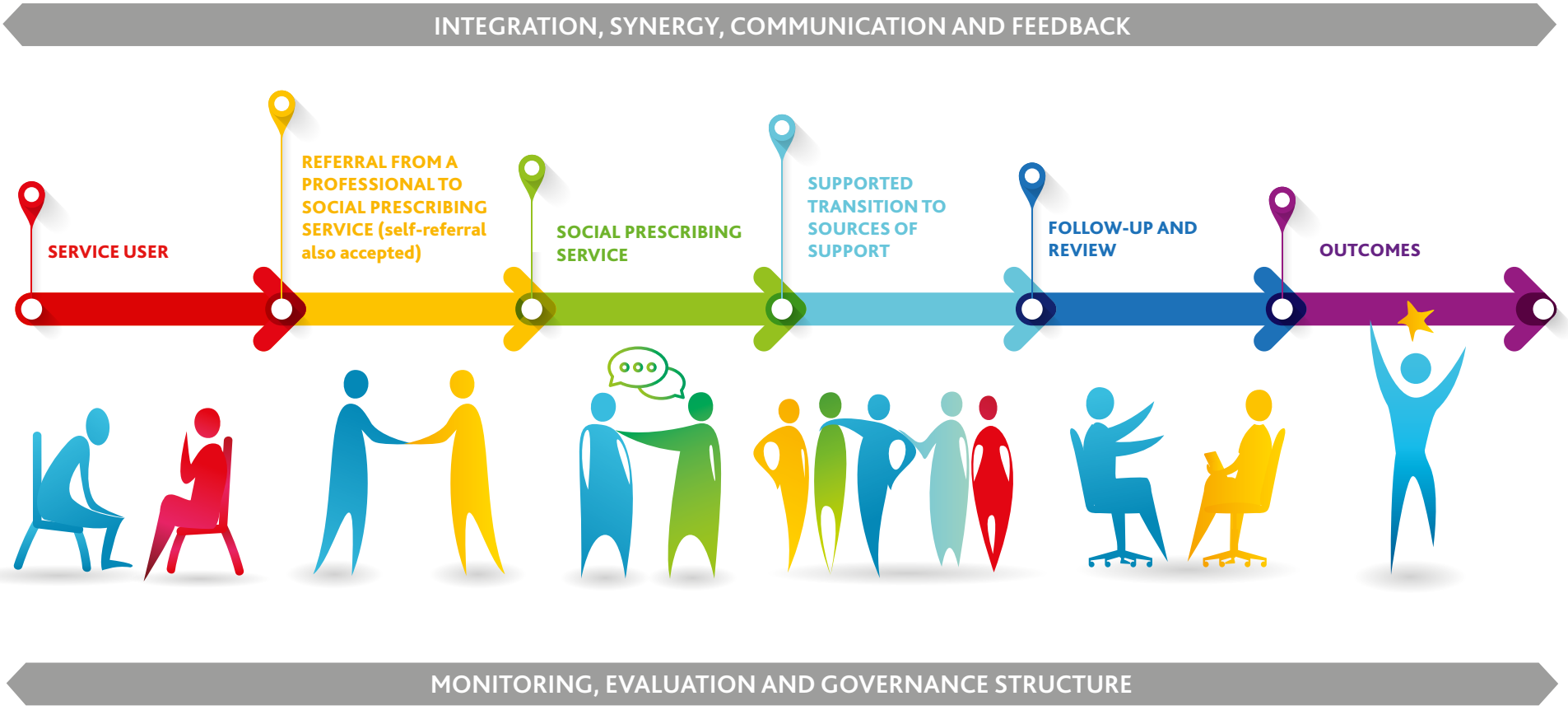


Figure 2: Social prescribing referral pathway

The social prescribing service and the social prescribing link worker

To fully address the social determinants of health the social prescribing link worker views the person not as a 'condition' or disability, but quite simply as a person (Polley, Fleming, Anfilogoff, & Carp, 2017). The focus is on 'what matters to the person' rather than 'what is the matter with the person'. The social prescribing link worker works in true collaboration with a person over a period of time, working together on their needs and goals using a personalised coaching and co-production approach. The social prescribing link worker can motivate and support individuals to achieve the change(s) that they want to achieve. It is important to highlight that social prescribing is not a replacement for adequate clinical services, nor is it a social work or counselling service.

The ultimate aim of the social prescribing link worker is to connect people with community groups, organisations and statutory services for practical and emotional support with the purpose of improving their health and wellbeing. They may also link people back into HSE programmes and services where appropriate, e.g. diabetes support courses, Living Well programme, stress prevention programmes or smoking cessation services.

The initial assessment requires on average two sessions and focuses on the co-design of a personalised health and wellbeing plan (see Appendix 1) which includes: what matters to the person, their goals, the support they may require and a summary of locally available options provided by the community and voluntary sector and the health service. Baseline questionnaires for evaluation will be completed at the initial meeting with the social prescribing link worker. If during the initial consultation it emerges that the person requires more support than social prescribing can provide, the social prescribing link worker will liaise with the referrer and refer the person appropriately.

The social prescribing link worker requires a broad range of skills to be able to work independently and proactively with people (Polley et al., 2017). They come from a wide variety of backgrounds, such as community development, health promotion, community education, social work, health and social care, among others. They have a mix of skills, experience and a range of personal qualities that they bring to the role. In addition, social prescribing link workers have excellent listening and communication skills, empathy, emotional resilience and can work in a person-centred, non-judgemental way across whole, diverse communities (NHS England, 2020). See Appendix 2 for a job specification template of the social prescribing link worker.

The current capacity of a full-time social prescribing link worker in Ireland is forecast to be approximately 120 new referrals per year in a well-established service. In the first year of a new service the number of referrals is likely to be an average of 100. This figure is based on the experiences of social prescribing link workers across the country, with an average of approximately 30 weekly contacts. Over a 12-month period, this equates to approximately 1,400 contacts. This includes initial assessments with new referrals and follow-up sessions with existing participants, and also includes face-to-face, phone calls and online support.

Supported transition to sources of support

The level of support each person will require in terms of engaging with local groups and organisations will vary. In some situations the social prescribing link worker may physically accompany the person to access their chosen option on the first occasion if they are lacking the confidence or motivation to do so.

The role of the social prescribing link worker involves dedicated time and resources to map the voluntary and statutory options and assets across their area, so they can co-develop a plan with the person based on their needs and preferences. They may also provide support and training to volunteers or community health workers to broaden the reach of social prescribing within the community. Another key aspect of the role will involve promoting the service with GPs and key HSE services and ensuring an integrated approach with the implementation of the Making Every Contact Count (MECC) programme and other Health and Wellbeing initiatives within the HSE.

The community and voluntary organisations and services that people are referred to are broad and diverse and depend on the existing options available locally. These include physical activity initiatives like parkrun or walking groups, reading groups/ books for health, library services, stress prevention/management programmes, self-help, adult education, men's sheds, community gardening, arts and creativity, and many more. Where there is an identified gap in community-based options available locally, the social prescribing link worker will work with local organisations to try to address this gap.

Follow-up and review

The social prescribing link worker typically has up to eight interactions (face-to-face or by phone, email, virtual meeting) with each person over a three-month period, although this may vary depending on the particular person's needs. Social prescribing is a short-term intervention empowering people to take an important step to improve their overall wellbeing, so once they have successfully engaged with their particular option and with their consent, their case is closed. It is always possible for a person to be re-referred or to re-refer themselves at a later point if the need arises.

Following the initial assessment, there is a follow-up phone call and sometimes a follow-up meeting to review how things are going. There may be weekly supportive follow-up phone calls depending on the particular needs of the individual. Baseline questionnaires for evaluation will be readministered post intervention. Feedback will always be provided to the referrer and GP (with permission of the person).

SOCIAL PRESCRIBING CASE STUDY 1

Gearóid, a 21-year-old man with spina bifida, was referred to the Waterford social prescribing service by his public health nurse following a hospitalisation. Gearóid was struggling mentally with isolation and a lack of meaningful activity in his daily life.

During the assessment process with his social prescribing link worker, he mentioned a passion for greyhounds and how he wished to pursue a career in greyhound training. Through her connections in the local community, the social prescribing link worker was able to link him in with one of the country's top greyhound racing trainers. She and Gearóid worked together to improve his self-esteem issues to get him to a place where he was comfortable to meet the trainer. The trainer supported Gearóid to learn the skills needed to become a racing trainer himself. Gearóid was then able to pursue his career in an area that he loved. His mood, overall quality of life and financial situation have all changed completely as a result of his involvement with social prescribing. Previously a shy person, Gearóid went on the national news to speak about his experience with social prescribing to mark International Social Prescribing Day in 2020.

Gearóid described his experience with social prescribing:
'I've something to get up now and do in the morning....I'm delighted, I love it to be honest... (social prescribing link worker) is wicked sound'.

SOCIAL PRESCRIBING CASE STUDY 2

Judy, is in her 60s, was referred by a colleague to the Adult Social Prescribing for Individual Resilience & Empowerment (ASPIRE) service run by Bray Area Partnership, as her wellbeing was affected by multiple stressors in her life, including physical health, family difficulties, low mood she struggled with for years, and the impact of Covid-19.

After positive engagement with social prescribing she joined a group online and had other opportunities for group support with the social prescribing link worker. Judy chose to engage with the HSE Living Well programme – a programme for adults with long-term health conditions, delivered online during the Covid-19 pandemic. To help her manage her anxiety further, Judy joined a relaxation group offered within the community. She remains positive about her progress and plans to commence an interactive online Wellness Recovery Action Plan and Stress Control programme soon.

Judy said of her experience:
'I think I was in darkness a lot of my life, you know. This was the start of lots of things for me... I have learned how to filter. I can stop and say 'Right what's happened here?'… To know what's going on in your head... it doesn't take away the stress… but it lessens it and then you're ready to face it. This whole thing is about talking to people and getting in there you know…. I'm able to converse with people without blushing now. Opening my mouth and not feel that I'm not relevant'.

SOCIAL PRESCRIBING CASE STUDY 3

Katie is a 49-year-old woman who lived with her father who had stage three Alzheimer's disease. She was feeling very isolated and tied to the role of carer. Feeling very low, she knew she needed to make changes in her life and wanted support to begin to develop herself and meet new people. In response to seeing a leaflet, Katie contacted the Flourish social prescribing service at the Family Centre in Castlebar, Co. Mayo.

At her first meeting with the social prescriber link worker, Katie described a range of feelings experienced in relation to her current situation of being at home in this role. She said she felt lost and missed many local activities that she had to give up, which was affecting her mental health. She described her feelings as such:
'All people see is the carer in me and I don't even know who I am anymore as I feel so tied into caring now and feel life is passing me by'.

Katie completed a Flourish six-week group programme called 'Discover your interests' and was referred to counselling in the community. She developed many new interests for example, attending a music circle, a regular meet-up group, and some creative courses in the community. She began to prioritise her own self-care and build in some outside help to free her up to attend activities. She was also considering a different career with the help of the local Educational Training Board.

'Social prescribing made such a big difference to me and my mental health. A year later when my dad passed away, I was already linked into many interests and people in my community. It came at the right time as I would hate to think where I would be if I had not made that initial phone call to Flourish'.

Evaluation

Outcomes

There is a need to provide a digital software platform to enable the collection of output and outcome data for social prescribing which will enhance the consistency and congruence of how information is collated and reported across the HSE-funded social prescribing services. Such a system will facilitate electronic referral, support case management, include a live database of all community options, and track the intervention and community-based options used. Evaluation tools to measure agreed evaluation outcomes and outputs will also be embedded within this software. HSE Health and Wellbeing is committed to procuring this software solution.

In September 2020, the HSE launched a Minimum Data Outcomes Framework for Social Prescribing in Ireland[3] (HSE, 2020). This framework provides a solid starting point for the evaluation of HSE-funded social prescribing services and identified a broad range of outcomes currently being reported by social prescribing services in Ireland which can be categorised as:

- Participant outcomes (the patient, the citizen, the resident)
- System outcomes (the health and social care system)
- Organisation outcomes (those organisations delivering social prescribing and also receiving referrals)

The framework proposed that the two critical outcomes central to social prescribing that should be measured are: personal wellbeing and social connectedness. Measuring both outcomes will require the use of validated tools, implemented at initial assessment and at agreed intervals. Examples of evaluation tools for measuring personal wellbeing are the WHO-5 Well-Being Index (World Health Organization, 1998)and the short Warwick-Edinburgh Mental Wellbeing Scale (NHS Health Scotland, University of Warwick and University of Edinburgh, 2008). The Social Wellbeing Scale (Keyes, 1998) and the Duke Social Support Index (Waridan, Robbins, Wolfersteig, Johnson, & Dustman, 2013) are examples of evaluation tools for measuring social connectedness.

These two minimum data outcomes represent a starting point for the systematic evaluation of social prescribing services in Ireland. Services should move beyond the minimum data outcomes and look at other additional outcomes if it is within their capacity to do so. Such outcomes could include reduction on health service utilisation: for example, GP appointments and presentation numbers to emergency departments. Further suggestions of additional outcomes to measure are available in the HSE Social Prescribing Minimum Data Outcomes Framework (HSE, 2020).

3. https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/building-capacity-for-the-evaluation-of-social-prescribing-evaluability-assessment.pdf

Outputs

To complement the outcomes outlined above and to encourage a consistent approach, data in relation to the following outputs should be routinely collected:

- Date of referral
- Demographics of service user
- Reasons for referral
- Who made the referral
- Contacts with social prescribing link worker
- Option that the person is linked to

Qualitative data

It is recommended that participant stories, testimonials and case studies be recorded to highlight the personal and human impact of the work. See HSE Minimum Data Outcomes Framework for further details (HSE, 2020).

SECTION 5

Aligning Social Prescribing with Existing HSE Services and Programmes

SECTION 5: Aligning Social Prescribing with Existing HSE Services and Programmes

Social prescribing has the potential to broaden the range of support that health professionals can offer to HSE service users and can be integrated within a wide range of health services and programmes. This section of the document provides an overview of how a range of HSE services can engage with social prescribing, although there is scope beyond these services too.

Health and Wellbeing

Health and Wellbeing services support the population to lead healthy lifestyles and enhance their wellbeing through implementation of Healthy Ireland, the overarching Government policy which provides a roadmap for achieving improved health and wellbeing for all in society. Staff delivering Health and Wellbeing services implement policy actions in relation to physical activity; healthy eating, mental health and wellbeing; alcohol; smoking cessation; staff health and wellbeing; sexual health; and positive ageing. They also partner with a wide range of community and voluntary organisations and networks such as Children and Young People's Services Committees (CYPSCs) and Local Community Development Committees (LCDCs). Health promotion and improvement officers, and other Health and Wellbeing staff as well as healthy city/county coordinators, can enable the uptake and reach of social prescribing across the wide range of community-based programmes and services, such as parenting programmes and walking initiatives.

In addition, social prescribing has the potential to reach those who are socially excluded and disadvantaged within communities and is a key programme within the Healthy Communities Programme targeting areas of disadvantage across the country.

Health and Wellbeing support on the implementation of the MECC programme is included in the integrated model of care for the prevention and management of chronic disease. MECC involves enabling health professional to recognise the role and opportunities they have in their daily interactions with patients to support them to make health behaviour changes. Social prescribing works best for people who may not have the confidence and skills at a particular time in their life to follow signposting advice after a MECC intervention. It helps to address the wider social determinants of health that could not be addressed in the context of a brief intervention with a health professional. Service users can be referred to social prescribing by health professionals who have delivered a brief intervention as part of their routine care as part of MECC implementation. A dedicated role of a MECC mobiliser is included in the Healthy Communities Programme to support the implementation of MECC across all health services and to embed prevention in the routine interactions with patients. This MECC mobiliser will work closely with the social prescribing link worker to ensure referrals of those who can most benefit from the service.

A key priority for health and wellbeing services is developing capacity to increase the ability and confidence of people with long-term health conditions to manage their health and to live well, through the implementation of the National Framework and Implementation Plan for Self-management Support for Chronic Conditions (HSE, 2020). This Framework provides direction for a collective shift in emphasis toward creating and enabling, supportive and transformative environments that put the patient first, realising the value of active participation and effective collaborative interactions between patients and healthcare staff. These principles are shared by social prescribing and healthcare professionals, and others involved in the care of people with chronic conditions who can be key referral agents to social prescribing.

Social prescribing can expand and develop the range of options available to health professionals to support people with chronic conditions to manage their condition and to cope with associated isolation, loneliness, anxiety and depression that often accompany chronic disease. Many non-clinical interventions are available in the community that can support people in making and maintaining healthy lifestyle choices and which can support self-management e.g. community based exercise programmes and peer-led cookery programmes for disadvantaged community groups such as Healthy Food Made Easy. Voluntary organisations, for example the Irish Heart Foundation, provide clinical supports for patients with chronic health conditions to enable them to self-manage their condition and which do not require a formal referral from a healthcare professional.

It is widely acknowledged that the prevalence of chronic conditions is significantly higher in people with lower levels of education and in lower socio-economic groups (Cockerham, Bryant, & Oates, 2017). Many patients in this category are often not able to avail of self-management programmes due to financial, social or personal factors. The National Framework for Self-Management Support recommends that social prescribing is developed to target such patients. In this context any information resources for social prescribing should consider health literacy needs.

Primary Care

It is estimated that around 20% of patients consult their general practitioner (GP) for what is primarily a social problem (cited in Polley & Pilkington, 2017). While healthcare professionals such as GPs are ideally situated to support their patients' clinical needs, they are not always equipped to help them with non-clinical issues. A resulting medical approach to non-medical problems can waste precious resources such as medication, manpower and time (Owens, 2020).

GPs, nurses and other members of the primary care team currently signpost patients to organisations and groups to support their 'non-medical' needs. However, workload pressures and the changing landscape of the community and voluntary sector make this difficult to sustain. This is where social prescribing can play a pivotal role in being the bridge between Primary Care and sources of support in the community. GPs have a strong and trusted relationship with many of their patients and their support of social prescribing and referrals into the service is a key dependency which will enable the successful mainstreaming of social prescribing within the HSE. 87% of participants from the RCSI trial said they would not have connected with a social prescribing link worker without a GP referral highlighting the importance of their role in terms of encouraging participation in social prescribing (Kiely, et al., 2021). There are many GP advocates of social prescribing in Ireland including the Deep End Ireland GPs and members of the Irish College of General Practitioners Sustainable Healthcare working group.

Nurses, particularly practice nurses and public health nurses, have a unique contribution to make in strengthening community-centred approaches to health and wellbeing in primary care and are uniquely placed to refer people to the service. In their respective roles they engage with a broad range of patients who may be socially excluded and would benefit from social prescribing including older people

who live at home, people with disabilities, expectant mothers and mothers who have recently given birth and members of the Travelling community and migrants.

Primary care based Health and Social Care Professionals (HSCPs) such as physiotherapists, occupational therapists, dieticians, social workers and others have been involved in active signposting of service users to community and voluntary organisations for many years as part of their holistic approach to health and social care. HSCPs are involved in the implementation of the Making Every Contact Count programme focused on supporting people to make healthy behaviour changes. Signposting works best for people who are confident and skilled enough to find their own way to community groups and services, after a brief intervention. This complements social prescribing when viewed in terms of 'as well as social prescribing' not 'instead of social prescribing' (NHS England, 2020).

There is a crucial role for HSCPs to promote and develop social prescribing, creating professional relationships with social prescribing link workers and promoting social prescribing as part of treatment plan options. The ways in which HSCPs will engage with social prescribing will vary according to their role. The hope is that HSCPs will champion social prescribing within their practice, work with social prescribing link workers to further embed holistic care into their roles and work with their local social prescribing link workers to build a picture of social prescribing opportunities applicable for their users (Royal Society for Public health, 2020).

The primary care team is often the main source of referral and it is vital that the team have an understanding of social prescribing to enable appropriate referrals and to this end social prescribing link workers need to establish and maintain relationships with referring health professionals. A period of time should be dedicated to this before the social prescribing service commences, although in reality building relationships and engaging with health professionals is an ongoing process. When working with health professionals within CHNs, the social prescribing link worker would ideally attend any primary care team meetings and/or other relevant meetings at CHN level in order to help facilitate relationships within the wider team and to facilitate referrals. Promotional resources will be developed at a national level to describe the role and function of the social prescribing link worker and the overall service.

Mental Health

Social prescribing services also supports people with mental health problems to access healthcare resources and psychosocial support, which can include opportunities for arts and creativity, physical activity, learning new skills, volunteering, befriending and self-help, as well as support with employment, benefits, housing, debt, legal advice or parenting problems.

Social prescribing has been quite widely used for people with mild to moderate mental health problems, with a range of positive outcomes, including enhanced self-esteem and reduced low mood, as well as social benefits. There is also a growing interest in social prescribing as a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with severe and enduring mental health problems as part of the Recovery agenda (Friedlii, Vincent, & Woodhouse, 2007).

Figure 3 outlines the layers of the HSE Psychosocial Response, where social prescribing will have a key role to play at all levels of the pyramid but especially levels 1-4. Participation in social prescribing at levels 1-3 may ensure that peoples' needs do not escalate into the next level. Social prescribing can also operate in the gaps between services. This can be at different stages including supporting individuals to manage their mental health and supporting those in the recovery phase where clinical services are less needed (Hassan, Giebe, & Morasae, 2020).

Figure 3: Covid-19 psychosocial response layered care framework.

Most social prescribing occurs in primary care and within the community setting and evaluations of these services from both Ireland and the UK identify benefits for patients with low-level mental health conditions such as anxiety or mild depression. GPs, Primary Care Psychology, Counselling in Primary Care and Jigsaw (over 18s) can all be key referrers into social prescribing.

In the Irish context there is anecdotal evidence from social prescribing services in Donegal, Waterford and Kerry which shows that social prescribing can be effectively extended to secondary mental health services as part of the recovery options available to adults availing of Community Mental Health Teams (CMHTs). An extensive nationwide consultation on how to provide a best practice standardised service was conducted in 2019 with staff, service users, their families and carers, of General Adult CMHTs. One of the key findings of this consultation highlighted that making direct links and/or signposting to wider community services and supports (including non-medical supports such as social prescribing) would be beneficial to both service users and their families and carers, to address any additional needs they may require that are not provided by the CMHT. This support was particularly important to include at the treatment and discharge planning stages of the care pathway. Some service users may require intensive support to access community-based groups and activities. The UK based Rotherham Social Prescribing Mental Health Service (Dayson, Painter, & Bennett, 2020) highlighted some useful learning for the Irish context in this regard.

CASE STUDY: ROTHERHAM SOCIAL PRESCRIBING MENTAL HEALTH SERVICE

In this project the local NHS Clinical Commissioning Group recognised that their existing primary care-based social prescribing service was unable to handle referrals from Community Mental Health Teams and that a 'holistic' service, tailored to the needs of secondary mental health services and their patients, was required to augment existing treatment pathways. A six-month pathway was developed in consultation with the CMHT to support the transition from secondary mental health services to community-based activities. It enabled CMHTs and social prescribing link advisors to work together alongside a patient for a period of ten weeks to ensure they are ready to engage with community-based activities.

The evaluation concluded that:
'This model helped patients build the confidence of service users and reduce reliance and dependence on service provision; enabled them to become enthused by an activity; and provided opportunities to retain and enhance their involvement, including through participation in peer-to-peer support networks and by becoming volunteers supporting subsequent cohorts. The key enabling mechanism within the social prescribing service was this supportive model of transition from secondary mental health services to community-based peer-led support' (Dayson, Painter, & Bennett, 2020).

Occupational therapists (OTs) on the CMHT team will be a key contact for the social prescribing link worker. OTs are key champions of service user recovery goals in relation to engagement in their meaningful occupations at home, work, education and in the community. Referral onto social prescribing following the occupational therapy intervention may support transition to community services and supports when the service user is discharged from the community mental health services.

In some cases, mental health peer support workers could be a bridge between the service user and the social prescribing service at a local level to support the transition from secondary mental health services to community-based activities. Peer support workers are typically individuals who have had personal lived experience of mental health issues and are generally employed in a professional role to use their expertise and experience to inspire hope and recovery in others who are undergoing similar mental health experiences.
For social prescribing to be a support to users of mental health services the following points are important:

- The relationship between the social prescribing link worker and the CMHT team is crucial. The potential of the social prescribing link worker to attend part of a CMHT team meeting has proven beneficial in some social prescribing services and CMHTs should be open to adopting this approach.
- Information on the social prescribing service should be included in the discharge plan.
- An agreed referral pathway, criteria and the referral process is essential.

The principles of recovery and social prescribing are very much aligned in term of the focus on a social model of health which is holistic, person-centred and embraces a salutogenic focus on enhancing positive mental health and quality of life so that people can flourish emotionally, psychologically and socially. Social prescribing could be integrated as a feature of local recovery services and supports once service users are discharged from specialist inpatient services back to the community. Again, peer support workers could have a key role working in collaboration with the social prescribing link worker to enable individuals on their recovery journey to participate and engage in social prescribing. Where peer worker roles do not exist or where demand exceeds their capacity, recruitment of trained volunteers through the local volunteer centre could be considered.

Recovery colleges are places where people who use mental health services and those who support them create and facilitate recovery education courses along with mental health professionals. The goal of the recovery college is to create a culture of recovery and to empower people with mental health difficulties, families, friends and the broader community to improve quality of life and to promote community involvement through the provision of co-produced and co-facilitated learning and conversation. Social prescribing inputs and content could be incorporated into recovery education courses to raise awareness among participants about the role of social prescribing and how to access it.

Acute Hospitals

Social prescribing can also be applied in the acute hospital setting. Already some early discussions have taken place to explore the potential of the Ambulance Service being a referral source. The case study below from St James's Hospital, Dublin is the first project to have a social prescribing link worker based in a hospital setting and was initiated in May 2020 in the height of the COVID pandemic.

CASE STUDY: HOSPITAL BASED SOCIAL PRESCRIBING SERVICE IN ST JAMES'S HOSPITAL DUBLIN (McGowan , et al., 2021).

The Mercer's Institute for Successful Ageing (MISA) at St James's Hospital, Dublin with financial support from Sláintecare appointed a Social Prescribing Link Co-ordinator to support the patients availing of this service. Both inpatients and outpatients are identified through usual clinical practice by any member of the multidisciplinary team of doctors, nurses, physiotherapists, occupational therapists, social workers, speech and language therapists, Home First Team in the MISA.

As part of the comprehensive geriatric assessment, the patient's psycho-social situation is assessed and where a need is identified the person is referred to the social prescribing link co-ordinator for further assessment and appropriate referral by any healthcare professional. A **Local Asset Mapping Project (LAMP)** web-based tool was developed as part of this project to connect patients attending St James's Hospital with the community assets surrounding the hospital that can contribute to the health and wellbeing of the 200,000 people living in the hospital catchment area. Project evaluation is currently underway and there will be valuable learnings from this project that could be applied to other acute hospitals settings across the country.

Older Person's Services

Older people's health and care needs are changing, as increasing numbers live with the combined effects of chronic disease or disability, social isolation, loneliness and poor mental health (Turner, Donoghue , & Kenny, 2017). Additionally, post Covid-19 high levels of deconditioning in older adults are expected with associated increases in falls etc. Figure 4 depicts the potential benefits of social prescribing for older people (Drinkwater, Wildman, & Moffatt, 2019).

Figure 4: Potential benefits of social prescribing for older people

Social prescribing is now embedded as part of the Integrated Model of Care for the Prevention and Management of Chronic Disease in older people (HSE, 2020) which will ensure that referral pathways to social prescribing will be embedded as part of the standard of care for the four major chronic diseases that affect older people in Ireland: cardiovascular disease, type 2 diabetes, chronic obstructive pulmonary disease (COPD) and asthma. The strategic direction for Older Person's Services set out in the HSE Service Plan 2021, is to deliver a new model of integrated, older person services, supporting people to be cared for at home and in their communities, across a care continuum. Social prescribing can support this goal in a number of ways for example:

- At CHN level the HSE Home Support Service could refer older people who would benefit from social prescribing to the social prescribing service.
- Social prescribing along with MECC will be one of the foundation stones of the Get Up Get Dressed Get Moving campaign, a campaign focused on encouraging older people to get up and get dressed each day and become more physically active.

Social Inclusion Services

A number of groups face higher risk of poverty and social exclusion compared to the general population. These vulnerable and socially excluded groups include but are not limited to: migrants and ethnic minorities (including Roma), Travellers, homeless people, ex-prisoners, people with alcohol and drug problems and those experiencing domestic violence. The challenges these groups experience are translated into homelessness, unemployment, low education, and subsequently, their further exclusion from society. HSE Social Inclusion aims to reduce inequalities in health and improve access to mainstream and targeted health services for vulnerable and excluded groups in Ireland. It provides a range of services to support vulnerable groups and works closely with different sectors and organisations to improve the health of vulnerable persons. The work is underpinned by the social determinants of health and current programmes of work underway in HSE Social Inclusion are focused on further developing peer support/peer health models; supporting service user involvement; and improving screening, referral and access to services.

Targeted approaches, and continued commitment to targeted work, are an effective way to reach particular groups, see figure 5. Those from socially excluded groups may need to overcome barriers to build engagement. Many may be unaware of the numerous services they can access that may benefit them. Providing outreach and utilising community development approaches, may create awareness of social prescribing and strengthen communities to engage with services.

Some groups may experience barriers specific to them which might make inclusion in mainstream activities difficult, such as language barriers or a fear of experiencing stigma or racism from others attending mainstream interventions (HSE, 2018).

Not all service users will be familiar with local community groups and structures. Identifying opportunities for peer support and networking will particularly benefit migrant groups who may fear accessing services or activities due to language or cultural barriers. Partnership working between the social prescribing service and non-governmental organisations (NGOs) who have established relationships with socially excluded communities will be important to enable service users to engage with social prescribing and identify further pathways for referral. Additionally, engagement with local 'champions' can promote the benefits of social prescribing.

The social prescribing link worker will need to be mindful of the barriers socially excluded groups may experience in terms of availing of social prescribing. For example any costs associated with participating in community-based activities may preclude participation. Similarly, transport to and from community-based activities can be an issue for some service users due to their rural location. Provision of information in plain English and considering interpretation and translation needs will further support access to social prescribing. Individuals who are presenting with limited or no social supports will require more assistance to maximise their involvement in activities.

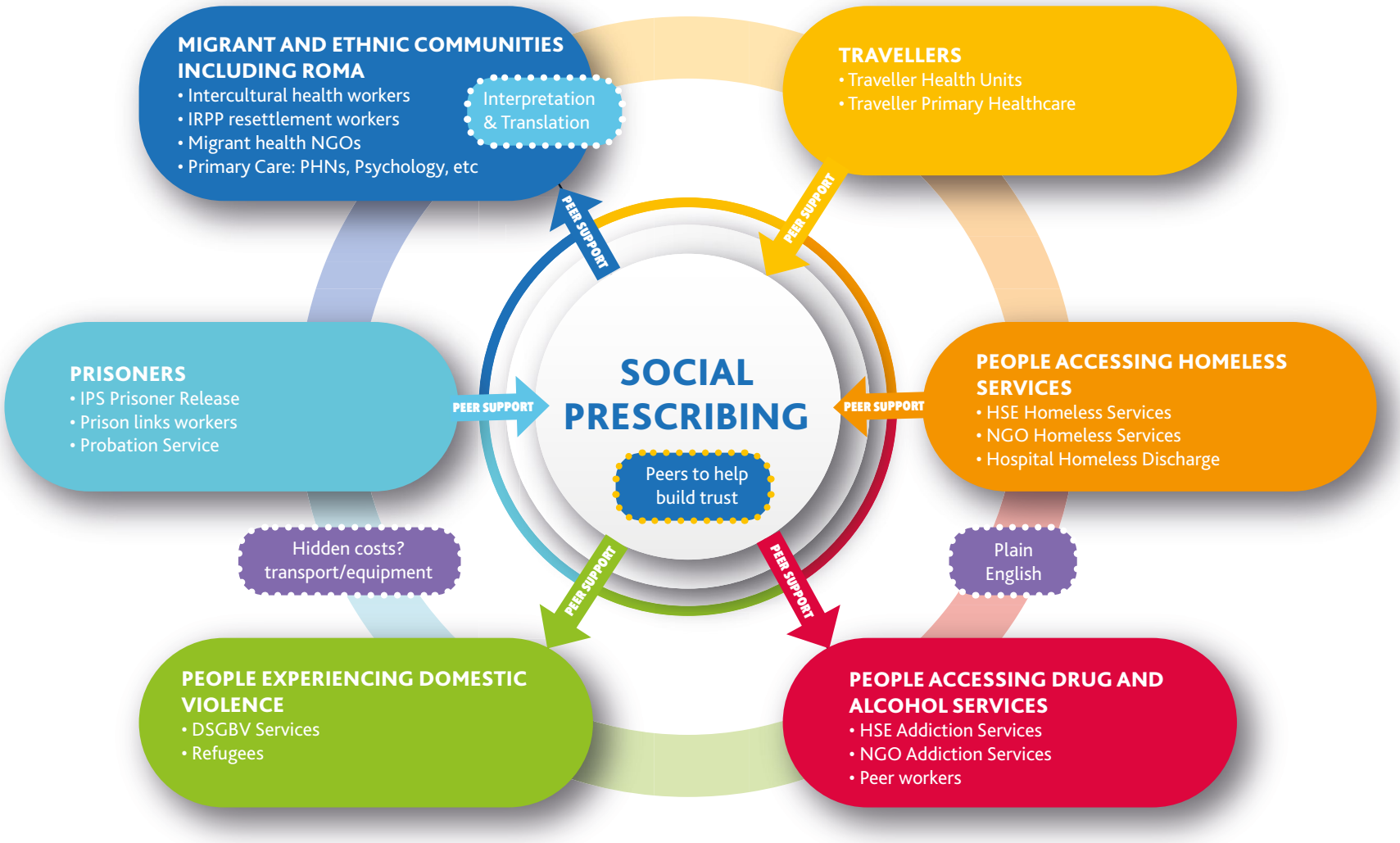


Figure 5: Routes to social prescribing from social inclusion services

SECTION 6
Implementation

SECTION 6: Implementation

Governance and accountability

HSE Health and Wellbeing will provide the strategic direction for social prescribing in the HSE and provide a range of supports including national training and evaluation support.

Oversight for social prescribing sites that are part of the wider Healthy Communities programme will be provided by the national Healthy Communities Steering Group, and governance will rest with CHOs through grant aid agreements. The Healthy Communities Steering Group will oversee the development and implementation of social prescribing in targeted areas of disadvantage along with other key Health and Wellbeing programmes.

At a local CHO level the Head of Service for Health and Wellbeing will be the lead for social prescribing and will commission the host organisation. A Healthy Community Co-ordinator based in Health and Wellbeing will manage and oversee the grant, as well as chairing a regional social prescribing link worker group to share learning, experiences and issues. He/she will also be responsible to ensure that monitoring and evaluation processes are in place. The Healthy Community Coordinator will be a member of the LCDC Healthy Communities subgroup which will report to the LCDC.

A health promotion and improvement officer will provide operational support to the social prescribing link worker at CHN level. This will include facilitating introductions to the HSE programmes and services locally and the provision of general support promoting referral pathways and an integrated approach. An integrated and collaborative working relationship with the MECC support within Health and Wellbeing will be crucial to ensure a joined up approach at local level. The health promotion and improvement officer will attend the regional social prescribing link worker meetings.

Funding

Social Prescribing is currently funded from a variety of sources including the HSE, the Department of Health, Healthy Ireland and Sláintecare Integration funds as well as the community and voluntary sector. The Healthy Communities Programme will provide a sustainable long-term funding model for social prescribing in targeted areas of disadvantage. HSE Health and Wellbeing will advocate for the sustainability and expansion of social prescribing in other areas through the annual estimates process in the HSE.

Implementation approach

Implementation of the HSE Social Prescribing Framework will commence in 2021. The first phase of implementation will be across 19 sites as part of the Healthy Communities Programme. The second phase of implementation will see further expansion of social prescribing to additional Healthy Communities areas, as well as other communities in Ireland. A detailed implementation plan will be developed by the National Implementation Group for the HSE's Mental Health Promotion Plan, which will be published in 2021. This will result in extensive mainstreaming of social prescribing within the HSE.

SECTION 7
Quality Assurance

SECTION 7: Quality Assurance

The term 'quality assurance' means maintaining a minimum level of agreed quality of support and service by constantly measuring the effectiveness of the organisations that provide it. In the case of Social prescribing this means:

- the model of social prescribing and the referral pathways and processes therein
- the social prescribing link workers and their competency to deliver a social prescribing service
- the providers to which people are linked to during or at the end of the service.

It is necessary to ensure that community groups have support with all relevant aspects to ensure both people and social prescribing link workers are safe. 'We view social prescribing as equitable to any other prescribing, therefore, it needs to show equity in terms of appropriate levels of quality, evidence and outcomes' (Quality Assurance for Social Prescribing, Lister, 2019). This includes, but isn't limited to, appropriate insurance, safeguarding, lone working, first aid, data protection, food safety and working with vulnerable citizens. All referral agencies and statutory bodies need to have an honest and transparent relationship with community and voluntary organisations to support and reduce risk to people, social prescribing link workers and organisations in the community and voluntary sector (NHS England, 2020).

The culture of risk aversion in statutory agencies can prevent innovative community initiatives from getting off the ground. Health and Wellbeing nationally will develop further guidance in relation to this.

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APPENDICES

Appendix 1: Sample of Personalised Health and Wellbeing Plan

Name and contact details for person:

PART ONE – TO BE COMPLETED TOGETHER AT THE START

What matters to me

How best to support me: what people need to know about me and my life

Any health conditions that agencies need to know about

My goals:

Summary of support that I am being connected to, including what I can expect from support

What I can do to support myself to meet my goals:

Review – when will we check in to how it's going?

PART TWO – TO BE COMPLETED AFTER 3 MONTHS

What changes have taken place?

I am happy to share my personal story? Yes ☐ No ☐

I am willing to complete a satisfaction survey? Yes ☐ No ☐

I am happy to participate in ongoing data collection and evaluation? Yes ☐ No ☐

Appendix 2: Social Prescribing Link Worker Job Specification

Social Prescribing Link Worker

Job specification and terms and conditions

Job Title and Grade	Grade V – social prescribing link worker
Taking up Appointment	Start date will be indicated at Job Offer stage.
Tenure	Grade V – social prescribing link worker
Remuneration	The Salary scale for the post is: €43,628; €45,019; €46,408; €47,797; €49,186; €50,797; €52,402 LSIs
Working Week	The standard working week applying to the post is 37 hours.
Annual Leave	The annual leave associated with the post will be confirmed at job offer stage.

Purpose of the post

Social prescribing generally involves three key components: – i) a referral from a healthcare professional, ii) a consultation with a social prescribing link worker and iii) an agreed referral to a local community activity or programme or service delivered by the Health Service or other organisation. A Social Prescribing service empowers individuals to take control of their health and wellbeing by referral to a social prescribing link worker who adopts a holistic approach to assessment of their needs. Social prescribing link workers work in true collaboration with individuals over a period of time, assessing their needs and concerns and developing a person-centred health plan based on these needs.

The ultimate aim of the social prescribing link worker is to connect people to community groups, organisations and statutory services for practical and emotional support with the overall purpose of improving health and wellbeing and improving social support. Social prescribing link workers support existing groups to be accessible and sustainable and working collaboratively with all local partners identify gaps and needs regarding particular groups or interests. Referrals to the social prescribing link worker come from various sources, including for example GPs, primary care teams, community mental health teams, community dieticians and older people's services and the community and voluntary sector organisation as well as self-referral.

Social prescribing can help to strengthen community resilience and personal resilience, and reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people's active involvement with their local communities. It particularly works for people with long-term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which affect their wellbeing.

Principal duties and responsibilities

Work on a one-to-one basis with individuals to improve health and wellbeing

- Work with individuals on a one-to-one basis, complete needs assessment and co-produce a plan to improve health and wellbeing through social prescribing.
- Provide non-judgemental support, respecting diversity and lifestyle choices working from a strength-based approach.
- Book appointments with individuals, meet them personally, follow-up cases and manage case load remaining as a point of contact and support throughout the individual's social prescription.
- Support and encourage individuals to access appropriate services in their community. Where appropriate, physically introduce people to community groups, activities and statutory services, ensuring they are comfortable. Follow-up to ensure they are happy, able to engage, included and receiving good support.

Work in partnership with health professionals and the Community and voluntary sector

- Build relationships with key staff in GP practices, members of the primary care teams within the local Community Healthcare Networks including dieticians, occupational therapists, mental health professionals, psychologists, social workers among others. Attending relevant meetings, becoming part of the wider network team, giving information and feedback on Social Prescribing.
- Develop supportive relationships with local community organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.
- Work closely with the HSE health promotion and improvement officer to support the ongoing development of the programme taking an active part in reviewing and developing the service and contribute to business planning.

- Build and maintain a comprehensive database of local community groups, resources and services and ensure information on sources of voluntary and community support is up to date at all times to enable effective and accurate supported access and linking of individuals with services
- Work with local partners to identify unmet needs within the community and address gaps in community provision.
- Work in partnership with all local agencies to raise awareness of social prescribing and how partnership working can reduce pressure on statutory services, improve health outcomes and enable a holistic approach to care.
- Provide referral agencies with regular updates about social prescribing, including information for their staff and how to access information to encourage appropriate referrals.
- Gather regular feedback and develop reports on the quality of service and impact of Social Prescribing on referral agencies.
- Ensure that local community and voluntary organisations being accessed have basic procedures in place for ensuring that vulnerable individuals are safe and, where there are safeguarding concerns; work with all partners to deal appropriately with issues in line with the HSE Framework for Social Prescribing.

Monitoring and evaluation

- Work sensitively with clients to administer evaluation tools in order to capture key information, enabling tracking of the impact of social prescribing on participant health and wellbeing and other outcomes measures.
- Document and report case notes and social prescriptions in online Social prescribing software.
- Provide progress reports and presentations to oversight groups and funders detailing the progress of the service.
- Develop effective and tailored referrals and feedback protocols to GPs and partners in CHNs.
- Populate and maintain social prescribing software.

Professional development

- Undertake continual personal and professional development.
- Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.
- Access external supervision as a mechanism of professional support

The above job description is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.

Eligibility criteria

Qualifications and/or experience

Eligibility criteria
Educated to degree level in Social, Community, Health or related field;
Or
A 3rd Level qualification in a Social, Community, Health or related field;

Health
A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.

Age
Age restrictions shall only apply to a candidate where he/she is not classified as a new entrant (within the meaning of the Public Service Superannuation Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age on the first day of the month in which the latest date for receiving completed application forms for the office occurs

Post specific requirements

- A minimum of 3 years' experience in a community development OR healthcare OR related field
- Experience of supporting people in a one-to-one or group capacity
- Experience of partnership/collaborative working and of building relationships across a variety of organisations

Other requirements specific to the post

Access to transport

Skills, competencies and/or knowledge

Knowledge and Experience
- Reducing health inequalities and proactively working with people with diverse needs from all communities to improve health and wellbeing
- Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities
- Working from an assets-based approach, building on existing community and personal assets
- Knowledge of the structure of the HSE and the health services provided at Community Healthcare Network level
- Working with the needs of small community groups and ability to support their development

- Ability to work to policies and procedures, including confidentiality, safeguarding, information governance, and health and safety
- Excellent IT skills
- Experience of data collation and reporting.

Communication and Interpersonal skills

- Listening and empathising with people and provide person centred coaching and support in a non-judgemental way
- Supporting people in a way that inspires trust and confidence, motivating others to reach their potential
- Organising, planning and prioritising on own initiative, including when under pressure and meeting deadlines
- Building and maintaining relationships with a variety of stakeholders including with people, their families, carers, community groups, GPs, health professionals and other stakeholders.
- Presenting information in a clear and concise manner
- Working both independently and collaboratively within a team and multi stakeholder environment
- Flexibility, adaptability and openness to working effectively in a changing environment

Evaluating information, problem solving and decision-making

- Analysing and interpreting information, develop solutions and contribute to decisions quickly and accurately as appropriate
- Identifying risk and assess/manage risk when working with individuals
- Understanding when it is appropriate or necessary to refer people back to other health professionals/agencies, when what the person needs is beyond the scope of the social prescribing link worker role – e.g. when there is a mental health need requiring a qualified practitioner.

Commitment to a quality service

- Appreciating the importance of working with clients with diverse needs in an empathetic, non-judgemental, empowering manner.
- Promoting and maintain high work standards
- Providing a quality and professional service to internal and external stakeholders
- Developing own knowledge and expertise.

Campaign specific selection process

Ranking/shortlisting/interview

A ranking and or shortlisting exercise may be carried out on the basis of information supplied in your application form. The criteria for ranking and or shortlisting are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements.

Failure to include information regarding these requirements may result in you not being called forward to the next stage of the selection process.

This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.

Appendix 3 - Sample Referral Form

Gender: Male ☐ Female ☐

Date of birth: Ethnicity:

Home address:

Eircode:

Lives Alone: Yes ☐ No ☐

Home Telephone:

Mobile Telephone:

Emergency Contact Name:

Contact Number:

No of Clinical Attendances in last 12 months (if known)

Reason for Referral

Consent given by client/patient to make this referral ☐

REFERRER INFORMATION

Referred by:

Profession:

*Telephone:

* Email:

FOR ENQUIRIES CONTACT orla.walsh7@hse

Designed by Elizabeth McLoughlin, mcloughlin.elizabeth@gmail.com