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Research Article

Social Prescribing Data and Outcome Recording Practices: An Interview-Based Study Into the Opinions and Experiences of Social Prescribing Stakeholders in the Liverpool City Region, UK

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Background: Social prescribing (SP) is a system-wide approach to reducing health inequalities through nonclinical healthcare interventions. The aim of this study was to explore the practices undertaken and the opinions held by various stakeholders involved in SP in relation to data collection and information utilisation within and between SP programmes/schemes.
Methods: Semistructured interviews were conducted with nine stakeholders involved in SP planning and delivery within the Liverpool City Region (LCR), including SP link workers, service managers and commissioners. A deductive thematic analysis approach was used to analyse the transcripts.
Results: Three themes were identified pertaining to quantitative data recording, qualitative data recording and the utilisation of data. The interviews revealed considerable variations in systems and consistency of data collection among stakeholders. While some data were collected via existing outcome measurement tools, their adequacy for use within SP in particular was critiqued. Case studies and qualitative feedback (formal and informal) were more frequently used and were felt to be more effective in capturing impact. Strengths of data sharing included the creation of data intelligence to inform more targeted service provision. Knowledge of national guidance pertaining to SP data collection and outcome recording was lacking.
Conclusion: Further research on the acceptability of incorporating further SP-specific indicators within commissioner reporting systems is needed, including formal acknowledgement of qualitative impact reporting on existing, quantitative health inequality indicators or key performance indicators. However, the burden of this on existing structures needs to be assessed. Support for data linkage arrangements and data recording processes, combined with wider routine outcome data recording, can support a targeted approach to increasing the evidence base for SP's impact on health and wellbeing.

1. Introduction

Social prescribing (SP) can be broadly defined as the non-clinicalcommunity-based support individuals can receive in response to nonmedical, health-related social needs or the wider determinants of health affecting them [1–3]. Routes into SP pathways vary. In England, as with many countries, general practitioners (GPs) and other professionals in all sectors of health and social care can refer people with physical and mental health-related concerns into services outside of traditional medical treatment [1, 2]. This forms the initial connection with a SP link worker (SPLW), who is charged with discussing their situation, identifying suitable activities and supportive services and coproducing a social prescription to improve health and wellbeing and strengthen community connections [4]. These services vary considerably in number, size, set-up and style across the health, voluntary, community and social enterprise sectors [5]. As a result, SP providers are incredibly diverse. Some providers go further to incorporate local community building into their schemes' model, working to develop community assets (forming new connections, groups and activities) as they work towards improving the health and wellbeing of individuals [6].

The National Health Service (NHS) England Long Term Plan, first published in 2019, sets out the policy commitment to personalised care for the population in England [7]. Its comprehensive model for personalised care describes six distinct components to supporting the health and wellbeing of all individuals and communities: shared decision making, personalised care and support planning, enabling choice, SP and community-based support, supported self-management, and guidance on personalised health budgets. The population-level tier included universal factors to support overall wellness, including but not limited to SP.

In 2020, NHS England produced a common outcomes framework to generate consistent data capture and reporting methods within SP [3]. The framework was developed across multiple iteration cycles with stakeholders from across healthcare, public health, academia, the voluntary, community and social enterprise (VCSE) sector and local authorities. After defining "what good social prescribing looks like" (p8-11) for individuals, communities and health and care systems, outcomes were created pertaining to these three categories [3]. Improvements to wellbeing, connection to others and degrees of loneliness or isolation experienced, physical activity and feelings of control over one's life were factors included for measuring the impact on people. While capturing capacity-building within communities was the primary focus for the related outcomes, reduction in primary care attendance, accident and emergency (A&E) visits, hospital stays and medication prescription formed the key system outcomes. Looking at nonsystem outcomes to monitor the success of SP schemes has been widely encouraged within the literature [8], and their omission in the common outcomes framework has been attributed to the relative ease of collecting data on hospital admissions and GP attendance over other wellbeing metrics [9]. This can be seen within the suggested data capture tools for all three categories with the most comprehensive tools pertaining to system outcomes [3].

Taking into consideration the infrastructure required for tailored SP pathways, it is evident that a strong and capable VCSE sector is critical to the successful implementation of SP in every region. NHS England and NHS Improvement's joint report into national experiences of SP highlighted several factors that influenced their successful involvement within SP schemes [5]. They included the financial health of the local authority and NHS; the quality of collaboration between VCSE organisations; the extent of the "established relationships" between themselves and statutory bodies within the health sector and local authorities; and the state of existing relationships between NHS bodies covering their area such as primary care networks (PCNs) and integrated care boards (ICBs, which replaced clinical commissioning groups across NHS England in July 2022 [10]). The interconnectedness of SP pathways poses challenges to establishing causality of outcomes and identifying the precise scheme components at play. Doing so is often difficult and resource-intensive. For this reason, there remains limited research on health outcome measures and the overall impact SP schemes have and are having on improving health and wellbeing and reducing health inequalities among the population.

Some organisations have tried to look at the tacit outcomes to establish scheme impact. Recent evidence reviews of outcomes for SP by the UK's National Academy for Social Prescribing [11–13] displayed overwhelmingly positive outcomes such as decreased loneliness and improvements in mental health. Use of psychosocial outcomes was most prevalent compared to overall health outcomes. Some wider determinants of health (such as housing, work and education) were noted, but the reviews did not find studies reporting on others (such as welfare, legal and crime). The reviews also acknowledged issues around appropriate measure selection (leading to unintended bias), patient drop-out rates and drop-out data points being poorly accounted for in relation to outcomes reported. Though the evidence collated covered a period of time where "crisis response" SP was implemented because of the COVID-19 pandemic—namely, an intentional shift for many providers to an immediate, acute response model with short-term outcomes [14, 15]—the evidence reviews and briefing built on the findings of previous work [16] and have their place in providing an important overview of the current landscape. One example of a novel initiative developed in 2022 (after the briefing's publication) is the Flourish Wellbeing Hub, created with a specific focus on addressing legal and welfare concerns within a SP model [17].

Despite the growing evidence base for SP, more research is needed to understand how outcomes can be appropriately captured by services working on the ground [18]. The findings reported in this paper form part of a broader interview study which explore the practices undertaken and the opinions held by various SP stakeholders within a combined authority area in North West England on data and outcome measurement. This paper focusses particularly on data collection and information utilisation within and between SP programmes/schemes.

2. Materials and Methods

2.1. Study Design. This study adopted a qualitative research method, applying a deductive thematic analysis approach [19] to place the findings within the context of existing understandings of data collection of key outcomes associated with SP. Semistructured interviews were conducted with stakeholders involved in the planning and delivery of SP within the Liverpool City Region (LCR). The qualitative research method was selected to provide a richer understanding of SP data processes [20]. As a specific group of people with expert knowledge on distinct aspects of SP within a local context (geographically), purposive sampling of participants was employed [21].

2.2. Participants and Settings. The LCR incorporates six local authorities (Halton, Knowsley, Liverpool, Sefton, St Helens and Wirral) in and around the city of Liverpool, North West England. Many of the 1.6 million people within the LCR live in situations that are detrimental to health [22, 23] due to structural inequalities in social determinants of health, such as housing and employment [24]. Similar to much of the UK, the LCR plays host to a range of commissioned and non-commissioned SP schemes, involving a variety of providers across health, social care and VCSE sectors [25].

Individuals and representatives from organisations across the SP scheme pathway in the LCR were sought for recruitment to enable a deeper understanding of the SP ecosystem from multiple vantage points, from the commissioner at one end, responsible for the creation and funding of the schemes, to the link worker at the other, working directly with members of the public on a one-to-one basis to drive meaningful change and improvement to their health and wellbeing.

Key service provision stakeholders, as identified through a mapping exercise of policy and strategic delivery documents, were recruited. They included integrated care board leaders, health and social care commissioners, public health directorship, SP scheme providers, SPLWs and members of VCSE organisations who conduct SP activities. The stakeholders were either working in or had knowledge of SP in the LCR.

2.3. Recruitment. Existing contacts within local SP schemes and networks were also approached via email. As more SP providers were identified through a service-mapping exercise, a snowballing approach was used to identify further potential participants. An email invitation was then sent directly to potential participants with information about the study. Those wishing to take part were required to express their interest in an email reply. Participants were given as long as they needed to respond, and recruitment materials were only sent once an e-mail response was received.

Nine SP stakeholders were recruited from various parts of the SP pathway, including two SPLWs employed by a PCN and a VCSE organisation, five managers of SP schemes offered by VCSE organisations and two stakeholders involved in strategic planning or commissioning. Overall, the participants represented five separate VCSE organisations and three PCNs or strategic authorities from across four of the six LCR local authorities (Liverpool, Wirral, Sefton and Knowsley).

2.4. Data Collection and Analysis. One-to-one interviews were selected as the most appropriate qualitative tool due to the ability of the researcher to explore current practice and attitudes at an individual level, without the influence of others [26]. As a researcher with no direct impact on the local SP system, the lead interviewer (FW) provided an objective stance, with no factors influencing any dynamics of power between the researcher and interviewee. The interview topic guide was informed by a review of the literature. Due to the rapid emergence of evidence in the field of SP and the variation between local schemes in the UK, grey literature searches were conducted together with traditional database searches. Google searches were also conducted to identify, review and evaluate documents of local SP schemes that may indicate the use of data for outcome measurement.

The interviews became an opportunity to understand stakeholders' knowledge of national SP data collection strategies and guidance; data collection activities on the ground; the interconnectivity of SP schemes and pathways in terms of partnerships; current 'ways of working' when it comes to data collection opportunities and gauging impact; and novel ideas of measuring impact that can be or are being implemented. Interviews were conducted in person or online (via Microsoft Teams) by the first author between April and August 2022, each lasting between 45–60 min. Audio recordings were transcribed, and transcripts were imported into NVivo Enterprise for thematic analysis by the first author. Participants were given a participant number to enable anonymous reporting and identification of quotes. Deductive thematic analysis allowed for identifications of patterns within the data collected [19, 27] in accordance with the existing literature regarding SP outcomes and data collection methods [11, 12, 16]. The analysis followed the phases described by Braun and Clarke [19]: after familiarisation, codes were identified within the data, and these were used to generate the initial themes. These themes were reviewed and refined through the lens of existing understanding of SP outcomes and data collection. Finally, the themes were written up, with quotes used to illustrate key points and ideas.

2.5. Ethical Considerations. Ethical clearance was approved by the Liverpool John Moores University Research Ethics and Governance Committee (22/PHI/002). Written informed consent was obtained from each participant – either on a paper consent form or via email – after the provision of a participant information sheet and the opportunity to ask questions. Participants were informed of their right to withdraw and were fully debriefed on completion of the interview. All data were anonymised at the point of transcription.

2.6. Reflexivity and Author Contributions. Both data collection and analysis were conducted by the first author, under the guidance and supervision of the coauthors, and it was therefore imperative that a process of continuous reflexivity was adopted throughout the research process [28]. In qualitative health research, the positionality of the researcher shapes the interpretation of the narratives within the data collected. As recommended by Ortlipp [29], a process of reflexive journalling provided opportunities for subjective reflection, particularly during the data collection and analysis phases. None of the authors are directly involved in the planning or delivery of SP and strived to maintain an objective stance throughout the analysis and writing up of this work.

3. Results

Ten interviews were conducted with the 9 key stakeholders (one stakeholder was interviewed in two separate sessions). The participant characteristics are outlined in Table 1.

Three overarching themes were identified as outlined in Table 2.

3.1. Quantitative Data Recording

3.1.1. Data Types. All participants spoke about the recording of a variety of quantitative outcomes relating to SP, including the use of standardised tools and key performance indicators (KPIs) required by organisations. In terms of national guidance around SP data collection, participants were explicitly asked about their awareness of the NHS SP common outcome framework, developments around the national minimum dataset and general briefings and guidance from NHS England and NHS Improvement [3]. All stated that they were unaware of any national guidance. Reasons given included a perceived lack of relevance to their work remit.

They all, however, described data collection activities in relation to SP. Most participants mentioned the use of at least one existing, standardised recording tool to capture outcomes. The most frequently mentioned of which was the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) [30, 31]. Other measures referenced included the Office of National Statistics personal wellbeing assessment (ONS4) [32]; the World Health Organisation's Five Wellbeing Index (WHO-5) [33]; The Euro Qol-5 Dimension (EQ5D) [34]; and the Measure Yourself Concerns and Wellbeing (MyCAW) [35].

> "So, we use SWEMWBS to measure wellbeing and we asked them when we first speak to clients, then we would ask them again, I think a couple of months later to see if we've helped." (HSC06, SPLW)
>
> "in terms of measuring outcomes...I will not say we do a full blown wellbeing plan for patients, we record the ONS4 as like, the universal." (HSC03, SPLW)

Aside from outcomes measures, participants also described recording output measurements from SP as KPIs for various commissioning bodies for their services:

> "we get asked about how many people have reported improved mental wellbeing and how many people are reporting just increase health and wellbeing" (HSC07, VCSE)

3.1.2. Suitability of Data Capture Methods. While all participants recorded data using their chosen tool or tools, their ease of use varied. Preference was shown for some tools over others due to the way in which questions were phrased. Some critiqued the style of the language used with others commenting on the ways they mitigated for this:

> "we use MyCAW. It's just a more favourable outcome measure in the way some of the questions are asked." (HSC05, VCSE)
>
> "SWEMWBS is...a bit more formal, and people-...become a little bit more on the guard when you're asking those questions. But if you can engage effectively with the person and have something like a pre-existing relationship, I think you can get more quality responses or realistic responses." (HSC02, VCSE)
>
> "I've got a slightly different one with an extended scale, so instead of it going from nought to five, seven questions, we've got five questions, but they go from the scale of nought to ten. They're less convoluted. SWEMWBS is around mindfulness, but it's how it's worded...for somebody who has got very little in terms of education, when you ask them 'are you paying attention to the present'...They cannot get that concept, especially if they're struggling with anxiety." (HSC04, VCSE).

This latter quote suggests that, while standardised measures are being used, they are not necessarily being used in a standardised way. While this idiosyncratic approach embodies the inherently personalised approach of SP, it limits the comparability of the data collected and hence its usefulness.

Several service providers expressed concern that, if the SWEMWBS score was considered in isolation, external reporting would lead to the incorrect conclusion that some clients were not moving forward on their journey towards improved wellbeing, despite gains being made. The measure was seen to provide a client story that did not encapsulate multiple aspects of the client's journey:

> "I mean we've got people in here and they've done really really well. You do this SWEMWBS with them and they score low. 'John' come in and his score on his SWEMWBS dropped by three points instead of increasing by two, but actually he's been in every single day this week. He's attended activities that he said he'd never ever go to and you know he's actually started volunteering somewhere else. How much of that is taken on board. I don't know." (HSC04, VCSE)

Participants commented on the challenges of capturing positive client feelings and improved attitudes from attending SP services, describing how they thought quantitative recordings of improvement and formal reporting did not always convey the positive work they had carried out with clients:

> "It's someone's mood, isn't it? And you can't measure that effectively, but by coming to a place like this and if it gives you something to look forward to in the week, I think we're doing our job, but it doesn't reflect that in the numbers often because it isn't measuring that." (HSC07, VCSE)

Table 1: Participant characteristics.

Subsector	Role	Interview ID
GP practice/strategic authority	SP strategy/commissioner	HSC01
VCSE	Service manager for SP services	HSC02
SPLW	SPLW-PCN	HSC03
VCSE	Service manager for SP services	HSC04
VCSE	Service manager for SP services	HSC05
SPLW	SPLW-VCSE	HSC06
VCSE	Service manager for SP services	HSC07
PCN	SP strategy/commissioner	HSC08
VCSE	Service manager for SP services	HSC09

Table 2: Overarching themes.

Theme	Subthemes
1. Quantitative data recording	a. Data types b. Suitability of data capture methods
2. Qualitative data recording	a. Data types b. Data collection challenges
3. Utilisation of data	a. Facilitating factors b. Data utilisation experiences c. Suggestions for improving data utilisation

Similar comments were raised around the data recorded at the service level and its ability to capture and therefore convey the change participants witnessed within their client population:

> "The tension with reporting and statistics, some people. . .need to stay on that [drug withdrawal] medication. So we won't get that successful completion, but they might have stopped committing crime. They might have addressed their physical health needs, their mental health needs, they could be working, they could have completely changed their life. But because they're still getting a prescription, none of that's taken into account. So yeah, it's a challenge." (HSC09, VCSE)

These criticisms of existing quantitative outcomes measures highlight a perhaps inevitable trade-off between the need for standardised national outcomes and a more personalised approach to capturing meaningful outcomes for SP.

3.2. Qualitative Data Recording

3.2.1. Data Types. All participants mentioned the use of collecting "short, punchy, well written" (HSC02, VCSE) client case studies or formal and informal service feedback as a means of recording the impact their service was having on their client population. Some collected case studies when a client's issue had been successfully solved or when they wanted to showcase outstanding improvements to an individual's wellbeing. Others collected a handful of case studies to illustrate their work to either their PCN health community (via newsletter) or to their commissioners when submitting routine reports:

> "it [the case study] was put in the newsletter and distributed around one of our GP networks. . .Sometimes we've done like a little video with them, it's all based on what the patients or the client is happy to do and it's nice to capture those nice stories." (HSC06, SPLW)

Formal and informal feedback was reportedly collected by the service providers once a client had accessed their services (via phone call or in-person). Feedback via phone call was collected during a follow-up call conducted by some providers who have seen clients complete a tailored health and wellbeing plan as part of the concluding stage of the plan.

Some service providers were seeing the benefits of their programme via two-way feedback between themselves and primary care once clients had engaged in their service – although the availability of this was not consistent between organisations. Feedback requests, in one example, were left in the hands of particular GPs with an interest in SP, rather than a requirement for all in the surgeries patients engaging with SP:

> "So I might ask 'so how are you now?' 'Oh I've got a repayment plan now' or feedback like, this mom had no nappies for their baby and they do now because the social prescribers sorted something out. Very basic data in terms of feedback from patients." (HSC01, GP/Strategic Authority)

This quote again highlights the need for a personalised approach to measuring the impact of SP than that provided by standardised approaches based on KPIs or common quantitative measures and the value of adopting a qualitative or mixed methods approach.

3.2.2. Data Collection Challenges. Opportunities to collect more information on how the clients had interacted with SP services were present during the follow-up calls to complete the outcome measures. However, some participants mentioned feeling restricted in expanding their line of questioning to capture more qualitative outcomes due to data collection agreements within their organisation:

> "We'll do the post outcome measure with them three-months from the date they signed up but in terms of ethics they [the social prescribers] are only allowed to do that,

> they can't ask anything else. What I'd like is if we can see 'And you're referred to XY&Z's service by the social prescriber. Did you access XY and Z or did you just access one or two? How come?'" (HSC05, VCSE)

The regularity of feedback collection varied due to primary care remote working patterns and styles and capacity to do so:

> "It is not as easy as it was because of workload, remote working, most GPs work part time clinically. So they [the patient] may be seeing different clinicians you know, then the feedback's not quite the same." (HSC01, GP/Strategic Authority)

3.3. Utilisation of Data

3.3.1. Facilitating Factors. Many participants spoke about how data were used within SP services and the factors that facilitated this.

Participants commented on the different systems they used for recording client and general data regarding SP. A variety of electronic systems - both standalone and with integrated components into existing primary care patient records systems - were mentioned, holding demographic data and outcome-related information:

> "Referrals are made directly from a GP practice. So we have a social prescribing database that we use called Elemental, we'll use that to register people on our system as a sort of a social prescription. Our main like demographic data is there, you can obtain a heat map of who's accessing the service per geographical area, your age groups, your gender breakdown." (HSC05, VCSE)

Others collected information directly from GPs of SP-referred patients' subsequent service use following their social prescription:

> "We get GP statements, so referrer statements, on whether or not they see the impact. Often it's about service utilisation. So are people going back with non-medical issues again and again, or how has the fact that they've successfully engaged in other wellbeing activities reduced that." (HSC02, VCSE)

Here, the quotes illustrate the importance of designing systems that capture information to help referrers and commissioners assess who is accessing SP services and what impact this is having on their subsequent healthcare service use.

Many participants described the usefulness of being able to track a patient's journey through the SP service and beyond. Local data sharing agreements with partner organisations were mentioned as helpful in facilitating onward referrals and follow-up conversations when referrals were not appropriately actioned. At times, data sharing between partner organisations was challenging, leading to frustration and an expressed inability to provide a safe service for clients:

> "There is one organisation that we are having a lot of difficulty with in terms of information sharing that's one of the alcohol services. It's the them sharing information with us. . .it's like working in the dark. . .there has been major risk. This isn't about data. This isn't about KPIs. This is about protecting an individual." (HSC04, VCSE)

3.3.2. Data Utilisation Experiences. Electronic systems with integrated components into existing primary care patient record systems allowed for SP information to be accessed by the SP service's stakeholders, sharing awareness of patient progress within an SP pathway:

> "it's called the Integrated Wellness service system that we use, there's questions about which priorities mainly to the person involved, then we can ask them questions about the lifestyle. The collection and passing notes back to the GP practices so they can use a tool there, it is called 'what matters to me'. We can access it at any point". (HSC07, VCSE)

Reasons given for reporting case studies – as opposed to simply quantitative data – to commissioners included the wish to use the stories as a vehicle to create the desired changes service providers wished to see within the local healthcare policy:

> "When I'm reporting back to funders about the work that we do, I'll give them a bit of background. . .and then give them a case study. . .to change hearts and minds. We feed back to policymakers and decision makers because we have to try and affect change. There is no point in responding to the same inquiries and issues again and again. . .if we're not going back to government or policymakers to say this is what's wrong" (HSC02, VCSE)

Some participants, however, felt that commissioners did not view quantitative data and case study data in equal strength as evidence of service impact, despite case studies harbouring multiple client outcomes:

> "They [commissioners] are not necessarily needing those softer outcomes. I mean, the commissioners and other managers will email and say our case study was fantastic. . .but actually the evidence of someone just leaving the house is so powerful when they've when they've not left the house, or we've got them to complete a basic Maths and English course when they're 44 and they left school at 14 because they were drinking." (HSC04, VCSE)

3.3.3. Suggestions to Improve Data Utilisation. Overall, many participants – particularly service managers – exhibited a keen understanding of the need for user-friendly systems for data capture and sharing and a desire to improve data collection within their services. Participants were keen to increase their knowledge on the reach of their local schemes in relation to the area the schemes were allocated to cover:

> "It'd be nice to find out the scope of your work in terms of the areas and neighbourhoods covered in people that you think you might be missing." (HSC02, VCSE)

Those who were not yet able to do so commented on the ability to distil demographic information for their scheme in order to provide the intelligence needed for a target outreach of underserved communities:

> "in terms of demographic breakdown of people who access the service, I think, where we can, we need to sort of make a more concerted effort to be more inclusive. . .I think a lot of it comes down to trust and knowledge of the service. . .and us to really hammer that out to the park and spread the word [about] what we're doing." (HSC05, VCSE)

In addition to service user improvement targets, the impact of SP on other health system targets such as primary care utilisation was also of interest:

> "I mean it would be interesting to know how many people didn't go back to the GP practice for example and stuff because of our intervention. But these things could take a long time." (HSC06, SPLW)

This latter quote is particularly interesting when compared to the earlier quote from HSC02, a manager within the same organisation, who reported receiving statements from referrers regarding the impact of SP, which often focussed on service utilisation. This illustrates a lack of consistency in data access – no doubt borne out of necessity and data protection requirements – even within the same organisation. The varied responses regarding data utilisation across all participants highlight the discrepancies that exist between services within one region, governed by the same ICB and the need for a reporting framework to guide commissioners and providers.

Going forward, participants thought it as useful for all existing system boards such as the PCN to request to receive SP data if they were not already doing so:

> "a reporting framework to evaluate what we do and what we need to target resource, [reporting to] the PCN board and stakeholders. It would probably be useful for all the PCN's data on social prescribing to be fed into that" (HSC08, PCN).

4. Discussion

Given the current focus and expectation placed on SP, evaluating and understanding the mechanisms of effectiveness is essential. Whilst evidence is emerging, comprehensive evidence of effectiveness and efficiency is limited, largely due to SP models lacking evaluative components [36]. The objective of this study was to examine the views expressed by various individuals involved in the delivery and planning of SP schemes across the LCR concerning the gathering and application of data to evidence impact within and across SP initiatives. The three themes identified within the data highlighted the recording and use of quantitative and qualitative data for capturing SP outcomes and the associated facilitators and challenges.

4.1. Issues With Current Outcome Measure Data Utilisation. Although much data (quantitative and qualitative) were being collected at various points within the SP service pathway, it was rarely utilised with intent. Also, whilst high quality studies are needed to determine the effectiveness and potential impact of SP [18], providers reported using a variety of outcome measures and were critical of the ability of standardised measures or KPIs to capture the client's story and the impact of their service's long-term outcomes. These included outcomes such as resilience, improved confidence and self-esteem and overall capacity building. Some standardised tools for measuring health and wellbeing were used, but knowledge of the range of tools available was sparse, and there was little to no discussion around the scores on the measures being acted upon in some form once reported, or how the scores led to any change in practice or processes, such as encouragement for more referrals to SP schemes. Current individual tools, while strong and validated, remain simplistic when attempting to capture the multifactoral outcomes that then lead to evidencing service impact. Given the co-production approach embedded within the definition of SP [2] and the policy discourse of SP as providing personalised care [7], the use of standardised tools or those based on KPIs are unlikely to capture the heterogeneity and nuances of people's experiences within SP schemes [37]. Indeed, many standardised measures may not be appropriate or acceptable for SP service users [16]. This led to some participants modifying standardised tools to enhance acceptability and data completeness, which has implications for the reliability and comparability of the data collected. Also, once information was placed on the notes or the case studies were submitted, some participants reported their perception that there was no further action taken, suggesting that the limited outcome data that are being collected are underutilised.

These findings show a need to not only mobilise existing SP tools and outcome measures used in practice (including regular collection of qualitative and quantitative data) but also to focus on discussing and deciding upon SP outcomes and measures with all SP pathway stakeholders involved. This would help to foster a common understanding of an SP scheme's intended aim, decide on its desired outcomes for health and wellbeing using input from multiple stakeholders – including service users to ensure acceptability – and reach an agreement as to what types of data need collecting and when to facilitate this.

The disparity in outcome measures employed by link workers further demonstrates the difficulties in obtaining consistent tool use across a key subsection of the SP workforce. These difficulties experienced in the LCR are not unique to the region. A recent study highlighted similar inconsistencies in routine outcome reporting across SP schemes in a similar geographical area [38], while a systematic review across 13 countries identified 347 unique patient-level and systems-level outcomes used in SP [37].

4.2. The Role of Qualitative Data Collection in Demonstrating Impact of SP Activities. All participants spoke about the prevalence and importance of collecting qualitative data of various types to capture the impact of SP services, a suggestion that mirrors the findings of previous reviews [16, 37]. Suggested KPI measures for assessing SP by SPLW host organisations include regular referral-in data (numbers and source of referrals), patient complaints and compliments and the results of the standardised tools mentioned by study participants (SWEMWBS and ONS4), with only quarterly or annual inclusion of a singular case study [39]. Preference for standardised tools over case studies would seem to stem from the ability to produce good quality, comparable data. However, examples within this interview study show how tools were being modified by some staff to facilitate data capture for SP clientele, inadvertently producing manipulated data.

Case studies were championed by many stakeholders as a method of providing the evidence needed to be accepted as an active player around the table during discussions on SP's role in reducing the health inequalities facing LCR. Case studies have been recommended as a supportive tool to strengthen local support for SP activities [40]. However, case studies were collected on an ad hoc basis, so they were not able to adequately map the impact of the services on all who accessed them. Whilst this provides useful evidence, it does not necessarily provide a comprehensive and robust understanding of the impact. In primary care, GPs were left to rely on patient feedback alone to gauge a sense of the impact SP referrals were having on their patients, highlighting the need for a system-wide approach to reporting SP outcomes more broadly. Case studies and ad hoc feedback alone cannot provide the full picture of service impact for a scheme's target population based on the sociodemographic data and the client mix of the area served. This provides a challenge in relying on this data to evidence the full impact of SP on health and wellbeing. SP client feedback may include mention of important indicators that could feed into a wider outcome framework, but assessing impact on health inequalities directly from client responses alone is inadequate.

4.3. Weak Cascading of SP Guidance From National Bodies to Local Grassroot Interventions. Whilst research has concluded the need for a more comprehensive, consistent and rigorous approach to measuring how and why SP works, for whom and in what conditions [18, 41], interviewees were not aware of existing support in the form of the national frameworks and guidance on recording and measuring outcomes. Participants were not aware of the national work such as the national minimum data set for SP in the NHS information standard [42], the SP national outcome framework [43] or the SP information standards [44]. Our study demonstrates that there remains a disconnect in the awareness of available resources and therefore implementation of recommendations mentioned.

4.4. Data Intelligence Leading to Improved Service Delivery. Participants reported that successful linkage of inter-organisational data allowed for intelligence gathering on service need and gaps in provision, which could be harnessed by the SP provider to reduce health inequalities for the subpopulation covered. However, the systems used within SP within the relatively small geographical area covered in this study are significantly varied, with some participants able to view personalised dashboards with indicators, while others struggled to view basic demographic information in a user-friendly and accessible way.

Sharing information with other providers remained a sticking point for third sector organisations, with our findings echoing those of similar previous studies [17]. Data sharing for the client's benefit was implemented by those who used an integrated system with primary care practices, but such practice was not widely found. Intrasector data sharing proved successful for some SPs with information sharing agreements, while others struggled to share mutually beneficial information.

Tracking reduced repeat primary care attendance was an example of successful data utilisation to evidence impact on local health services. Buy-in from all SP stakeholders (commissioners, healthcare professionals, service users and the VCSEs) has been identified as a key component in successful SP, leading to tangible benefits to health and wellbeing and trust creation across all relationships [45]. This demonstrates how proactive coworking between health professionals to manage all aspects of a client's health holistically can have multiple benefits at an individual and systemic level. Again the disparity of practices in SP within the localised area of the study is reflected in how some participants sought after such feedback and saw it as a beneficial improvement to evidencing their service's impact, while others already had the information available to them.

The introduction of ICBs across NHS England [10], covering large and diverse geographical areas, allows for the possibility of detailed analysis of management information across a wider range of services and providers than was previously available. This therefore might allow for commissioners of SP schemes to drive forward the development of minimum standards for data collection as a funding requirement. At the very least, they could enable the implementation of the national outcome framework for SP as part of contract monitoring.

Future work-in-progress via the NHS England's SP maturity framework draft quality improvement tool [43] looks promising and is set to address the need for continual growth and development of SP in the service structure, network connectivity, intelligence sharing and pragmatism with available data. It encourages ICBs to work collectively towards six-monthly improvement goals. Embedded within this is a focus on SP outcome data, digital systems of collection and sharing, sharing data cross-sector (healthcare and VCSE) and a common understanding of *how* SP can lead to realising certain specific outcomes for health and wellbeing.

4.5. Implications for Further Research and Practice

1. Further exploration of the implementation of existing national guidelines and their effect on community

level activities is needed to understand their translation in practice.

2. Further exploration of feedback on the practicalities of recording outcomes is needed to develop robust tools to monitor and evidence service impact. These should be tailored to scheme goals within a place-based health and social care system in line with the neighbourhood/locality, place and system setup of the ICBs created in July 2022.
3. Further research is needed on the acceptability of incorporating further SP-specific indicators within commissioner reporting systems, including formal acknowledgement of qualitative impact reporting on existing, quantitative health inequality indicators/KPIs, in order to assess burden and identify suitable criteria for measurement across schemes/providers.
4. Further exploration of where the responsibilities of data collection for evidencing impact should lie within SP systems, and the individuals best-placed to conduct collection, is needed to ascertain feasibility of future routine, evidence-gathering practices.

4.6. Strengths and Limitations. This interview study was a small snapshot (10 interviews) of diverse views within the LCR, a geographically defined region of North West England. As mentioned previously, the LCR experiences multifactored health inequality, and therefore work to reduce such inequality is comparably greater than areas of England with the same size of population. Also, SP in particular has developed widely within the region and has over time become a well-established approach to address the area's health needs [25], so a sound awareness of data collected and expected outcomes could be expected. The stakeholders included link workers, managers and commissioners, representing views from different aspects of the SP pathway, with similar themes and ideas being raised by all participants regardless of role. The study is not, however, without its limitations. With substantial changes to the NHS plan for England [10] taking place during the period the interviews were conducted, responses around data collection practices may have been influenced by the evolving processes nationally and locally. This interview study was primarily concerned with the professionals involved in planning and delivering SP services, and it would be valuable to explore the experiences and opinions of service users regarding outcome data collection, particularly regarding the acceptability of existing quantitative and qualitative outcome measures and the personalisation of measures to capture meaningful outcomes. Finally, the use of deductive thematic analysis as opposed to more inductive approaches may have limited the breadth and depth of participants' responses. However, this approach enabled the findings relating to the practices and opinions held within this one, diverse region within the North West of England with a strong history of SP to be viewed through the lens of existing knowledge and understanding.

5. Conclusions

The study explored the opinions and experiences of stakeholders involved in the delivery and planning of SP regarding data and outcome recording practices within the LCR. Interviews found that a variety of data collection methods were essential for assessing the impact of SP on individuals and communities. Improved communication of existing national guidance to local communities can potentially support the practices employed within services and local systems. Encouragement for future data linkage arrangements, together with wider routine outcome data recording and a collaborative agreement on the outcomes to be collected, can support a targeted approach to increasing the evidence around SP's impact on health and wellbeing. Understanding the value of all quantitative and qualitative data collected across the SP system can further improve data utilisation for evidencing impact. For a more seamless operation within the health sector, wider data sharing for the client's benefit across the broader health system is needed. It is hoped that addressing the gap in data and information on SP will provide the supporting evidence needed for the growth and development of regional services.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

Conflicts of Interest

The authors declare no conflicts of interest.

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