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EUROPEAN UNION
Northern Ireland - Ireland - Scotland
European Regional Development Fund

Evaluation of the mPower Project 2017-2022

Full Report

A project supported by the European Union's INTERREG VA Programme, managed by the Special EU Programmes Body (SEUPB)

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Full Report

Published by The University of the Highlands and Islands

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Date: 28th July 2022

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1. Executive Summary

1.1 Introduction

This report presents the findings from the evaluation of the mPower project. The project aimed to deliver social prescribing and eHealth interventions within deployment sites in Scotland, Northern Ireland and the Republic of Ireland.

Social prescribing is any activity in which a non-pharmaceutical intervention is recommended or provided to people with a non-clinical need such as loneliness, social isolation or low-level depression. eHealth interventions are any use of digital technology to promote health, wellbeing, self-management or efficient and appropriate use of statutory or private healthcare services.

This report examines the outcomes from the mPower project as evidenced through qualitative and quantitative work, as well as the differences and similarities between mPower deployment sites. Our evidence mainly consists of interview data gathered from a range of stakeholders including beneficiaries, local staff, mPower Project Board members, primary care representatives and third sector representatives, as well as questionnaire data collected by Community Navigators.

1.2 Social Prescribing and eHealth – the Policy Context

The health, care and wider ageing and community policy contexts within each of the mPower partner areas appear to be conducive to supporting both eHealth and social prescribing implementation. Scottish health policy indicates digital technology will play an important part in achieving the Government's person-centred vision for health. Social prescribing is also central to the Government's strategy on self-management of long-term conditions. In the face of an ageing population and limited funding, Northern Ireland is seeking to maximise the potential of technology to develop and modernise its health and care system to make it more responsive and better focused on the people it serves. According to the eHealth Strategy for Ireland, eHealth is a critical enabler of best-practice health systems and optimum healthcare delivery, and the Republic of Ireland (ROI) has a framework that aims to mainstream social prescribing.

1.3 Existing Evidence on Social Prescribing and eHealth

Common positive outcomes from social prescribing identified in the existing evidence base include increases in self-esteem and confidence; improvements in mental wellbeing; reductions in anxiety and depression; and reductions in social isolation. However, there is a lack of evidence on whether social prescribing decreases non-clinical primary care usage.

Several eHealth interventions are more numerous within the mPower deployment sites: home alarms (pendants and wristbands); Florence (text-based medication reminders) and video conferencing (VC) through the Attend Anywhere system, known as 'NHS Near Me' in Scotland. Home alarms have been shown in the existing evidence base to contribute to enabling older people to live at home, and as independently a possible, for as long as possible. As a text-based reminder system, Florence has been shown to have a positive impact on self-management. Video conferencing has also shown positive outcomes when it is used in clinically appropriate situations. In addition, communications technology has been shown to reduce social isolation of older people. The use of technology has rapidly become more widespread since the beginning of the COVID-19 pandemic.

1.4 Methodology

Our evaluation of the mPower project took a realist approach (Pawson and Tilley, 1997). Its key principle is that the context in which an intervention takes place determines whether the intended outcomes are achieved. Realist evaluation aims to identify the underlying generative mechanisms that explain 'how' the outcomes were caused and the influence of context.

Multiple data sources have been used in our evaluation, including eHealth readiness questionnaires; baseline deployment site data; beneficiary questionnaire data; qualitative interviews; and observational notes. Interviews have been undertaken with mPower project beneficiaries (56); Community Navigators (20); Implementation Leads (12); primary care staff (14); third sector staff (14); mPower Business Leads (1); mPower Programme Manager (1) and mPower Project Board members (18). Participant observation has also been carried out at three deployment sites. Interview transcripts and observational fieldnotes were analysed within the NVivo software package, using thematic analysis.

As interview participants were recruited through local mPower teams, the sampling may not provide a holistic picture of the range of beneficiaries and other stakeholders involved in the mPower project.

Quantitative beneficiary data was collected between May 2018 and May 2022 through baseline and follow-up questionnaires which were administered by project Community Navigators.

1.5 Overall Project Targets

mPower has achieved its target number of digital health interventions and Wellbeing Plans. Just over half of the digital health interventions and Wellbeing Plans have taken place within the Scottish deployment sites.

Our evaluation has shown that context and approach to service delivery are central to understanding the generation of outcomes within each deployment site and for the mPower project as a whole. The Scottish sites, for example, have benefited from having mPower staff in post quicker and employing staff already familiar with the landscape of their local areas. Their work has been aided by embeddedness within multi-disciplinary teams (MDTs). In addition, their eHealth readiness assessments generally show environments more conducive to the use of (innovative) technology.

The highest overall numbers of both eHealth beneficiaries (1,722) and Wellbeing Plans (762) were reported by NHS Ayrshire and Arran. The beneficiary figures for NHS Dumfries and Galloway are the second highest within the project and they have the greatest reach of any of the deployment sites – equating to reaching approximately 20% of their over 65s population. Relatively high numbers of beneficiaries were also reported for the Southern Trust (929 eHealth and 427 Wellbeing Plans).

1.6 Local Identity

Areas in which higher numbers of Wellbeing Plans have been completed, tended to have fairly well-developed identities as 'specialist' social prescribing providers for older people. Areas in which staff reported feeling unsure about mPower's role in eHealth service provision tended to have lower numbers of eHealth beneficiaries.

1.7 Connections to Primary Care and the Third Sector

Evidence shows that Community Navigators and Implementation Leads have put a lot of time and effort into establishing connections to primary care and local third sector organisations. The amount of effort was sometimes greater for those staff who had not previously worked or lived within their deployment site. We have seen evidence that effective social prescribing requires good links to both primary care and the local third sector. It was a difficult task for Community Navigators to both build these links and to carry out the Wellbeing Plans/interactions with beneficiaries. Community Navigators and Implementation Leads being physically based within the same space as multidisciplinary teams/primary care, and being embedded within the broader health service or third sector, were seen as facilitators of success.

1.8 The Relationship between Community Navigator and Beneficiary

Across all deployment sites, the relationship between Community Navigator and beneficiary was central to the generation of outcomes. Beneficiaries highlighted, for example, that they were able to engage with the project and achieve health and wellbeing outcomes because Community Navigators visited them in their own home, spent an adequate amount of time with them on each visit, and demonstrated genuine engagement and caring in interactions with them. Community Navigators were shown to be flexible, adaptable and in possession of a considerable skill set. This was also evident in the ways in which they adapted to keep the service going through the COVID-19 pandemic.

The Community Navigators have been shown to have the power to act on the social determinants of health. The importance of the human contact that they provided for older people, who may be experiencing loneliness and isolation, is hard to overemphasise. It is the relationship between Community Navigator and beneficiary that is the foundation of much of the generation of positive outcomes within the mPower project. However, this role carries with it a not inconsiderable burden in emotional terms. Evidence suggests that Community Navigators could be further supported through more formal debriefing processes and peer support.

1.9 A Broad Approach to eHealth

Numbers of eHealth beneficiaries are higher in the Scottish sites that report the adoption of a broad conceptualisation of eHealth. For example, the use of video conferencing software for social interaction (rather than just interaction with a healthcare professional) supports older people's self-esteem and wellbeing. Supporting the use of technology for increased social connection has the potential to increase self-esteem, reduce depression and alleviate anxiety.

1.10 Increasing Beneficiaries' Confidence and Empowerment

There is evidence that engagement with the mPower project increased beneficiaries' confidence and sense of empowerment – this is largely through their interactions with Community Navigators and the completion of Wellbeing Plans. We have seen how the process of a guided conversation and goal setting with a Community Navigator is particularly important in generating confidence and empowerment for the beneficiaries.

1.11 Reducing Loneliness and Social Isolation

There is evidence that interaction with mPower led to reductions in loneliness and social isolation. This is the outcome most frequently discussed by beneficiaries, staff, third sector representatives and interviewees working in primary care. Group activities, in particular, were considered to contribute to the realisation of this outcome. From the overall quantitative sample of beneficiaries, 20% reported reductions in loneliness on the measurement scale between baseline and follow-on. However, the proportions experiencing decreases were much higher within deployment sites Western Trust (52%) and HSE CHO1 (48%) and much lower in Ayrshire and Arran (8%). The positive changes were statistically significant for those with depression.

1.12 Enhancing Mental Wellbeing

Evidence suggests that interaction with mPower contributed to maintaining or enhancing older peoples' mental wellbeing. Our analysis suggests that it is social prescribing, and in particular, the nature of the contact with the Community Navigator, that generated a positive impact on mental wellbeing. However, there are also examples of eHealth and technology solutions contributing to the enhancement of mental wellbeing. From the overall quantitative sample of beneficiaries, 18% reported an improvement in life satisfaction between baseline and follow-on. However, proportions were much higher in deployment site HSE CHO1 (42%) and the Western Trust (40%). Proportions were also higher for those with depression (48%), chronic pain (39%) and chronic kidney disease (31%).

1.13 Facilitating Self-Management

There is some evidence from the analysis of our qualitative material that mPower encouraged older people to engage with self-management behaviours. This was most often seen as a result of an interaction with a Community Navigator that kick-started a change in behaviours. In our quantitative sample, 72% of respondents said they felt more confident managing their long-term conditions on a daily basis after their interaction with mPower. Again, this was higher for those living with depression (44%), chronic kidney disease (40%) and chronic pain (33%).

1.14 Safety of the mPower Approach

Generally, mPower stakeholders felt that social prescribing and eHealth are both acceptable and appropriate ways to facilitate self-management and to improve physical and mental health, and that safety issues do not outweigh the positive outcomes that can be achieved.

1.15 Impacts on Primary Care

Interviews with beneficiaries do not suggest that interaction with mPower affected their level of primary care attendance. This may indicate that 'frequent flyers' were not always targeted for referrals. For beneficiaries who were referred for social prescribing and completed their follow-up questionnaires before the COVID-19 pandemic, there was no statistically significant difference between the number of primary care appointments attended before mPower and during participation in mPower (n=305).

1.16 Benefits of the mPower Project-Level Approach

Many of the local staff cited a key benefit of the mPower project-level approach being that it gave them the ability to 'pick up the phone' and speak to local staff in other sites if they had a problem or concern they wanted to discuss. The presence of the central operational service spanning the deployment sites took some of the pressure off project leads once this central team had been established.

1.17 Challenges with the mPower Project-Level Approach

The main challenges discussed by interviewees surrounded the non-realisation of their expectations of mPower prior to starting in their project posts. Commonly, they had the expectation that there were joining a team to implement a specific service and eHealth solutions, that would be centrally provided by mPower. Participants expresses disappointment that these expectations were not realised.

1.18 Cross-Border Knowledge Exchange

Interview participants sometimes struggled to describe ways in which effective shared learning had taken place, although many accepted it did occur. Even when opportunities for shared learning were available, the cross-border aspect of the project meant that learning was not always easy to transfer across areas. However, not all shared learning was formal e.g. through workshops or classroom settings. Many effective instances of shared learning occurred on a 1:1 basis between professionals introduced in mPower where exploring the different contexts was instructive. Furthermore, the introduction of case studies to project assemblies was broadly welcomed by local staff as it provided a good platform to communicate about challenges and approaches to service delivery across deployment sites. The introduction of ECHO sessions was also viewed as making a positive contribution towards knowledge exchange.

1.19 Project Legacy

A concern often raised by local mPower teams and Project Board members alike was whether mPower would have a meaningful legacy. In particular, they raised concerns about the ability to embed Community Navigator posts within their local systems. It is important to build in an understanding of potential legacy of short-term projects from the outset.

Relationships between mPower and community organisations were considered key to creating a legacy from mPower; as was alignment with national strategy and policy. mPower has built pathways that can be sustained longer term, provided the networks built are strong enough. Again, this is dependent on how embedded mPower was in the local health and social care structures, as well as the third sector. Several deployment sites have set up Community Digital Hubs which will ensure legacy.

1.20 Implications and Conclusions

Whilst work has been done to ensure the legacy of mPower, fully embedding and mainstreaming the type of services started during the project requires consideration of the lessons learned from mPower for wider technology enabled social prescribing and eHealth interventions.

- Highlight and disseminate the good work of the Community Navigators as without them outcomes would not have been achieved.
- Three elements have been shown to be key to the realisation of benefits from Community Navigators' work: the time spent with the beneficiary, the visit to their home space and the manner in which the Navigator engages in a person-centred approach.
- Recognise the benefit of the physical location (base) of Community Navigator or Implementation Lead type posts as we have seen the benefits of sitting within the same space as MDTs and/or primary care staff, or the third sector.
- Where possible, Community Navigators and social prescribing services within a locality should work together, understanding the specialist nature of each one.
- The tasks of local project promotion, asset mapping and relationship brokering were time consuming for Community Navigators and Implementation Leads within mPower.
- It is important to consider the staffing resource level of Community Navigators relative to the area and the population to be covered at the planning stage.
- Several staff talked about capacity issues within the local third sector.
- Transport was also a much-cited challenge in terms of remote and rural beneficiaries being unable to easily access services.
- Another key challenge was liaison with primary care.
- Basic financial analysis suggests that a project like mPower can cost less than GP time, SSRI mediation and psychological support.
- In relation to eHealth, mPower has shown the potential of 'low level' and 'off the shelf' technological solutions.
- Evidence suggests that health/care technology is not the only avenue to achieving the mPower outcomes – wellbeing and self-management can be promoted through things as simple as supporting someone to use a smart phone that they already own.
- Through guided, person-centred conversation, those in Community Navigator roles can also support the identification of appropriate eHealth and technological solutions for individual beneficiaries.
- Several deployment sites also set up Community Digital Hubs. The hubs continued to run beyond the mPower project, thus contributing to its legacy
- Some sites felt having Community Navigators specifically focussing on digital support to be beneficial.
- The ECHO format has been a successful vehicle for sharing learning and peer support/safe debriefing opportunities.

In order to focus future activity on areas of greatest benefit to both patients and providers, integrated eHealth and social prescribing systems may profit from identifying and targeting frequent primary care users or those with particular conditions such as depression, which was the one long-term condition within the mPower quantitative sample that showed statistically significant improvements in health and wellbeing measures.

2. Introduction

2.1 Purpose of Report

This report presents the findings from the evaluation of the mPower project. Thus, the report presents what we have learned about the efficiency, effectiveness and experience of using social prescribing and eHealth interventions in order to facilitate health and wellbeing amongst the older population.

The report examines the outcomes that we have been able to evidence through qualitative and quantitative work, as well as differences and similarities between mPower deployment sites.

The report draws on both qualitative and quantitative data gathered and analysed by researchers from the University of the Highlands and Islands (UHI). This data was generated through interviews with a range of stakeholders, as well as observational notes from shadowing Community Navigators. Quantitative data was collected by Community Navigators between May 2018 and May 2022.

2.2 Research Questions and Research Data

As the aim of the evaluation work package was to monitor and evaluate the delivery of the mPower project against its targets; the work carried out by UHI researchers (and reported on here) assesses:

- The effectiveness of new strategies for the delivery of care as a means of facilitating self-management of health and wellbeing.
- The clinical and cost effectiveness, as well as the cross-border suitability, of new services in assisting an ageing population to live well at home for as long as possible.

The findings of this evaluation report are broadly structured around the domains of the evaluation framework, approved by the Project Board in 2018. Within each domain, we seek to answer the following research question(s):

- Evaluation domain 1 - Demographic capture: what are the demographic characteristics of mPower beneficiaries?
- Evaluation domain 2 – Beneficiary safety: is self-management a safe way to manage Long-term Conditions (LTCs) in the opinion of healthcare professionals and beneficiaries who interact with the mPower project?
- Evaluation domain 3 – Beneficiary Outcomes: what are the positive outcomes of the mPower project for beneficiaries; does physical health improve; does isolation decrease; does overall wellbeing improve; are people more inclined to self-manage; does digital literacy increase?
- Evaluation domain 4 - Patient and professional perspectives: does mPower effectively support self-management and/or decrease pressure on primary care in the opinion of healthcare professionals and beneficiaries who interact with the mPower project?
- Evaluation domain 5 - Economic: what are the costs of running the service? (Local staff costs, materials, training.); what are the costs per 15 minutes of time spent with a beneficiary?
- Evaluation domain 6 - Organisational aspects: what are the benefits/challenges of a central operational service across seven health and social care organisations and across borders in the opinions of mPower project staff?

- Evaluation domain 7 - Social, ethical and legal aspects: what are the local/cross cutting professional, administrative, technical and legal obstacles to implementation in the opinions of mPower project staff?
- Evaluation domain 8 – Cross-border knowledge exchange: How effectively is shared learning and knowledge transfer enacted in the context of mPower in the opinions of mPower project staff?

We have also included two additional domains that emerged from the qualitative data collection:

- Context
- Approach to service delivery

The section on context contains descriptions and characterisations of the seven deployment sites, as provided by interview participants. This was deemed important for the purposes of the report, as cross-border and cross-site differences emerged from the data collected, and context is key in understanding outcomes.

The approach to service delivery was also deemed key in understanding the mechanisms behind outcomes achieved and therefore merited investigation and inclusion in this report.

The evidence associated with each of the nine domains, consists of both qualitative and quantitative data. UHI Researcher, Dr. Anna Terje (AT), has interviewed a range of stakeholders; beneficiaries, local mPower staff, Project Board members, primary care representatives and third sector representatives, in order to explore each of the research questions. AT also shadowed some Community Navigators and the resultant observational notes were used to inform the findings presented here.

Quantitative data was also collected by Community Navigators with questionnaires administered at initial and six month follow-up.

Financial data was provided by the central mPower team, and eHealth readiness questionnaire data came from a 'Baseline Report on Readiness for eHealth Interventions'.

The mPower evaluation team would like to thank everyone we spoke to and everyone who filled in questionnaires as part of the evaluation for their generosity.

2.3 Disclaimer and Limitations

Before the publication date of the report, AT visited all deployment sites to speak to local mPower teams. Data was collected at different time points in each location, due to limitations in researcher capacity.

More extensive visits where beneficiaries, primary care representatives and third sector representatives were interviewed, were only possible in Dumfries and Galloway, the Western Isles and Ayrshire and Arran. Due to the COVID-19 pandemic, interviews in other deployment sites had to be conducted by phone or video conference. This is inevitably reflected in the level of richness of the data.

As interview participants were recruited through local mPower teams, the sampling may not provide a holistic picture of the range of beneficiaries and other stakeholders involved in the mPower project. However, this is mitigated by the inclusion of findings from the questionnaire data.

This report nevertheless aims to provide a rich and holistic view of the experiences of the mPower stakeholders.

2.4 Report Structure

This report begins by providing an overview of the policy context across Republic of Ireland, Northern Ireland and Scotland, to help situate and contextualise the mPower project. It then discusses existing evidence on the effectiveness of social prescribing and eHealth in achieving health and wellbeing outcomes. The next section discusses our theoretical (realist) approach to evaluation, as well as the methods of data collection and analysis.

The findings section of the report presents an overview of key results, in line with the domains outlined in the introduction of this report.

Finally, we discuss the findings, including implications and recommendations for future service delivery.

3. Social Prescribing and eHealth in Scotland, Republic of Ireland and Northern Ireland

Sitting at the heart of the mPower approach are the concepts of social prescribing and eHealth. These two areas have become increasingly prominent in health and care policy during the lifetime of the mPower project. There have been shifts in how each area has been conceptualised within policy and initiatives over time, not least due to the impact of the COVID-19 pandemic. In this section of the report, we reflect on the policy context within each mPower deployment site.

3.1 Scotland

As the number of people in Scotland aged 65 and over rises, the Government has recognised that the country's health and care services must change in order to continue to meet the population's needs. In 2021a, The Scottish Government produced A Scotland for the Future: Opportunities and Challenges of Scotland's Changing Population. As the country's first national population strategy, this document sets out the ambition for Scotland to *'be a place where everyone can live long and healthy lives'. There* is a recognition that Scotland's population is increasingly older and that there is a need for a health and care, and wider public services, system that *'not only supports our older population to live healthy lives but ensures they have opportunities to participate, contribute and thrive'.* The activities of mPower have been shown to be well-placed to help deliver on these objectives.

The Scottish Government (2021a) recognises an *'increasing demand for health and social care'* that accompanies an ageing population and that there is a need to *'manage and mitigate the levels of demand'.* The Scottish Government's (2012) 'Reshaping Care for Older People: A Programme for Change 2011-2021', described eHealth as having the potential to support greater independence for older people and bring cost of care saving. The Statement of Intent published March 2021b to *'develop a new integrated health and social care strategy for older people'* further demonstrates the connections between population ageing and health and care services reform. Both non-clinical interventions and eHealth (for access to clinical services and for the support of self-management behaviours) can be seen as key parts within reformed, integrated services.

When the mPower project was in its infancy, the Scottish Government's Digital Health & Care Strategy (2018) noted that fundamental advances in technology would mean that digital services would become the first point of contact with health and care services for many people, and potentially their preferred method of engagement on an ongoing basis. It emphasised the importance of using digital technology in an integrated manner, as a key enabler to delivering excellent care.

Over the lifetime of the mPower project, we have seen huge shifts in the use of digital technology within health and social care, not least due to necessity during the COVID-19 pandemic. In Scotland, the use of NHS Near Me for video conference communication with healthcare professionals saw a rapid roll-out and huge spike in usage of around 900% per month (Scottish Government, 2021d).

In October 2021c, the Scottish Government released a 'refreshed' Digital Health & Care Strategy. This document's aim is to describe *'how we will work together to improve the care and wellbeing of people in Scotland by making the best use of digital technologies in the design and delivery of services, in a way, place and time that works best for them'.* The first aim of the strategy, in particular, can be supported by activities such as those delivered by mPower:

Aim 1: Citizens have access to, and greater control over, their own health and care data – as well as access to the digital information, tools and services they need to help maintain and improve their health and wellbeing.

Digital access and digital services are two of the key mechanisms through which the aims of the strategy could be realised. Appropriate use of digital technology is also recognised in the NHS Recovery Plan (Scottish Government, 2021e).

Social prescribing is also central to the Government's strategy on self-management of long-term conditions. Long-term conditions become more prevalent with age; with nearly two-thirds of people in Scotland developing a long-term condition by the age of 65. In Scotland, long-term conditions are defined as*: 'health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support'* (Scottish Government, 2019). According to 'Gaun Yersel!, The Self-Management Strategy for Long-term Conditions in Scotland', the impact of long-term conditions on NHS services can be reduced through supported self-management (LTCAS and Scottish Government, 2008).

Supported self-management is a person-centred approach that empowers individuals to manage their life well, with their long-term conditions. Self-management mechanisms range from specific medical interventions, e.g. insulin balance for people living with diabetes, information leaflets, courses run in the community by people with similar conditions, community-based social and educational activities, and community groups run by volunteers (LTCAS and Scottish Government, 2008).

Scotland's National Clinical Strategy (2016) highlights the important place of primary and community care in supporting self-management and the ageing population. Wherever possible, it states that this type of care and support should be offered locally and names Link Workers as one of the professional roles within local teams.

The types of support offered by Link Workers can particularly assist those who utilise primary care for non-clinical needs or who have long-term conditions that may benefit from non-pharmaceutical interventions. People who live with long-term conditions are, for example, more likely to experience loneliness. There is a recognised link between loneliness and health and wellbeing, with people who are lonely being more likely to visit their GP, to experience depression, have higher medication use, have higher incidence of falls, and to require residential or nursing care at an earlier age. It is recognised that general practice is often not the most appropriate setting to address non-medical, social determinants of health, due to the limited time for exploring issues within a primary care appointment and limited knowledge of available sources of community support (Alliance, 2016).

According to NHS Health Scotland's (2016) 'Social prescribing for mental health: guidance paper', holistic social prescribing models, using 'linking systems' may offer a useful framework in which people with mental health issues can access multiple sources of support, thus contributing to improved psychological and social wellbeing. The Scottish Government funded five early adopter sites for Community Link Workers in 2017 (Public Health Scotland, 2020). Through the General Medical Council contract, there is now a commitment to embedding Community Link Workers within general practices in Scotland (Healthcare Improvement Scotland, 2019). Furthermore, in 2020, the Scottish Social Prescribing Network (SSPN) was established and mPower provided some seed funding for this.

The national policy context within Scotland currently seems supportive of, and conducive towards, the roll-out of social prescribing and eHealth initiatives such as mPower.

3.2 Northern Ireland

Similarly to Scotland, Northern Ireland has an ageing population which, by 2028 is projected to contain 20% aged over 65 years (Age Northern Ireland, 2021). Thus, the population in Northern Ireland is ageing at a quicker rate than other parts of the UK (Age Northern Ireland, 2021). Northern Ireland faces similar challenges and strains on its health and social care system to those previously described as associated with Scotland's ageing population.

In Northern Ireland, the direction of policy response to this ageing has also been similar. In its Active Ageing Strategy 2016-2022, for example, the Northern Ireland Executive (2016: 4) expresses its central vision for Northern Ireland as *'an age friendly region in which people, as they get older, are valued and supported to live actively to their fullest potential; with their rights respected and their dignity protected'.* As the proportion of Northern Ireland's population aged 65+ rises, this Strategy focuses on removing barriers to people living actively as they age (Northern Ireland Executive, 2016).

In the face of an ageing population and limited funding, Northern Ireland's public sector seeks to maximise the potential of technology to develop and modernise its health and care system to make it more responsive and better focused on the needs of the people it serves (Digital Health, 2014). A discourse around the need for change and transformation is also evident in Northern Ireland policy and strategy documents.

Northern Ireland's IT strategy consultation led to the development of the Health and Social Care Board (HSC, 2016) and the eHealth and Care Strategy for Northern Ireland. The Strategy's vision that *'through eHealth, we will empower people to be more active in their own care and support health and social care staff in delivering the best possible health and wellbeing for everyone',* is underpinned by five key principles: Citizen centred, Connectivity, Consistency, Creativity, and Cost effectiveness (HSC, 2016: 5). The Strategy outlines how eHealth can support people and services, as well as help the flow of information to support improved decision making, for better care. However, it also describes the difficulties HSE face in making eHealth work, e.g. length of time for ideas to become mainstream; resistance to change; paper records still being widely used; older information systems' incompatibility with newer systems; concerns about confidentiality; and internet access issues. They recognise that it is not always easy to prove the benefits of eHealth when trying to justify the use of scarce funds in the testing of such systems (HSC, 2016).

Health and Wellbeing 2026: Delivering Together (2017) provided a ten-year approach to *'transforming health and social care'* within Northern Ireland. The types of services provided by mPower are well placed to assist in achieving elements of this transformation, particularly related to prevention and primary care. Drawing on this approach, Digital Health and Care Northern Ireland aims to *'harness the power of data and digital technology to improve health and care for every patient, client and citizen'* (DHCNI, 2022). As in other parts of the UK, the COVID-19 pandemic brought rapid shifts in the use of technology and eHealth in Northern Ireland.

We have previously noted that the likelihood of having more than one long-term condition increases dramatically with age (DoH, 2016). Northern Ireland draws on the World Health Organisation's definition of chronic disease to define a long-term condition as: *'a disease of long duration and generally slow progression'* (DHSSPS, 2012: 4). In Northern Ireland, 20.69% of people have a long-term problem or disability that limits their daily activities (NISRA, 2013). Having one or more long-term condition means people's care and treatment needs are more complex. This is coupled with health and social care expectations being the highest they have ever been (with people wanting to lead full and productive lives, and stay independent for longer), while health inequalities persist (DoH, 2016). As part of enhancing support in primary care, DoH (2016) are seeking to maximise the potential for developing social prescribing models, which can be more effective than traditional treatments. A Northern Irish health initiative, the SPRING Social Prescribing Project, funded by National Lottery, is currently operating in Northern Ireland (DoH, 2019). There is also an All Ireland Social Prescribing Network, established in 2018. The policy and strategy environment therefore seems conducive to the support of social prescribing initiatives within Northern Ireland.

3.3 The Republic of Ireland

The Republic of Ireland (ROI) also has an ageing population with associated health and social care services challenges. In 2019, 14% of the ROI population was over 65 and this is projected to rise to 26% by 2051 (Institute of Public Health, 2020). As Ireland's population of those aged 65+ is rising, life expectancy in Ireland is now greater than the EU average (Smyth et al, 2017).

Similarly to Scotland and Northern Ireland, policy and strategy within ROI recognises the need to address the challenges of an ageing population and that this must involve equity, reform and change. The Healthy Ireland Framework has a vision for *'a Healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility'* (HSE, 2013). Ireland's National Positive Ageing Strategy has a central vision for Ireland to be *'a society for all ages that celebrates and prepares properly for individual and population ageing... [and which] will enable and support all ages and older people to enjoy physical and mental health and wellbeing to their full potential'* (DoH, 2013: 3).

According to the eHealth Strategy for Ireland, eHealth is a critical enabler of best-practice in health systems and optimum healthcare delivery; and to be properly executed, must involve all stakeholders, feature strong clinical engagement, and a willingness to embrace process re-organisation from the outset (DoH, 2013b). A new entity called 'eHealth Ireland' has been established, to bring improved population wellbeing, health service efficiencies, and economic opportunity through the use of technology-enabled solutions (HSE, no date). This suggests policy support for the appropriate use of eHealth in activities such as those provided by mPower.

The Irish Health Service Executive (HSE) (2018a) states: *'a long-term health condition is one which can be treated and managed but usually not cured'.* In Ireland, 65% of those aged 65+ have two or more long-term conditions (HSE, 2017). According to HSE's (2017) 'Living Well with a Chronic Condition: Framework for Self-management Support', chronic diseases are a major contributor to health service activity and expenditure, yet most of the care for chronic conditions is provided by the person themselves. Ireland's predicted significant increase in its older population (those aged 65+) will result in a continued increase in chronic diseases and a resulting burden on individuals and the healthcare system (HSE, 2017). Self-management support is seen as an important aspect of long-term condition management – with citizens empowered to actively participate in the management of their condition, through access to information, education, support, and services.

The HSE recognises that social prescribing can be used to direct patients to appropriate non-medical sources of social and peer support in the community, thus improving patients' physical, emotional and mental wellbeing, while saving money from reduced healthcare utilisation including hospitalisation (HSE, 2017). Social prescribing is offered as a free service from HSE, to link people aged 18+ with sources of support and social activities in their community, if: they feel they need some health and wellbeing support; feel isolated, stressed, anxious, or depressed; or feel they simply need the service (HSE, 2018b). HSE has a Social Prescribing Framework which aims to support the mainstreaming of this approach (HSE, no date).

3.4 Conclusion

The mPower project was embedded within and predicated upon the outcomes and priorities of the policy context across all three deployment areas. While this policy overview highlights the similarities across areas, localised challenges to implementation and service delivery existed. These will be discussed later in the report.

4. Literature Review: Evidence of Social Prescribing and eHealth Outcome Achievement

This section of the evaluation report summarises the existing evidence base within recent academic literature (since 2009) on the outcomes and 'what works' in terms of social prescribing and eHealth, with particular reference to older people. This is not a systematic review but aims to give an overview of key themes within the academic literature with some examples of key studies.

4.1 Social Prescribing in Academic Literature

Social prescribing is defined as any activity in which a non-pharmaceutical intervention is recommended or provided to people with a non-clinical need such as loneliness, social isolation or low-level depression or anxiety.

Within the mPower project, social prescribing took the form of a guided conversation with a Community Navigator – resulting in the co-production of a Wellbeing Plan for the beneficiary. This plan contains a set of actions that the beneficiary agrees to undertake following their initial meeting with the Community Navigator. The beneficiary could receive varying levels of on-going support from the Community Navigator in order to engage fully with the actions contained within their Wellbeing Plan.

The label of social prescription has, however, been applied to varying types of interventions. People may be referred directly from a General Practitioner (GP) to a third sector organisation, for example, or people may self-refer to a Link Worker functioning in a similar way to mPower's Community Navigators. Social prescription has even been used to describe social, cultural or physical activity interventions that are considered to deliver health and wellbeing benefits but do not involve referral from, or interaction with, any element of health services.

This section of the report highlights some of the main themes from the existing peer reviewed literature on the evaluation of, and research relating to, social prescribing. We consider studies that were focused on the over 65s as this was the target population of the mPower project.

4.1.1 Social Prescribing for Older People

There is not a great deal of existing peer reviewed evidence on the impacts of social prescribing for over 65s. The most common positive impacts of social prescribing within the general population are summarised by Chatterjee et. al.'s (2018) systematic review as:

> *...increase in self-esteem and confidence; improvement in mental well-being and positive mood; and reduction in anxiety, depression and negative mood. (p.97)*

A paper by Elston et. al. (2019) is one of the few before and after evaluations of social prescribing specifically for older people. Their study considers a social prescribing programme in the South of England that specifically targeted those aged 50 and over with two or more long-term conditions (LTCs). The evaluation described in their paper used specific outcome measures: wellbeing, frailty, activation and use of health and social care services. The before and after study found a statistically significant improvement in participants' physical health, wellbeing, activation and frailty.

Social prescriptions for creative and participatory arts-based programmes, such as 'arts on referral', are numerous within the social prescribing evaluation literature; although, as noted above, there are few studies that focus specifically on the impacts for older people taking part. In general, arts on prescription type programmes show positive benefits in the form of improved mental wellbeing, decreased social isolation and even improved self-management and increased self-efficacy. These impacts are generally related to both the physical and mental immersion in creative practice and the social elements of engaging in creative practice with others and/or in a group setting (e.g. Redmond et. al., 2019; Waddington-Jones et. al., 2019).

Thomson et. al.'s (2018) study is one of the few to evaluate a creative social prescribing scheme specifically for older people – they look at the impacts of taking part in museum-based activities led by either staff or volunteers. Using a wellbeing measure designed for use with older people (the Museum Wellbeing Measure for Older Adults or MWM-OA), their study shows improvements in the self-assessed areas of psychological wellbeing post-intervention. The benefit of social contact is emphasised in Thomson et. al.'s (2018) paper – this reflects a theme running throughout social prescribing evaluation literature; that social prescribing can reduce social isolation.

Vogelpoel and Jarrold (2014) also consider arts on prescription for older people; specifically those living with sensory impairment and experiencing social isolation. They report positive impacts on health and wellbeing for participants, including *'increased self-confidence, new friendships, increased mental wellbeing and reduced social isolation'.* Noguchi et. al.'s (2022) Japanese study also concludes that art and cultural activity can prevent depressive symptoms in older adults.

Interactions with nature, particularly gardening or walking outdoors, are also well represented in the social prescribing academic literature. Benefits to participants include decreased social isolation and improved mental wellbeing. Often this is related to group activities such as community gardening (McGuire at. al., 2022) which can simultaneously foster social connection and a sense of belonging. Many studies relating specifically to older people focus on human-nature interactions for people living with dementia and their carers (e.g. Evans et. al., 2019).

The pivotal role of the person in a Community Navigator post is clear within the existing literature base. Elston et. al. (2019) note that in their social prescribing programme, the *'co-ordinators played a valuable key-worker role, improving the continuity of care, reducing isolation and supporting carers'*. Baker and Irving (2016), within the context of social prescribing for people living with dementia, note that success requires someone in the Navigator role that can act as *'boundary-spanner'* and *'develop referral pathways and collaborative relationships through networks.* Araki et. al. (2022) highlight the importance of these relationships not being 'hierarchical' in order to achieve impact generation.

Although their systematic review does not focus specifically on older people, Husk et. al.'s (2019) paper is useful in highlighting some of the characteristics of successful social prescribing projects; which they categorise into the three areas of 'enrolment', 'engagement' and 'adherence'. Through a synthesis of 109 studies, they reflect that (emphasis added):

> *...patients are more likely to enrol if they **believe** the social prescription will be of **benefit**, the referral is **presented** in an **acceptable** way that **matches** their needs and expectations, and concerns are **elicited** and **addressed** appropriately by the referrer.*

And

> *Patients are more likely to engage if the activity is both **accessible** and **transit** to the first session supported.*

In remote and rural areas, such as some of those served by the mPower project, this element of 'transit' may take the form of physical transportation to a particular location in order to take part in activities.

Panagioti et. al.'s (2018) study also indicates the importance of achieving good levels of ***engagement*** with a social prescribing intervention. Their paper outlines how being selected for social prescribing (or referred) does not necessarily translate into action or ***engagement*** by the older person. Although the intervention that they evaluated used a telephone-based (rather than face-to-face) meeting with a Community Navigator they observed 'low levels of uptake amongst those selected for the intervention'. However, it is interesting that the control group of older people within this study was seen to have a higher usage of emergency care, compared to those offered the telephone-based social prescribing.

Loftus et. al. (2017) report on the impact of a social prescribing programme within primary care. They note that only 41% of those who agreed to participate followed through and completed a socially prescribed activity. They found no change in the number of repeat prescriptions or GP visits but do acknowledge that social prescribing can help patients' self-esteem and wellbeing.

Todd et. al.'s work (2017) also highlights the importance of the quality of the activities that may form part of a social prescription for older people. Activities that are *"facilitated by skilled and knowledgeable staff"* are more likely to promote engagement and adherence.

Elston et. al.'s (2019) before and after study of a social prescribing programme for the over 50s found that such interventions do not necessarily reduce health and care service use or cost in the short to medium term. They looked at usage 12 months after intervention and found that 44% of their participants either decreased or maintained levels of usage (and, therefore, 56% of participants saw an increase). They detail that most of this increase can be accounted for by the contribution of 13 particularly high cost users who experienced *'significant, rapid escalation in morbidity and frailty'*. This type of finding highlights that social prescribing programmes may have greatest impact on health and social care usage/cost reduction if targeted at specific groups around the middle of the Kaiser Permanente1 risk stratification pyramid (e.g. supported self-care).

Baker and Irving (2016) provide one of the only assessments of a social prescribing system that was discontinued. They relate this to *'institutional logics' that 'mitigated against the collaboration necessary to support'* social prescribing. This highlights the importance of the relationship between service provider/commissioner (usually the health service) and the organisations that provide the social prescription activities (often the third sector). Brunton et. al.'s (2022) recent paper also tackles the subject of primary care staff views on the integration and operationalisation of Community Navigator type roles within primary care – they highlight some of the challenges such as a lack of clear understanding of these roles within the wider health and care system and a lack of

[1] See the King's Fund website for more details: https://www.kingsfund.org.uk/publications/population-health-systems/kaiser-permanente-united-states

preparedness and training for those being asked to take on these roles. Like all other services, social prescribing was affected by the COVID-19 pandemic and in many areas switched to remote contact with beneficiaries out of necessity (this happened in most of the mPower deployment sites). This posed challenges for people in Community Navigator roles, not least in terms of trying to preserve the important rapport building necessary for tackling social isolation (Fixen et. al., 2022). As Morris et. al. (2022) found in a social prescribing intervention in Northeast England, the COVID-19 pandemic meant those in Community Navigator roles felt it difficult to meet the aims of social prescribing interventions through remote delivery, particularly in relation to those who were 'digitally excluded'.

4.2 eHealth in Academic Literature

eHealth Interventions are defined as any use of digital technology to promote health, wellbeing, self-management of LTCs or efficient and appropriate use of statutory or private healthcare services.

The mPower project's relationship with eHealth is complex. The project had a target of delivering 4,500 eHealth interventions, separate from the delivery of 2,500 Wellbeing Plans. Yet, an eHealth intervention can, and has, formed part of the Wellbeing Plan (or social prescription) negotiated between the Community Navigator and beneficiary. Therefore, it is hard to disentangle the relationship between the two and their respective influences on outcomes and impacts for beneficiaries. In addition, as the mPower project progressed, the staff have seen strength and benefit in a wide definition of eHealth that includes supporting digital literacy and the use of technology for wellbeing benefits in ways that are not necessarily about interaction with clinical services or monitoring of physical or mental health status.

This section of the report considers themes within the research and evaluation literature on the most common eHealth intervention types within the mPower project. We consider studies that focused on the over 65s as this is the target population of the mPower project.

4.2.1 Outcomes of eHealth Interventions

There are specific eHealth interventions that are more numerous within the mPower deployment sites: home alarms (pendants and wristbands); Florence (text-based medication reminders) and video conferencing (VC) through the Attend Anywhere/Near Me system. Therefore, this section of the literature review considers recent (since 2009) peer reviewed evidence on the outcomes achieved for people over 65 using these types of eHealth intervention.

4.2.2 Home Alarms

Home alarms can be used to monitor and/or predict falls. Much of the academic literature in this area is concerned with the accuracy of falls prediction (e.g. Chelli and Patzold, 2019; Kangas et. al., 2015). Home alarms are cited as contributing to enabling older people to live at home, and as independently as possible, for as long as possible (Pritchard and Brittain, 2015).

Home alarms in the form of pendants, wristbands and ceiling mounted chords are generally considered to be 'established technology' that have been proven to be useful in both issuing an alert when needed and offering a sense of reassurance to older people and their family and carers (e.g. Stoke, 2017). Alarms have, for example, been shown to be effective in instigating timely assistance in the event of a fall or medical emergency (Miguel et. al., 2015). Such timely assistance can mitigate against costly hospital admissions or long-term care (Nyman and Victor, 2014; Wang et. al., 2021).

However, some sociological investigations have raised concerns about an association between alarm pendants and *'feelings of dehumanisation'* (Pritchard and Brittain, 2015). It's also been suggested that they can be limiting because they tie feelings of security to the home and not to spaces outside it (Aceros et. al., 2015).

These types of social barriers to pendant use may help to explain the findings of Nyman and Victor's (2015) analysis of the English Longitudinal Study on Aging that showed that only 6% of adults living in the community, aged 65 or over, and reporting *'difficulties of mobility or activities of daily living',* reported using a personal call alarm. This leads Nyman and Victor (2015) to conclude that *'personal call alarm use may be markedly lower than the 30 percent annual incidence of falls among community-dwelling older people'.* This suggests that, despite the quoted 'acceptance' of this type of technology, there is still work to be done through projects such as mPower to encourage greater use of personal alarms amongst those sections of the population that may be most at risk of falls and, therefore, benefit the most from such technology.

4.2.3 Florence

Florence is a text-based system often used for medication reminders. There are few academic studies that have evaluated Florence as a medication reminder intervention for older people.

Two papers do, however, consider Florence in the context of a hypertension management intervention. In their 2015a paper, Cottrell et. al. describe how Florence was used to send patients *'prompts via text message to submit [blood pressure] readings',* as well as sending them *'educational messages and user satisfaction questions'.* The patients were able to respond to Florence and the data submitted was stored for future viewing by their primary healthcare team. Although the study found positive results in terms of supporting the diagnosis and monitoring of hypertension; it was seen to be less effective in the area of supporting patients to control their blood pressure through self-management. In their analysis, between 5 and 22 % of patients managed to achieve blood pressure control. The rates at which people engaged with Florence decreased over time and it appeared that patients came to accept their 'sub-optimal' levels of blood pressure.

Cottrell et. al. (2015b) also discuss this phenomenon of patient 'drop off' in another 2015 paper. In considering the use of Florence in the areas of hypertension, medication reminders and smoking cessation, they come to the following conclusions, which are pertinent to the work of the mPower project (emphasis added):

> *...satisfaction... appeared optimal when patients were **familiar** with the system, the programme addressed a problem with the previous service delivery that was **identified by the users** and users took an **active approach** to achieve clinical goals... future applications may be optimised by identifying and addressing reasons for the waning use of the service and enhancing support during implementation of the service.*

4.2.4 Video Conferencing with Healthcare Professionals

Video conferencing was introduced in mPower deployment sites in order to connect older people with healthcare professionals – allowing, for example, remote outpatient consultations without travel. Some studies have shown that patient anxiety is reduced in video consultations when compared to in-person outpatient appointment attendance (e.g. Nissen and Lindhardt, 2017). Studies such as that by Rasmussen et. al. (2016) suggest that non-attendance at video

consultations may be lower than at in-person clinics. Fatehi et. al. (2015) demonstrate the effectiveness of video consultation in the management of diabetes (2015) and Poulsen et. al. (2015) suggest patient acceptability, or even preference, for video consultation in rheumatology.

Apart from Versleijen et. al.'s (2015) evaluation of a telegeriatric service, there are few studies that consider the impact of video consultations specifically for older people. Versleijen et. al.'s work (2015) shows that a telegeriatric service can be less costly than a visiting geriatric consultant to small rural hospitals.

Although not specifically looking at older people, Greenhalgh et. al.'s (2018) paper is an important piece of work in the evaluation of video consultations within the health and care sector. Their observations, for example, that *'video consultations appeared to work better when the clinician and patient already knew and trusted each other'* have implications for how, and how effectively, such methods may be implemented within remote, rural and regional areas. Greenhalgh et. al. (2018) reflect on findings of several other video consultation papers:

> *Video outpatient consultations appear safe, effective, and convenient for patients in situations where participating clinicians judge them clinically appropriate... some clinicians will adopt readily, whereas others will need incentives and support.*

The COVID-19 pandemic meant that many services across all of the mPower deployment sites switched from in person to video conferencing or telephone provision. The use of NHS Near Me became much more prevalent. An evaluation of the rapid roll-out of NHS Near Me in Scotland at the start of the COVID-19 pandemic showed that 'most patients and professionals perceived video consulting as beneficial... patient surveys showed positive outcomes in terms of patient satisfaction and patients' views on how the consultation helped them cope with their condition' (Wherton and Greenhalgh, 2021).

4.2.5 Other eHealth Interventions

Within the mPower project, the definition of eHealth intervention was broad and often went beyond the specific digital technologies outlined above. Community Navigators, for example, saw first-hand the benefit of supporting older people to use smartphones and tablets which, not least, can help to reduce social isolation.

Systematic reviews in this area conclude that more evidence from robust studies is needed in order to examine the links between use of communications technology and social isolation in older people (Baker et. al., 2018; Chen and Schulz, 2016). However, individual studies suggest that social and communications technologies do have a role to play in reducing social isolation. Chopik (2016) has, for example, shown an association between *'higher social technology use' and 'better self-related health, fewer chronic illnesses, higher subjective well-being and fewer depressive symptoms'.* This highlights the link between increased social connection (through technology) and physical and mental health. This suggests that a broadening out of the definition of eHealth to include the use of technology for social interaction could be useful.

5. Evaluating the mPower Approach to Social Prescribing and eHealth

5.1 Theoretical Approach

Our evaluation of the mPower project takes a realist approach.

The key principle of realist evaluation (Pawson and Tilley, 1997) is that the context in which an intervention is taking place determines whether the intended outcomes are achieved. The central question for this approach is: '*What works, for whom, in what respects, to what extent, in what contexts, and how?*'. In order to answer these questions, realist evaluators aim to identify the underlying generative mechanisms that explain 'how' the outcomes were caused and the influence of context:

Context + Mechanisms = Outcomes

Central to the development of a realist evaluation framework is programme theory: how a programme is expected to lead to its effects and in which conditions it should do so. This is based on previous research, experience and intervention designers' assumptions about how the intervention will work. It is therefore crucial to have a clear and explicit understanding of the intended aims and outcomes of a programme from the outset (Pawson, 2013).

Whether or not an intervention works is due to decisions actors make in response to the intervention. These decisions are dependent on the resources or opportunities provided by the intervention (Pawson and Tilley, 1997).

Realist evaluation is increasingly used in examining health interventions as it can illuminate how they can be improved by unpicking their underlying contextual factors. It has been used to evaluate implementation of both eHealth interventions (e.g. Bartlett et al. 2014) and social prescribing (e.g. Bertotti et al., 2017). Bertotti et al. (2017) note that a realist approach to evaluation can be particularly helpful for interventions such as social prescribing because they involve a wide range of stakeholders (from primary care, third sector and patients to Community Navigators). Context and mechanisms need to be examined from the perspective of all stakeholders in order to understand the resulting outcomes. In practice, this means collecting evaluation data from a wide range of sources.

As deployment sites were implementing mPower in slightly different ways, understanding the context in which local teams work is extremely important. Context can be understood as the individuals involved, their interrelationships, the institutional location and the surrounding infrastructure (and potentially many more factors) (Pawson, 2013). These contextual factors have an impact on how beneficiaries receive their interventions (the 'mechanism'), along with the other contextual determinants (geographical, social, physical etc.) relating to individual beneficiaries.

The context section (6.2) presents the views of local mPower project staff and not necessarily the views of managers as they were not interviewed on this topic. Additional content is from responses to the eHealth readiness questionnaires, which were completed anonymously in early 2018 by staff external to the project teams.

5.2 Data Sources and Stakeholders

In line with the 'Evaluation Framework', multiple data sources have been used during the formative evaluation of the mPower project. The key elements of data collection were:

- **eHealth readiness questionnaires:** used to determine the starting point of each deployment site for implementing eHealth interventions.
- **Baseline deployment site data:** used to gain an understanding of the demographic and geographical make up of each deployment site.
- **Cohort identification:** used to identify the number of those eligible to take part in the mPower project in each deployment site and the demographic composition of the cohort.
- **Wellbeing questionnaires:** used to document individual outcomes experienced by beneficiaries as a result of completing a Wellbeing Plan.
- **eHealth questionnaires:** used to document individual outcomes experienced by beneficiaries as a result of taking part in eHealth interventions.
- **Financial data:** provided by the project team in order to track the economic impacts of the project.
- **Qualitative interviews:** conducted by UHI researcher (AT) in order to further examine the impacts of mPower for various stakeholders.
- **Observational notes:** collected by UHI researcher (AT) while shadowing Community Navigators to gain an understanding of service delivery mechanisms on the ground.

There are several key stakeholders in the mPower project and one of the aims of the evaluation is to capture their views and experiences throughout the lifespan of the project:

- eHealth and/or Wellbeing Plan beneficiaries
- Community Navigators
- Implementation Leads
- Primary care staff
- Third sector staff
- mPower Business Leads
- Project Board members
- The mPower Programme Manager

The following sections of the report provide an overview of the forms of data collection relevant to the evaluation findings.

5.3 eHealth Readiness Assessment

A 'Baseline Report on Readiness of eHealth interventions', provided a summary of the 'eHealth readiness' of all deployment sites. Some of this data has been used in this report to provide contextual background. (Appendix items 9.8.4 and 9.8.5)

The UHI research team provided partners with eHealth readiness assessment questionnaires. Questionnaires were based on the validated MOMENTUM blueprint for telemedicine deployment (Jensen et al. 2015) which sets out 18 success factors critical to implementation of eHealth technologies.

The Momentum blueprint takes into account both management and operational considerations for implementing eHealth interventions. In light of this, partners were asked to determine who were the most appropriate people to answer the two versions of the questionnaire (managerial and operational) in their area. Completed questionnaires were returned to the research team for collation.

The questionnaires were completed in early 2018, at the start of the project and before local project teams were in place. Questionnaires were filled in anonymously. mPower board members in each deployment site decided who to circulate the questionnaire to for completion. The number of completed questionnaires in each deployment site varied. There was also considerable variation in the extent to which deployment sites had existing provision for eHealth in place at the time of completing the questionnaires. However, the results from the survey are used as an indication of the various starting points of the deployment sites in terms of eHealth readiness.

5.4 Economic Data

Financial data on the cost of employing Community Navigators and Digital Navigators was provided by the NSS project management team from project accounts.

5.5 Qualitative Interviews

The mPower project was built around a person-centred approach and qualitative monitoring is, therefore, essential in understanding project effectiveness. Semi-structured interviews with key stakeholders were conducted by AT throughout the project. These provided the opportunity for conversations to focus on the key themes we sought to explore as part of the evaluation (through a number of pre-determined questions), while also allowing for exploring any additional themes that arose during the interview.

Interviews were conducted face-to-face in the location most convenient to participants. However, when meeting in person was not practical, interviews were conducted over the phone, and with the onset of the COVID-19 pandemic, all subsequent interviews were conducted via phone or video call. Where the participant provided consent, interviews were audio-recorded and transcribed by a professional transcription company, ensuring confidentiality and security of the data.

Local mPower staff (Community Navigators and Implementation Leads) were asked to approach beneficiaries, primary care representatives and third sector representatives to ask if they would be happy to be contacted by the UHI research team to arrange an interview. Once consent had

been obtained, AT made contact with participants and, if they were happy to take part, arranged a time and place for the interview. All beneficiary interviews were conducted in the home of the participant or over the phone, while interviews with other stakeholders generally took place in a public space, in their workplace or over the phone or video call.

In addition to interviews with beneficiaries, primary care representatives and third sector representatives, AT conducted interviews with local mPower staff in all deployment sites, Project Board members, one Business Lead and the Programme Manager.

STAKEHOLDER GROUP	Number of interviews conducted
Community Navigators	20
Implementation Leads	12
Beneficiaries	56
Primary care representatives	14
Third sector representatives	14
Project Board members	18
Business Leads	1
Programme Manager	1

Table 1

Conducting beneficiary interviews over the phone could be challenging. Building rapport was more difficult than doing so face to face, and engagement with interview questions varied. Interviews were also shorter than face to face. However, overall, the research team were able to gather a lot of rich data on outcomes, while adapting to this new data collection method.

Interviews sought to explore the themes of patient safety, patient and professional perspectives, organisational aspects, social/ethical/legal aspects and cross-border knowledge exchange in particular.

5.6 Participant Observation

In addition to qualitative interviews, AT conducted participant observation at three deployment sites. This involved shadowing the local Community Navigator in their work, mostly as they visited beneficiaries at different stages of involvement with mPower, but also at community activities they referred beneficiaries to. Seeing the processes and events described in interviews in the context they actually occur in was important to developing an understanding of what, in realist evaluation terms, would be described as the mechanisms through which outcomes are produced for beneficiaries, as well as some of the contexts in which these take place.

After observation, the researcher wrote down 'fieldnotes', which comprised descriptions of the events observed. These were written down as soon as possible after the observation had taken place to ensure good recall. These texts were then analysed along with the interview transcripts.

5.7 Analysis of Qualitative Data

Both interview transcripts and observation fieldnotes were analysed using the NVivo software package. This allowed us to code the content of interviews and notes in accordance with various themes.

We used thematic analysis to code the data. This entails identifying patterns and themes within qualitative data, that allow us to say something about the research questions we are interested in exploring (Braun and Clarke, 2006).

We followed Braun and Clarke's (2006) guide in analysing the data. This entailed familiarising ourselves with the data by reading interview transcripts and making notes on early impressions. We then generated the initial codes that the data was to be grouped under and coded each section of data that was relevant to our research questions. Open coding was used, where codes were not pre-defined but rather emerged from the data itself. The codes were then grouped under various themes, using the domains identified at the start of the research process (see Introduction). Here, we noted that two new themes were emerging from the data: 1) context and 2) approach to service delivery. These were incorporated into the coding framework.

In writing up the findings, the research team explored each key theme. The coding framework is complex and contains a large number of codes. We therefore selected the codes most relevant to our research questions when making decisions on what to include in this report.

5.8 Quantitative Data

5.8.1 Data collection

Data on the impact of participating in mPower was collected using three questionnaires:

- Wellbeing questionnaires: used to document individual outcomes experienced by beneficiaries as a result of completing a Wellbeing Plan (Section 9.8.1). Completed at initial, 3-month and 6-month follow up appointments.
- eHealth questionnaires: used to document individual outcomes experienced by beneficiaries as a result of taking part in eHealth interventions (Section 9.8.2). Completed at initial and 6-month follow up appointments.
- Virtual Clinic questionnaires: used to document individual outcomes experienced by beneficiaries as a result of taking part in a virtual clinic, (Section 9.8.3). Single timepoint questionnaire completed after the virtual clinic.

Questionnaire data was collected between May 2018 and May 2021.

Additional data collected for each beneficiary included:

- demographic details
- referral routes
- long term conditions
- primary care appointments

A number of fixed lists were included for ease of data capture and analysis.

Data field	Details
Deployment site	Ayrshire and Arran HSE CHO1 HSE CHO8 Dumfries and Galloway Southern Trust Western Isles Western Trust
Reason for referral	eHealth Social prescribing Both
eHealth services received	Virtual clinics Home monitoring Digital application Personal eHealth[2]
Source of referral	GP Other Primary Care Social worker Self referral 3rd/Voluntary/Charity Sector Other
Long term conditions, up to 6 selected from a fixed list	COPD Arthritis Asthma Chronic kidney disease Chronic pain Dementia Depression Diabetes Epilepsy Heart disease Hypertension Cancer Frailty Other LTCs (with free text fields to enter details)

Table 2

[2] Personal eHealth was added as an eHealth service after analysis of the data. It was not included as a list option.

The fixed lists for long term conditions and sources of referral were generated and agreed following consultation with partners across all deployment sites.

Prior to beginning data collection it was anticipated that fixed lists for long term conditions and sources of referral would be reviewed once data became available for analysis. However, data only started to become available in December 2020 by which point significant data had already been collected across all sites and introduction of modified lists would have been problematic both for data collection and analysis.

5.8.2 Questionnaire administration

Wellbeing and eHealth questionnaires were administered by Community Navigators on or around the time of initial appointments and then again at 6-month follow-up appointments.

Wellbeing Plans were completed by the majority (98%) of beneficiaries who took part in the evaluation. The small number of beneficiaries who did not complete Wellbeing Plans went on to have eHealth interventions only.

Some beneficiaries (20%) completed both wellbeing questionnaires and eHealth questionnaires. For these beneficiaries, wellbeing questionnaire responses only were included in the analysis[3].

Virtual Clinic questionnaires tended to be given to beneficiaries after their Virtual Clinic appointment to take away and return once completed.

Community Navigators entered beneficiary responses and other details as described above in the Excel database which was then shared securely with the UHI research team.

5.9 Analysis of Quantitative Data

Datasets were transferred into SPSS and variables coded before combining datasets for all deployment sites in a single SPSS dataset.

Inclusion criteria

The full dataset was filtered to include only beneficiaries who:

- were ≥65 years of age at the time of their initial assessment
- had ≥ 1 long term condition
- had completed both baseline and 6-month questionnaires
- had given consent for data to be shared.

Differences between baseline and 6-month questionnaire responses were calculated and coded to create change categories for:

- Loneliness
- Life satisfaction
- Physical health
- Digital confidence
- Long term condition management

Analysis was carried out using SPSS. Data visuals and charts were produced using Power BI and Excel.

[3] Analysis of eHealth questionnaire and wellbeing questionnaire responses for these beneficiaries indicated that there was no significant difference between the responses.

5.10 Population Characteristics

The final dataset for analysis contained data for 1033 beneficiaries from across the different deployment sites.

Deployment site	n (%)
Ayrshire and Arran	504 (49%)
HSE CHO1	73 (7%)
HSE CHO8	22 (2%)
Dumfries and Galloway	186 (18%)
Southern Trust	129 (13%)
Western Isles	24 (2%)
Western Trust	95 (9%)

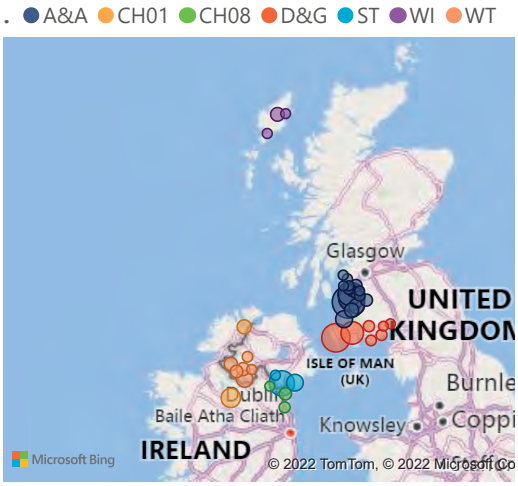
Table 3 Numbers of evaluation participants across deployment sites in the final dataset.

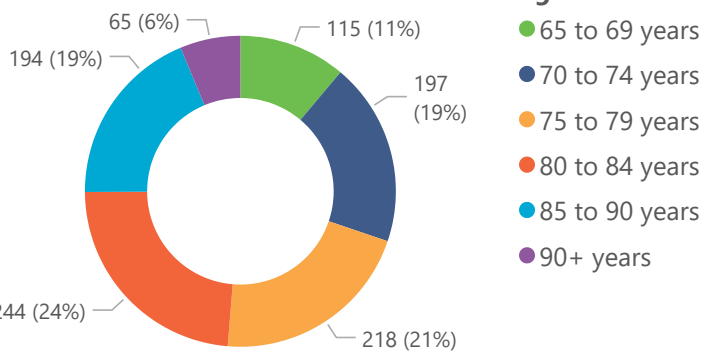
The numbers of beneficiaries in Western Isles, HSE CHO1 and HSE CHO8 are low due to issues around obtaining consent to share data.

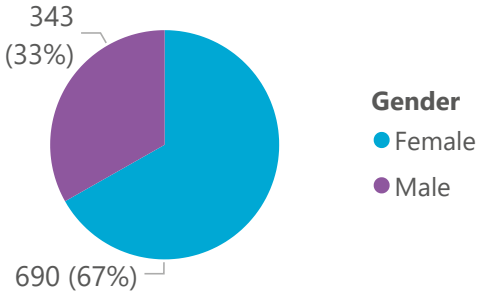
An overview of the population characteristics and referral routes - see right.

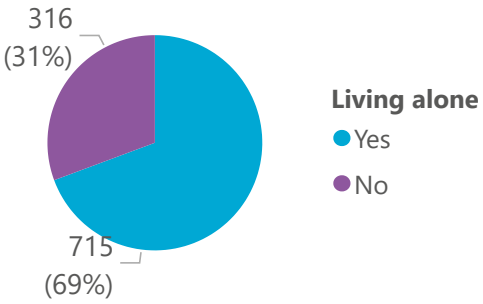
All mPower deployment sites

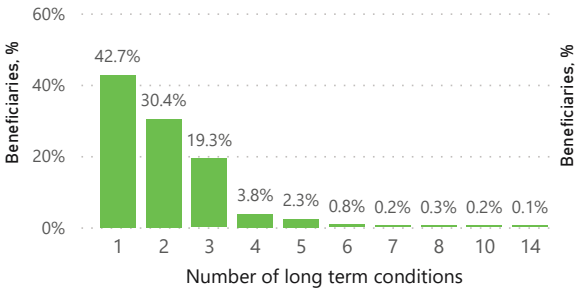
1033
Evaluation Participants



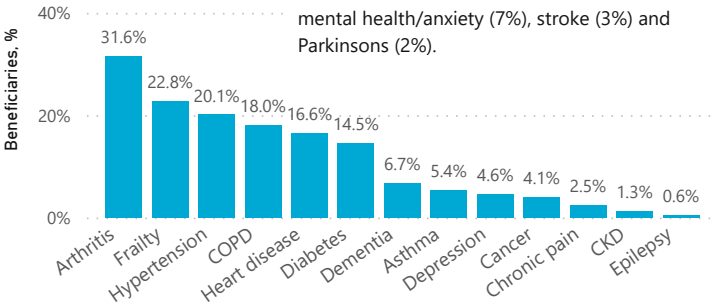


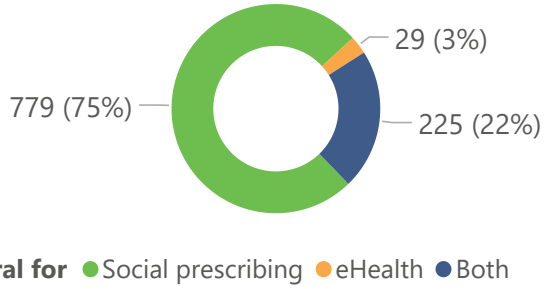






37% of beneficiaries also had long term conditions listed as 'other'. These included mental health/anxiety (7%), stroke (3%) and Parkinsons (2%).





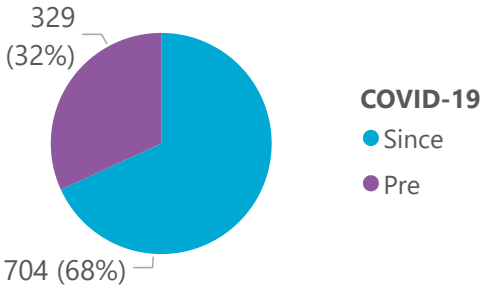


Figure 1 Description of mPower beneficiaries who consented to take part in the evaluation across all sites where quantitative data was collected. Data collected from May 2018 to May 2022.

Primary care appointment in past 12 months (n=528)	
Average	7
Minimum	0
Maximum	69

Table 4 Primary care appointments in the 12 months prior to participation in mPower.

Information on numbers of primary care appointments was available for 528 (51%) of beneficiaries, with most of this data (498, 94%) for Ayrshire and Arran beneficiaries.

No significant difference was seen between the number of primary care appointments in the twelve months prior to participating in mPower for beneficiaries completing their follow-up appointments before and since the introduction of COVID-19 public health measures.

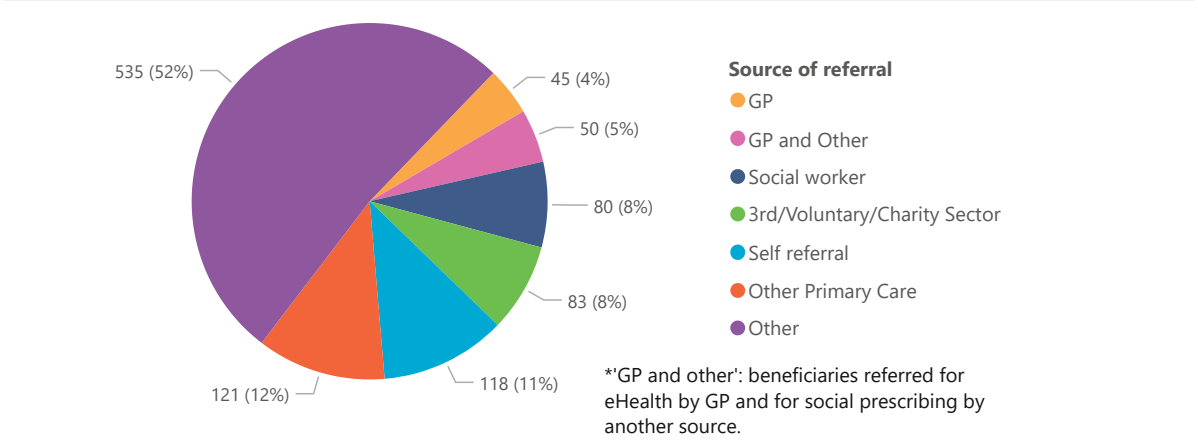


Figure 2 Breakdown of sources of referral for mPower evaluation participants.

Referral sources were selected from pre-defined lists agreed across all deployment sites. For 52% of beneficiaries the source of referral was not on the list and has been recorded as 'other'. The opportunity to review the list of referral resources did not arise until almost 2½ years into data collection at which point it was agreed that revising the list would be problematic both for data collection and analysis. Some 'other' referral sources were provided in the data sets for some sites. These included occupational therapist, pharmacist, fire service, mental health nurse, physiotherapist and family member.

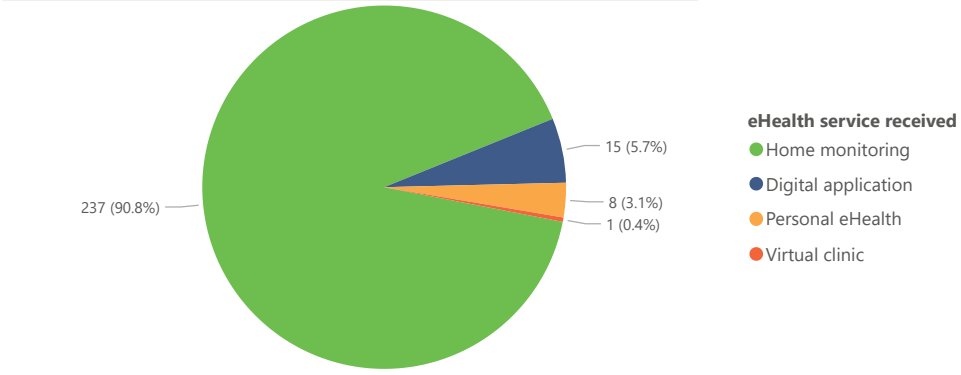


Figure 3 Breakdown of eHealth services received by mPower evaluation participants.

Four beneficiaries received more than one type of eHealth service.

After completing Wellbeing Plans, 3% of beneficiaries initially prescribed for social prescribing were also offered eHealth services

Only one beneficiary returned a Virtual Clinic questionnaire. This beneficiary was referred for social prescribing but subsequently went on to have a Virtual Clinic appointment.

Further analysis of the specific eHealth service types which beneficiaries were offered revealed that not all types matched one of the three listed eHealth services (virtual clinics, home monitoring and digital applications). An additional category 'personal eHealth' was added to enable items such as support in making use of various citizen technologies.

eHealth service type	**n**	**%**
Alert	84	31.7
CUI	41	15.5
ARMED	39	14.7
FLO	22	8.3
Telecare	17	6.4
Lifeline	14	5.3
My Diabetes My Way	9	3.4
Florence	8	3.0
Connecting Scotland	5	1.9
Faire	5	1.9
Care Call	4	1.5
Personal alarm	2	0.8
Ability Net	1	0.4
Blood Pressure Monitoring	1	0.4
Call Blocker	1	0.4
COPD A&A app	1	0.4
Crossword app	1	0.4
IT assistance	1	0.4
Libre device (diabetes)	1	0.4
NHS weight loss app	1	0.4
Online self help guide managing anxiety and panic	1	0.4
Samsung tablet	1	0.4
Self-management sessions delivered by Health and W	1	0.4
Telehealth	1	0.4
Virtual Clinic	1	0.4
WhatsApp support	1	0.4
YouTube for arthritis recommended exercises	1	0.4
Total	**265**	**100.0**

Table 5 Breakdown of types of eHealth services received by mPower beneficiaries included in the evaluation analysis.

After completing Wellbeing Plans, some beneficiaries initially prescribed for social prescribing were also offered eHealth services.

6 Findings

6.1 mPower Project Targets

The numbers provided to the evaluation team demonstrate that the mPower project has met its target numbers of eHealth interventions and Wellbeing Plans. However, there is some variation between the deployment sites in terms of the numbers achieved: 5,525 digital interventions, 2,742 Wellbeing Plans and 1,353 instances of shared learning.

6.1.1 Overall description of targets

The distribution of beneficiary numbers is not even across the deployment sites, nor can it be explained by differences in overall population numbers.

TARGETS[4]	**eHealth Interventions (number of beneficiaries in receipt)**	**Wellbeing Plans (number of beneficiaries in receipt)**
NHS Ayrshire and Arran	1,722	762
NHS Dumfries and Galloway	1,116	479
NHS Western Isles	280	204
HSE CHO8	497	167
HSE CHO1	754	325
Western Health and Social Care Trust	227	368
Southern Health and Social Care Trust	929	437
TOTAL	**5,525**	**2,742**

Table 6 Digital interventions and Wellbeing Plans undertaken by mPower.

mPower has achieved its target number of digital health interventions and its target number of Wellbeing Plans.

Over half (57%) of all digital health interventions have taken place within the Scottish deployment sites; the Northern Ireland sites account for 21% of digital health beneficiaries and the Irish sites the remaining 22%.

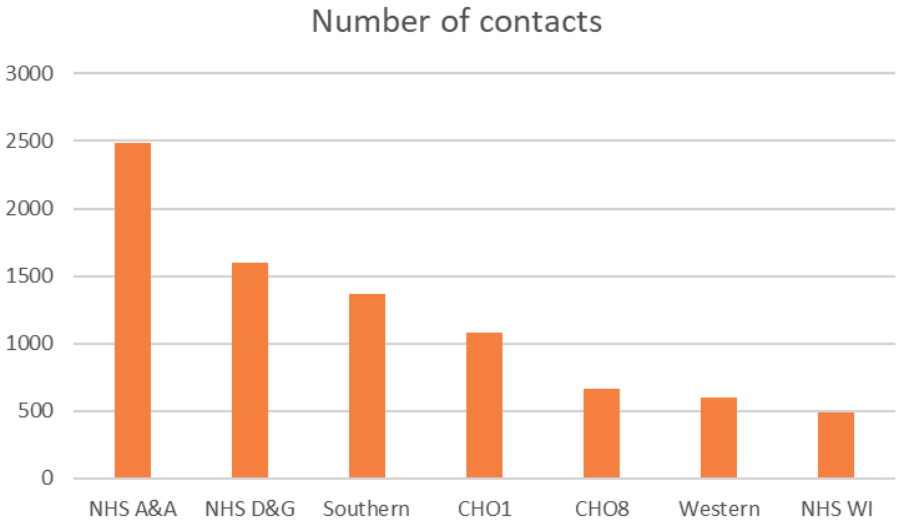


Figure 4

[4] mPower was set a target by their EU funding body of 4,500 eHealth interventions and 2,500 Wellbeing Plans

Just over half (53%) of all Wellbeing Plans have been carried out within the Scottish deployment sites. The Irish sites have seen completion of 29% of Wellbeing Plans, with the Northern Ireland sites responsible for the remaining 18%.

The following sections of this report explore the context within which these numbers have been generated and the variations between deployment sites.

6.2 Context

This section of the report describes the contexts in which mPower was implemented. For each deployment site, we have collated statistical data, data from eHealth readiness assessments (Section 5.3), and qualitative interview data, to describe the various barriers and facilitators to implementing social prescribing and eHealth.

While there is significant overlap across sites, some areas also faced distinct challenges and it is important to gain an in-depth understanding of how these may have impacted outcomes. Due to the COVID-19 pandemic, which took place while the project was being implemented, there were significant changes to the contexts in which local mPower teams worked in. These changes will also be documented in this section of the report. Analysis of demographics and referral routes for beneficiaries included in the evaluation analysis are also included.

Access to quantitative data was significantly delayed due to data sharing challenges and the lack of a central database. There was therefore limited opportunity to feedback to deployment sites during implementation as intended which could have provided a more dynamic and reactive delivery model. Furthermore, due to the limited time the evaluation team had to work with the data, we were not able to carry out as detailed an analysis as originally planned.

6.2.1 Dumfries and Galloway – Wigtownshire

The chosen deployment area in Dumfries and Galloway is Wigtownshire, which is defined as 26% Remote Rural and 23% Accessible Rural. It has a population of 28,750, comprising 26% aged 65+ (NHS Dumfries & Galloway, 2017)[5]. Out of the 40 datazones in Wigtownshire, 12 are within the 20% most deprived across Dumfries and Galloway (NHS Dumfries & Galloway, 2016a). Thirty-four percent of those in Wigtownshire have one or more long-term conditions (NHS Dumfries & Galloway, 2016b). Dumfries and Galloway's self-assessed health scores show that 9% of its population have bad or very bad health. The mean WEMWBS score of the population is 49.4 (SHeS, 2019).

Within this deployment site, 1,116 digital health interventions and 479 Wellbeing Plans have taken place. Although the combined total does not necessarily give the total number of beneficiaries (as some individuals may have received both), it does give an indication that the Dumfries and Galloway team have reached approximately 21% of the over 65 population. The HSE CHO1 and HSE CHO8 deployment sites in ROI reached approximately 13-14% of their over 65s, but all other deployment sites were much lower in the region of reaching 2 to 7 percent of over 65s.

Of those beneficiaries in Dumfries and Galloway, 186 completed the evaluation. A description of this population is shown in Figure 5.

[5] Please see Appendix for more detail on the various classifications referred to in this report.

mPower deployment site Dumfries and Galloway

186

Evaluation Participants

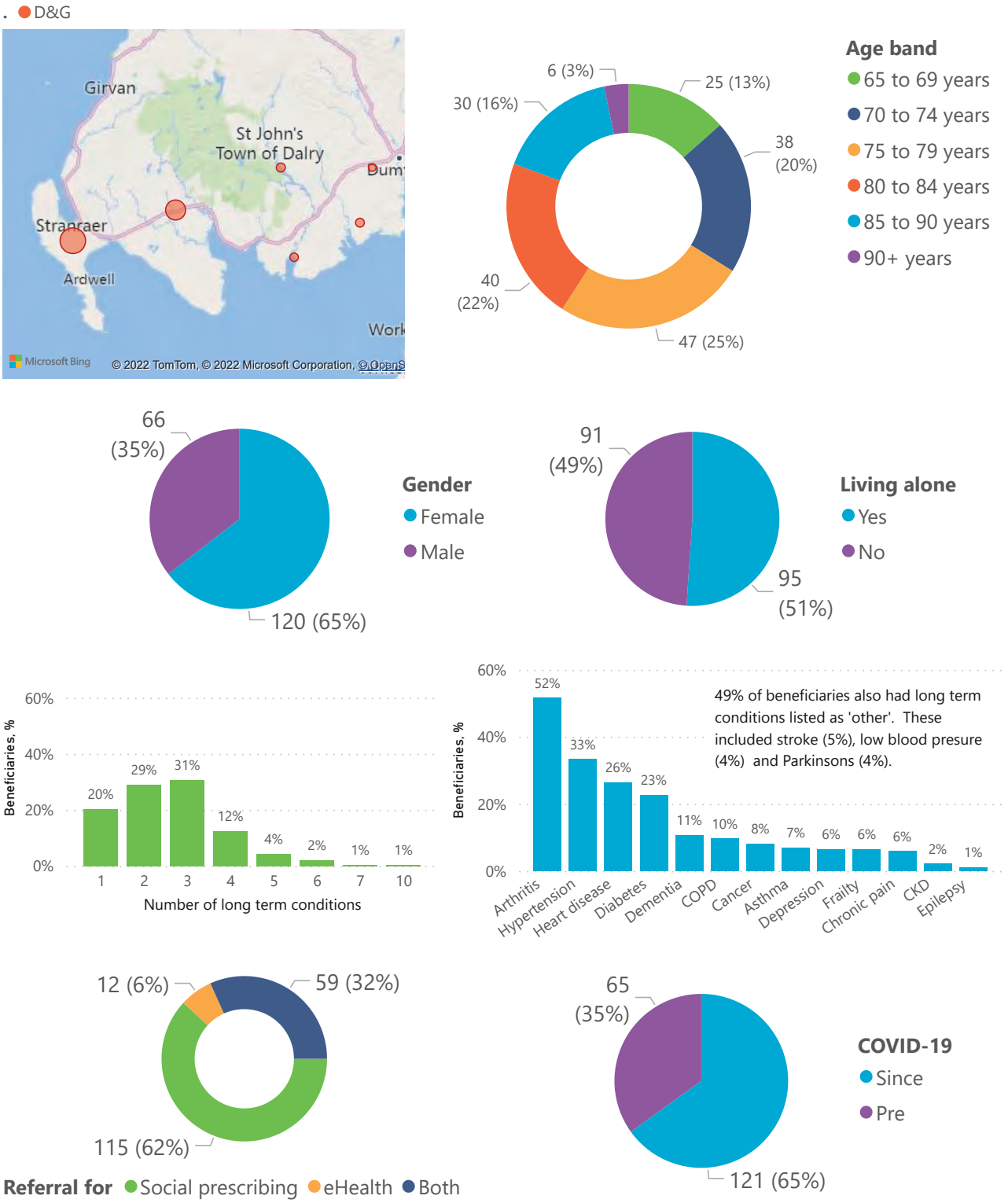


Figure 5 Description of mPower beneficiaries who consented to complete and share evaluation data in Dumfries and Galloway. Data collected from May 2018 to December 2021.

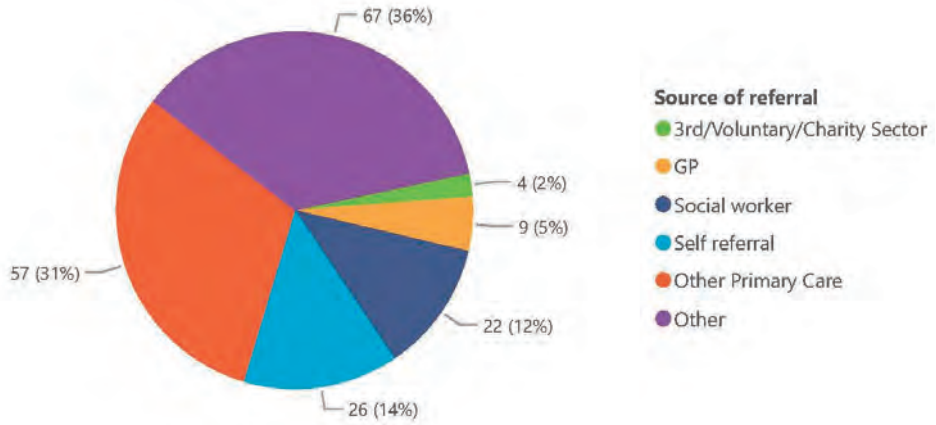


Figure 6 Breakdown of referral soruces for mPower evaluation participants in Dumfries and Galloway.

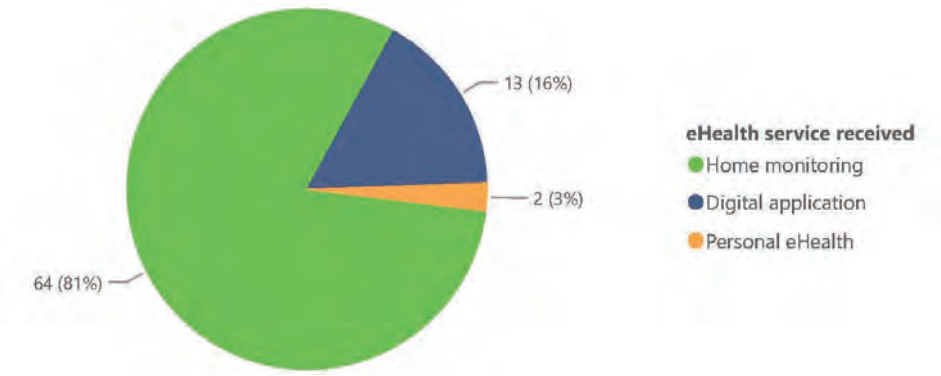


Figure 7 Breakdown of eHealth services received by mPower evaluation participants in Dumfries and Galloway.

eHealth service type	n	%
ARMED	39	47.0
Telecare	14	16.9
Florence	8	9.6
My diabetes My Way	8	9.6
Connecting Scotland	5	6.0
Care Call	4	4.8
Libre device (diabetes)	1	1.2
NHS weight loss app	1	1.2
Online self help guide managing anxiety and panic	1	1.2
Self-management sessions delivered by Health and Wellbeing	1	1.2
YouTube for arthritis recommended exercises	1	1.2
Total	**83**	**100**

Table 7 Details of eHealth service types received by mPower evaluation participants in Dumfries and Galloway.

The local staff explained that working in this geographical and socio-economic context could be challenging:

> *"It's a lot of travelling so we're really keen to make sure that Newton Stewart gets a good service because traditionally it's probably not as well serviced as the likes of Stranraer and the more urban areas… It's just further from Stranraer and the main services and there's a kind of culture in Newton Stewart who are not as engaging, well that's what people suppose. (Local mPower staff)"*

The local member of staff acknowledges the wide geographical area and different settlement types within the deployment site. This poses challenges as different approaches may be needed for different localities, requiring an in-depth understanding of the context of each one. Navigators may also have to travel large distances to see beneficiaries and create third sector connections.

Local staff also had an awareness of the fact that a large proportion of the Wigtownshire population is over the age of 65. This, combined with the level of deprivation in the deployment site, meant that the mPower team focussed on developing strategies to target areas of high deprivation. They felt that these areas were where the largest impact in terms of improving wellbeing could potentially be made. However, this approach also meant they were targeting potential beneficiaries who were also the hardest to reach.

Participants also acknowledged that loneliness and isolation are key issues in the area and pose challenges for the third sector, as well as health and social care services:

> *"They go unnoticed… elderly people who are lonely and isolated. … It's a big issue that we don't see, it's almost invisible. And…agencies, organisations, families become aware of it when a crisis happens. (Third sector representative)"*

These are the people mPower sought to target, as a preventative measure, prior to the crisis point being reached. This concern was also raised by participants working in primary care and highlights the importance of being able to connect these people to services at an earlier stage. We will further discuss issues around reaching 'hard to reach' groups later in the report.

Changes brought on by COVID-19

As the COVID-19 pandemic started, local mPower staff were either redeployed, or asked to pause all mPower work in preparation of being redeployed:

> *"I literally started the job and within a week and a half I was redeployed into… the main hospital here in Stranraer, so the General Hospital, I was in to help with the patient flow stuff so it was about, at that time, getting people out of hospital and safely into care homes or into other settings… it was… at least three months… it was a long time. So I felt I was a wee bit more detached away [from the rest of the mPower team… they were very much hunkered down and looking at potential calls for shielders and stuff like that."*

As the Community Navigator explains, the local team were redeployed in different roles – some conducting shielding calls while others being redeployed to hospitals. This meant that mPower work had to be partially put on hold for a number of months. However, there were still opportunities to conduct Wellbeing Plans:

> *"At one point we were phoning patients from certain GP practice lists who were shielding… we did it for a few days and then they said, 'oh, stop'. So there was lots of stop-start sort of phoning projects that never really got off the ground. We were phoning diabetic patients who have been using the Libre devices – these little sensor things – in order to see if we could get them to upload their data onto the Libre system. But that was quite good and I suppose the mPower part of that was we could offer a Wellbeing Plan to the people while we were on the phone. (Community Navigator)"*

Redeployment also opened up potential new referral pathways. For example, having one Community Navigator redeployed to the hospital helped build connections that subsequently were helpful for another Community Navigator who specifically worked to set up a pathway to support patients who had recently been discharged. However, due to COVID-19, this pathway became delayed.

eHealth and Social Prescribing Services in the Area

Local deployment site staff, as well as primary care and third sector representatives, explained that another Interreg VA project operating in the area, CoH-Sync, also provided a social prescription service. However, this was seen as distinct from mPower due to its focus on all adults, rather than just those over the age of 65. The two social prescribing services worked together to achieve common goals:

> *"I suppose there's the COH-Sync project, but… it's more sort of for everyone that's building healthier communities, it's just about healthy lifestyle and things so I tend to, if it's anyone who's… got long-term conditions and they are a bit older, I would go to mPower first. (Primary care representative)"*

This quote demonstrates an awareness and understanding of what the different social prescribing services offer.

In terms of eHealth provision, data from the eHealth readiness assessment questionnaires completed in early 2018 (Appendix items 9.8.4 and 9.8.5) indicated that Wigtownshire was deploying mPower within a context of willingness by patients and healthcare providers to use ICT and a culture that embraces new technology; this may have helped the deployment site achieve the second highest number of digital beneficiaries within the mPower project. Healthcare professionals were indicated as having a stronger belief in the perceived need for eHealth and home and mobile health monitoring than patients; and while it was suggested that patients perceived a need for eHealth, this was not the case for virtual clinics, which may indicate a preference for face-to-face communication.

The findings also indicated a relatively strong belief in the presence of eHealth leadership through a champion; but neither healthcare professional nor patient involvement in eHealth development, which could negatively affect buy-in. The surveyed eHealth technologies (home and mobile health monitoring, digital applications, virtual clinics) were felt to have relatively high user-friendliness, though training needs were unclear due to uncertainty surrounding the type of eHealth to be deployed as part of mPower. There was also an indication of uncertainty about local ICT competences for eHealth implementation and a lack of financial resources.

Data from qualitative interviews also indicated that eHealth services were not common in the area prior to mPower:

> *"So it really has been starting from scratch and introducing it to services from scratch. And I think we found with eHealth, that services and professionals – because everybody is full to capacity, everybody is under pressure …often they don't have the time to dedicate to things .. In terms of eHealth, maybe those initial conversations … maybe looks as simple and as easy as saying 'we've got this, you can use it', there's a lot more behind the scenes and a lot more processes that have to be put in place with health professionals. (Local mPower staff)"*

Both primary care interviewees in the area further elaborated on the difficulties of securing GP buy-in for eHealth, with one noting:

> *"A lot of what the GPs do, is obviously hands-on, it has to be, and so for a while we were trying to encourage GPs to use Attend Anywhere rather than to go out on home visits to people….in discussions with GPs they are saying this is such a pain and we can use the phone if we need to speak to patients when we are not in their company. It takes such a long time to set this thing up, the Wi-Fi is not always working. You are barking up the wrong tree, you need to be looking at secondary care… GPs traditionally don't like to try new things … the thing is if you need patient contact why do it on a screen when that old lady needs you to be there and feel their tummy. (Primary care representative)"*

Using Virtual Clinics may then, for some primary care practitioners, be more effort than it is worth on balance. Therefore, this type of technology may be more helpful in a secondary care setting. To ensure buy-in, it is important that primary care practitioners have a thorough understanding of when virtual conference technology may be helpful, why and how. Beneficiaries could also be resistant to the use of technology. As one Community Navigator explained:

> *"When you mention technology it scares… some older people… And there is a bit of negativity around, 'you are trying to sell us using the internet and using apps but at the same time we're reading about scams and frauds'….so that is something we regularly come up against and we need to talk our way round."*

Older people having a fear of being scammed was reported by local staff in several of the sites and even acted as a barrier to being able to contact beneficiaries by phone.

Wigtownshire were also part of the Scottish Government initiative Connecting Scotland managed by SCVO (The Scottish Council for Voluntary Organisations), which provided digital devices to citizens lacking connectivity, kit and confidence in technology use.

Despite some challenges, the culture of embracing new technologies and the presence of eHealth champions may have underpinned this deployment site having achieved the second highest overall number of eHealth beneficiaries within the mPower project (1,116).

Health and Social Care Services

Beneficiaries, local mPower staff, primary care representatives, and third sector representatives all expressed concern about the lack of GP resources in the area. Many GPs were retiring and finding new staff could be challenging. Beneficiaries often saw locums, had to wait a long time for appointments, and travelled long distances to the hospital in Dumfries. There was however acknowledgement among beneficiaries that services were stretched and the need to prioritise:

> *"I was going to make an appointment… 'what are you wanting?' ' To see a doctor', 'what's wrong with you?' 'pains in my chest'. 'Oh right, wait there.' and she got on to the doctor, so you get that day, if you said it was your finger, you'd maybe have to wait a fortnight. Ken, that's what it should be I think, you ken? Somebody worse than yourself, you shouldn't be complaining if it's no life threatening or anything like that."*

Many beneficiaries also reported having to travel great distances in order to receive certain health services, an issue particularly for those with reduced mobility:

> *"We loved it [outside Newton Stewart] and we still do but it's got disadvantages. I had some falls and if the ambulance takes me anywhere they want to take me to Dumfries, that's a bumpy hour ride and very often you are stuck there to get back yourself which is expensive, by taxi."*

While consultants could sometimes go to local practices, often trips to Dumfries or Glasgow were required for more complex problems, which could be taxing for beneficiaries. They were often dependent on transport by friends and family. A primary care representative reiterated that NHS Near Me can potentially provide a solution to this issue in some cases, specifically in the context of secondary care.

A service like mPower could act as a buffer for overstretched services in the deployment site. However, this must take place in the wider context of the local Health and Wellbeing team and the services they offer, so as not to create more work for GPs in keeping track of the various services offered:

> *"We are within the Health and Wellbeing team… so again we're trying to make it as easy as possible for people to refer to a Health and Wellbeing team, because GPs…they are full to capacity and they are struggling with recruiting and there's going to be GPs retiring and even in their practice, they really don't try to think– 'I'm going to refer to mPower, I'm going to refer to Healthy Connections, I'm going to refer to CoH-Sync.' (Local mPower staff)"*

Building relationships with primary care could be challenging. Local staff attended multi-agency meetings regularly to ensure that the right people are referred to services, maintained a presence at GP practices, spoke to practice and specialty nurses, as well as community pharmacy teams. They also shadowed social work, district nurses, mental health and re-enablement services. This extensive work enabled the team to obtain referrals from a wide range of health and social care sources. However, this was time consuming:

> *"Just the amount of time that it takes, it's not really as straightforward as it seems. And it's working with the healthcare professionals, with social work because you may have a meeting or you do a presentation on mPower and this is what we can offer. But then following on from that, there needs to be more meetings and a lot of the time, we realised there needs to be steering groups and things set up with social work so they can identify people who can lead on it. (Local mPower staff)"*

GPs remained difficult to engage with. A member of local staff explained:

> *"So I'd really like to be working much closer with the GPs … I think it's just about communication and sometimes we're going to need to make them understand what mPower and CoH-Sync are really about and probably gain a bit of credibility with them. I think the problem for health professionals is so many of these short-term projects seem to come and go and disappear and by the time they've been accepted they've disappeared and I think they maybe lose confidence."*

Offering short-term services can act as a barrier to engagement with both primary care and the third sector. Disillusionment and discontinuation of services can mean that healthcare professionals are not willing to invest time and energy into gaining a thorough understanding of the service on offer. It is therefore important to build in an understanding of potential legacy of short-term projects from the outset.

As previously noted, as staff were redeployed at the outset of the COVID-19 pandemic, new connections and opportunities arose and there was also an increased openness to technological solutions by health and social care professionals. The Community Navigator who was redeployed to a hospital had the chance to gain an understanding of technological solutions that mPower could help to facilitate, for example the use of NHS Near Me. One Community Navigator also specifically focussed on the implementation of ARMED. ARMED (Advanced Risk Modelling for Early Detection) is a falls prevention and self-management medical device that uses predictive analytics, wearable technology and health and social care data. This helps identify risks early to allow people to live independently for longer. ARMED was trialled over several test sites in the community and required an extensive effort from the local team, both in terms of the rollout itself, but also in terms of technical skills:

> *"I suppose there has been a lot of onus on myself to just – I wouldn't say it's a skillset I've been trained in, I think it's just something you just learn through previous experiences, I guess, so it's kind of been me, I guess. (Community Navigator)"*

Despite these pressures, initial outcomes observed from the ARMED work were encouraging.

Another technology that was being implemented prior to COVID-19 that became increasingly important in the wake of the pandemic was Libre, a glucose monitoring system:

> *"We've been doing some work with the diabetes centre around Libre... We were doing wellbeing calls for them, a lot of it was to try… and offer them to move on to using… an app to scan your blood sugar readings and… it would automatically go to the diabetes centre and be uploaded in real time. And given the fact that a lot of patients aren't seeing diabetes specialists at the moment or they would be having their diabetes appointments as before, there was a kind of drive to try and get that to work but at the same time, give us the opportunity to discuss any health and wellbeing needs they maybe had. (Community Navigator)"*

Community Resources

The mPower team worked with several community groups; they gave talks on the project to build connections and cooperation. They reported that the reception was largely a positive one.

Local staff noted that the lack of befriending services was a key issue for the area, as they had observed a need for these among beneficiaries. Furthermore, a lot of groups tended to be based in Stranraer, which limited geographical reach:

> *"I think it's not so much gaps of what's available, it's where it's available. There's not so much available in Newton Stewart, some of the villages don't have as much going and people…maybe you and me wouldn't think much of travelling ten miles but I think some older people in villages do, it's quite a big thing for them and a lot of them have to get the bus. So I think it's all about gaps about where it is and I think the longer-term strategy we've got with that is to take it them with Attend Anywhere. (Local mPower staff)"*

Video conferencing technology was therefore recognised to have the potential to bridge some of the gaps in community resources.

Funding and capacity were also reported to be key issues by third sector representatives. This can be a major obstacle for social prescribing services as groups may be unable to accept referrals:

> *"At the time of mPower it was also CoH-Sync was coming along and we were becoming aware that within the next year our funding would stop. So we were sitting there going 'we need another signposting organisation like a hole in the head, we want an organisation that will fund some of our activities'. (Third sector representative)"*

This demonstrates the importance of gaining a thorough understanding of the capacity of third sector services in the area prior to implementation of a project, or the provision of additional support to enable delivery of services.

COVID-19 resulted in a drastic reduction to what third sector resources Community Navigators were able to refer beneficiaries to:

> *"Respondent: A huge reduction [of services]. There's been one positive development… which is a telephone befriending service called Listening Ear. So that's been our main place to signpost people to, as well as Food Train which is a food provider, locally. But…a 90% reduction, I would say.*
>
> *Interviewer: Okay. So have a lot of the services moved online or have they just stopped?*
>
> *Respondent: Stopped."*

A limited number of services were available over virtual conference but barriers to beneficiaries accessing still existed and local staff reported that, generally, only people who were already using technology were interested in exploring this as an option.

Transport and Accessibility

Local mPower staff, third sector representatives and beneficiaries, all reported that poor transport options were a barrier to connecting people to their communities. This was particularly the case in more remote and rural areas outside towns. While community transport does exist, it is tied up with contracts for schools and care organisations, restricting availability. While buses within Stranraer were frequent, transport to Dumfries for hospital appointments could be problematic:

> *"If we had to go to hospital, which I've had to – to go down to Dumfries, it's always morning. We get the twenty past six bus to get to Dumfries because it's two hours, sometimes two hours, five, ten minutes and that's into the hospital. So we're up about five o' clock in the morning getting ready and then we have to get a taxi fae here doon to the bus stance, ken. (Beneficiary)"*

Many beneficiaries were reliant on either their car or lifts from family and friends. This means that those needing to build community connections the most are potentially the least likely to benefit from social prescribing:

> *"I think the health and wellbeing team and NHS overall needs to realise that if they are serious about health and social care integration and not just talking about it, they've got to understand that people out in remote communities, older people, can't get in and we're going to need to take the service to them. (Local mPower staff)"*

This quote demonstrates recognition of the fact that while transport does need to be improved, new technologies could offer a way to remotely connect isolated people to services.

6.2.2 Western Isles

The whole of the Western Isles, *Na h-Eileanan Siar,* was chosen as an mPower deployment site. According to the 8-fold Urban Rural classification, the Western Isles comprise 72.4% Very Remote Rural Areas and 27.6% Very Remote Small Towns (Scottish Government, 2018a). Twenty-two percent of the population is found in the 2nd SIMD quintile, i.e. in the 2nd most deprived households (Scottish Government, 2019c). Although the Western Isles have a very dispersed settlement pattern, the total population of 26,830 means that this area has a similar population to the Dumfries and Galloway deployment site.

The Western Isles population of 26,830 comprises 25% aged 65+ (NRS, 2019); and 17% of households contain a single older adult aged 65+ (Scottish Government, 2019a). In the Western Isles, 38.5% of adults aged 65+ have a limiting long-term condition (Scottish Government, 2019b). Data on self-assessed health shows that 8% of the population have bad or very bad health. The mean WEMWBS score is 51.5 (SHeS, 2019).

In comparison to most other deployment sites, the Western Isles saw relatively low numbers of eHealth (280) and Wellbeing Plans completed (204). However, the combined number of interventions in the Western Isles, amounts to a reach of approximately 7% of their over 65s population (this is notably higher than in Ayrshire and Arran, the Western Trust and the Southern Trust; and comparable to HSE CHO8).

Western Isles offered the mPower service to anyone older than 18. Only people over 65 counted towards the project targets and were invited to participate in the evaluation.

Of those beneficiaries in the Western Isles, 24 completed the evaluation. A description of that population is given in Figure 8.

mPower deployment site Western Isles

24
Evaluation Participants

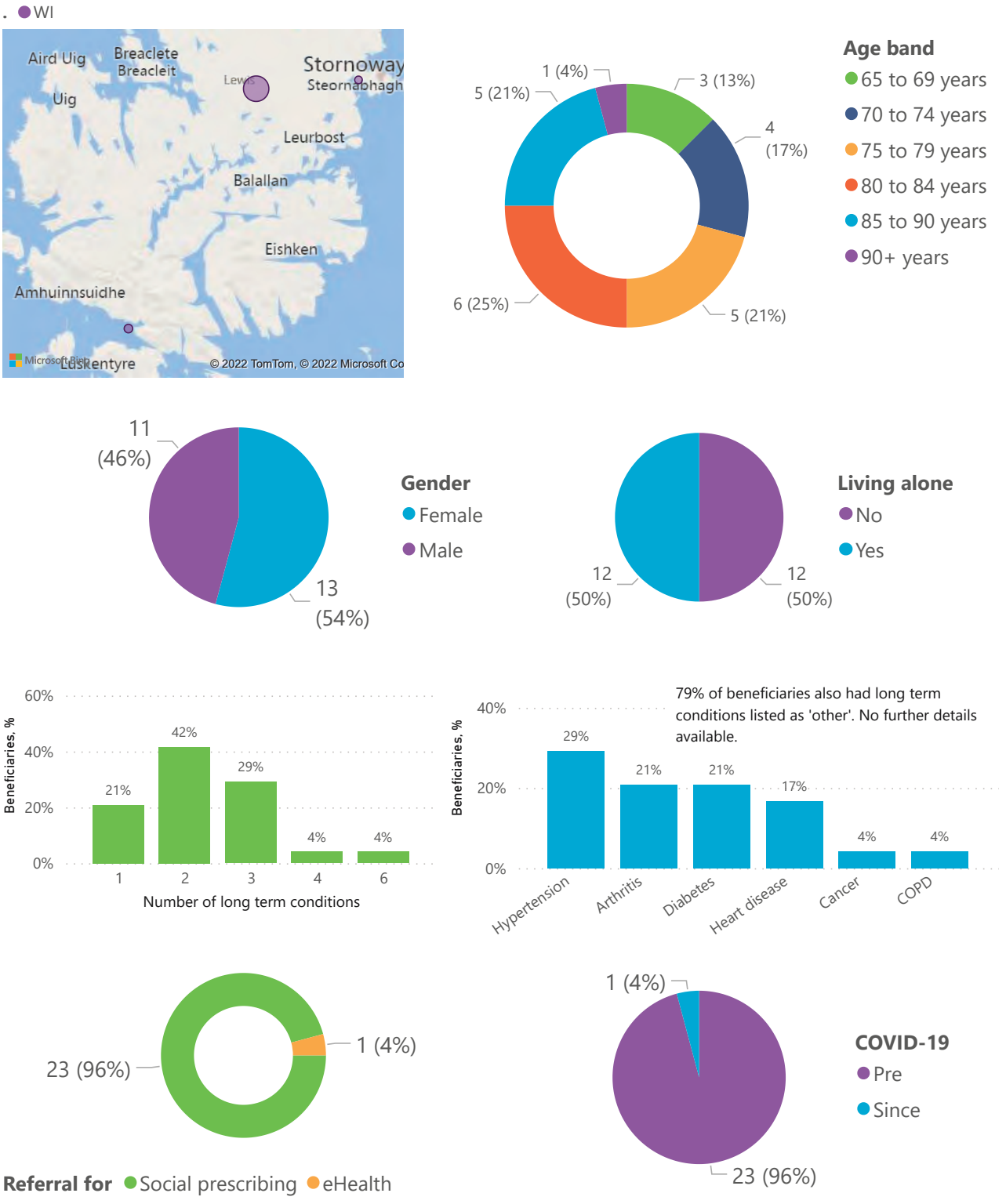


Figure 8 Description of mPower beneficiaries who consented to take part in the evaluation in Western Isles. Data collected from May 2018 to September 2021

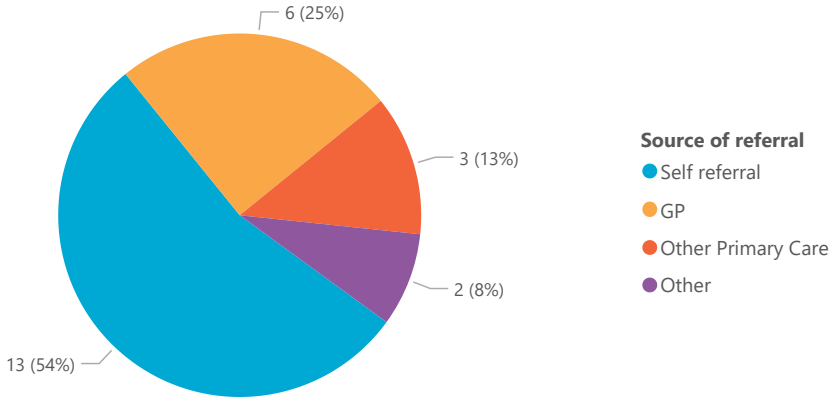


Figure 9 Breakdown of referral sourced for mPower evaluation participants in Western Isles.

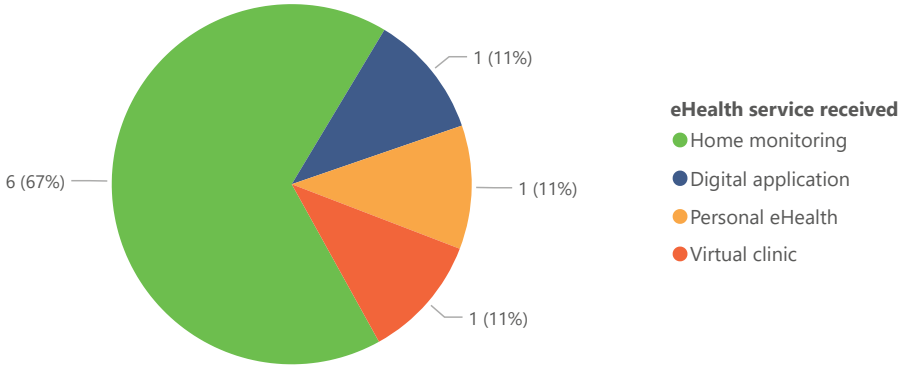


Figure 10 Breakdown of eHealth services received by mPower evaluation participants in Western Isles.

Only one Western Isles beneficiary who participated in the evaluation was referred for eHealth and that person went on to use My Diabetes Way. However, after completion of Wellbeing Plans eight other beneficiaries were also offered eHealth services (Table 8).

eHealth service type	n	%
Faire	5	55.6
Blood Pressure Monitoring	1	11.1
My Diabetes My Way	1	11.1
Samsung tablet	1	11.1
Virtual Clinic	1	11.1
Total	**9**	**100**

Table 8 Details of eHealth service types received by mPower evaluation participants in Western Isles.

The geography of the Western Isles poses distinct challenges for both health and social care services and the third sector. A third sector representative explained how one Community Navigator covering Harris and Lewis could be challenging:[6]

[6] It should be noted that at the time that data collection took place, the mPower deployment site had not expanded beyond Lewis and Harris, and that two additional Community Navigators were later recruited.

> *"It's really hard to have an impact with a project when you've only got a very, very limited resource with [one Community Navigator]. And I think the engagement from that person to the person in their home is pretty much the crux of the whole project… I think to have had even half a dozen Community Navigators would have really made a bit more of an impact within the wider community. You can see how far Uig is from Ness, completely different communities."*

The participant recognises the importance of the personal engagement with the beneficiary in the home, and the distance and differences between communities in the region. This may have had an impact on the overall number of beneficiaries within the Western Isles.

Isolation was cited as a key issue in the Western Isles, particularly among the more rural and remote communities. One primary care representative explained the social importance attached to attending GP practices in the area:

> *"There's a huge social aspect in coming to the surgery as well and I think patients like to do that. So especially on the smaller sites... And I think that kind of fits in with some of the mPower stuff as well; it just shows that there is quite a lot of isolation out there too… You hardly see anyone all day but as soon as the surgery time is on, everybody comes in at the same time...even people who are coming to pick their prescriptions up, because they think that other folk will be around then too."*

This quote shows that there was an opportunity for the mPower project to meet the needs of the local community by providing a way for people to connect socially, outside of a primary care setting.

Context of COVID-19

At the onset of COVID-19, the Community Navigator for the Western Isles, covering Lewis and Harris, had left their post. While two Community Navigators were employed to work in Uist and Barra, they also left their posts months after the advent of the pandemic. While another Community Navigator did fill the Lewis and Harris post a few months into the pandemic, it was a hectic time for the local team. However, no one was redeployed and efforts were largely focussed on providing solutions for the emerging social issues brought on by the pandemic, building on previous work in the area. Home visits stopped in March 2020 but, unlike other sites, resumed in the Summer of 2020 due to low COVID-19 numbers.

Existing eHealth Services

The findings from the eHealth readiness questionnaires indicated that mPower in the Western Isles deployed its eHealth service within the context of a level of trust between patients and healthcare professionals to share clinical information; a willingness by patients and healthcare providers to use information and communication technology; and a culture of embracing new technology. Healthcare professionals were indicated as having a stronger belief in the perceived need for eHealth, and home and mobile health monitoring, than patients; and while patients were reported to perceive a need for eHealth, this was not the case for virtual clinics, which again suggests a preference for face-to-face communication.

The findings also showed a relatively strong belief in the presence of leadership through an eHealth champion; and patient and healthcare professionals' involvement in eHealth development to ensure buy-in. The surveyed eHealth technologies were felt to have relatively high user-friendliness, though training needs were unclear. Findings also indicated that Western Isles had the financial resources and ICT competences for eHealth implementation.

Local staff also referred to several forms of eHealth technology available in the Western Isles pre-dating mPower, including Florence, Morse (the recording platform also used for the mPower Wellbeing Plan), Near Me clinics (powered by Attend Anywhere) and a home and mobile health monitoring service called Faire. While this could be advantageous, it also posed challenges in terms of mPower fitting into pre-existing service models:

> *"And we found very soon… we came across a difficultly in that Florence and Attend Anywhere are so widely used in the Western Isles, before mPower even came into existence, so it's how do you break that cycle and actually do you want to break it because we were being encouraged to approach anyone who was already doing Florence protocols, and saying, 'can we help you, can we support you and do some more?' And my thinking is, 'well why would I do that, because I won't be here in two years' time but the nurse who is doing it, the heart nurse may be here...' and it's very specific to them. So a lot of time spent on thinking – where is the value at? (Local mPower staff)"*

In order to deliver a service that is fit for purpose and patient centred, it is important for the service to situate itself within existing structures in a way that does not disrupt service delivery models that are already effective. The local team therefore increasingly turned to the use of technologies they had observed to be of particular benefit to the beneficiaries they encountered.

At the beginning of the COVID-19 pandemic, the team worked on providing care homes with tablets and supported them in their use. Digital support was indeed key during the pandemic:

> *"Though I say there weren't a lot of referrals, there were other bits and pieces looking at digital support, getting devices, finding out what was available, perhaps… to help people get on Zoom, and then seeing if that then created an opportunity for mPower to have a wider conversation with someone. So being involved a bit more around digital inclusion. (Local mPower staff)"*

Another key piece of technology implemented by the local team is Komp, a one-button computer. The team reported this had been a success and enabled those with limited IT abilities to engage with technology. There had been a delay in being able to procure tablets for beneficiaries to trial as intended, and many were in a situation where their health had deteriorated to the point where this would no longer be a suitable technology for them. In these cases, Komp could provide a viable solution:

> *"You are not trying to ram an iPad or a laptop down someone's throat, you are thinking about what it is that you are offering and you are thinking about what device might be the best for that person. (Local mPower staff)"*

This person-centred approach to considering what types of technologies are most appropriate can lead to increased digital literacy.

Western Isles were also part of the Scottish Government initiative Connecting Scotland managed by SCVO (The Scottish Council for Voluntary Organisations). They were able to provide tablets to beneficiaries through the initiative. It was noted that there seemed to be an increased interest in technology during the pandemic among some beneficiaries, particularly as church services moved online. Being able to provide people with a tablet and to support them in its use thus contributed to the wellbeing of beneficiaries during the pandemic.

The mPower team were recognised locally by their health board as a flexible and innovative resource. This meant the team were often asked to adopt national initiatives and deliver them in alignment with mPower objectives. The project team extended an initial British Heart Foundation pilot of blood pressure monitoring through Florence reaching more people than originally planned. The project team were at the centre of delivering the local implementation of low-level mental health products including Silvercloud, Sleepio and Chatpal.

In 2022, NICE guidance recognised Sleepio as the recommended treatment of insomnia symptoms; the Western Isles are working with partners to add Gaelic as language in Chatpal to increase access for islanders; and the community navigators support for users of Computerised Cognitive Behaviour Therapy (cCBT) is said, by the local project lead, to have better outcomes due to greater user engagement.

A key digital service during the pandemic was online food shopping. Beneficiaries had already been supported in this pre-pandemic due to the rural and remote nature of the area, but the service became increasingly important when people were isolating.

Health and Social Care Services

In the Western Isles, GP surgeries cover large geographical areas. Similarly to other deployment sites, GPs are retiring, recruitment is a challenge and it can be difficult to get appointments. One primary care representative identified the role mPower could play in this challenging context:

> *"Things are changing in primary care just now with the new contract … and one of the things that we…will be doing as well is signposting to patients and making them aware of what's available… I think more and more of that is coming along and trying to make communities more resilient. I think that's where mPower really fits in, they are gathering that database of knowledge and things so they'll know what's out there and what's happening."*

While mPower was a relatively short-term project, this primary care representative identified one potential legacy as being asset mapping. However, it should be noted that ownership of asset maps needs to be determined to ensure that they are kept up to date. In terms of building relationships with health services, the reception was indeed largely a positive one. Local staff organised meetings and presented the project at various events to raise awareness.

As in Wigtownshire, beneficiaries often had to travel to receive health services. This could be to Stornoway, Inverness, or Glasgow, sometimes requiring helicopter transport. Ambulances could also be in short supply at times of high usage, rendering access to services difficult without access to a car:

> *"See the day that I phoned for the ambulance? Now, there wasn't any available and there was no doctors available either! … He says, 'can you not get a neighbour to run you over?'… and there was no neighbours to run me over…they haven't got [driver's] licences, they're ninety, you know? … but there was no one to take me.... So I drove over. (Beneficiary)"*

This quote illustrates the challenges posed by distance, limited resources and the demographics of rural communities, and lack of social support systems.

The local team reported that at the start of the pandemic, there was a period where they received no referrals at all from health and social care. It was assumed that this was due to services being busier, not seeing patients in person, and changing working arrangements. After a while though, referrals from social care in particular increased. It should also be noted that as the service evolved, third sector organisations became an important referral source in themselves as relationships were built up and organisations could see the benefits mPower could provide for third sector service users. This shows that health and social care are not the only appropriate referral routes for social prescribing. Indeed, referrals from GPs remained elusive throughout:

> *"There's one GP who is very pro mPower... I don't know what the barrier is with other GPs. I don't know, do they fully understand the service and the benefit that it could be to them by reducing the social appointments; where if someone has gone in, not with a health issue but with a social issue."*

Viewing mPower as a service that could reduce non-clinical appointments therefore rarely fully materialised as intended.

Community Resources and Transport

Local mPower staff and third sector representatives acknowledged that the Western Isles has a vibrant community and multiple community groups in operation. The mPower team worked hard to keep up with the 'ever changing' community landscape through several different forums: Facebook, newspapers and attending smaller scale community groups to make them familiar with what mPower is providing. However, this was not without its challenges. A befriending service, for example, perceived mPower as a project offering something similar to them, therefore presenting a threat to their work:

> *"Some organisations, they are … struggling [for funding] so they might see us as a threat in that way but I think it's showing that mPower… it's about empowering these groups … to carry on and doing what they are doing. (Local mPower staff)"*

This highlights the importance of ensuring an understanding of the type of service that mPower offered. The team later reported that organisations indeed became more receptive to mPower:

> *"[It's about] building these relationships of not just putting in the referrals to them but having those conversations about how can I help your service users as well, to show it can be a mutual beneficial relationship. So I can put people to them but also if they have people that need those wellbeing issues helped with that they could then get back to me and they knew that I would do that."*

While some areas had a range of active community groups, the team acknowledged that there is a lack of activities in the more rural and remote areas, and transport provided a challenge:

> *"I think there's gaps in terms of community groups and things going on. Especially in the really rural areas where it's needed the most. But we've found that people can't get to groups because of transport so the groups don't carry on because there's not enough people going and it feeds round in a circle like that. (Local mPower staff)"*

Community transport was available in some parts of the Western Isles, although these were often areas with community development trusts. Third Sector Hebrides offered mini-buses and cars but the cost was often prohibitive to beneficiaries. Public buses were infrequent and didn't service all areas of the deployment site. One beneficiary commented: *'driving is essential'.*

The pandemic understandably brought changes to the third sector in the area. While some activities completely ceased, many moved to digital platforms:

> *"It was telephone befriending instead of face-to-face befriending, everybody has developed a digital approach… our local befriending service are developing Zoom art sessions, they do knit and natter so if people are working on their own projects it's more of a social interaction. They've been looking at getting some of their smaller groups of people who are quite like-minded to do small Zoom sessions, so it's like a peer support. Everything moved very much digitally but had its own issues of people having access to devices, access to internet or their ability to use it. That's where they've involved me more and I think that's where our relationship has built from quite a bit – from helping with that."*

This move to digital provided the local team with the opportunity to support beneficiaries in developing digital literacy in order to engage socially in a time where face to face interaction was rarely possible. The local team were able to lend beneficiaries tablets from an early stage of the project but Connecting Scotland enabled them to extend this service even further.

Beyond services moving to digital platforms, a key service to refer beneficiaries to was telephone befriending. Some groups also began to meet outside to allow for safer face to face interactions.

6.2.3 Ayrshire and Arran

The whole of Ayrshire and Arran was chosen as an mPower deployment site. North, East, and South Ayrshire combined equate to 43% Accessible Rural, 13% Remote Rural, and 3.3% Very Remote Rural (Scottish Government, 2018a). Ayrshire and Arran's population of 369,670 comprises 22% aged 65+ (NRS, 2019). Thus, it has a substantially larger population than either of the other two Scottish sites.

The Ayrshire and Arran localities feature the following rates of single older households: North Ayrshire (18%), East Ayrshire (13%), and South Ayrshire (13%) (Scottish Government, 2019a). The rate of the most deprived households (those in the 1st SIMD quintile) in each area is as follows: North Ayrshire 39%, East Ayrshire 37%, and South Ayrshire 20% (Scottish Government, 2019c). The following percentage of adults aged 65+ have a limiting long-term condition: North Ayrshire (43.8%), East Ayrshire (49.4%), and South Ayrshire (45.8%) (Scottish Government, 2019b). Ayrshire and Arran's mean WEMWBS score is 49.1 (Scottish Government, 2018b).

Ayrshire and Arran have achieved the highest number of digital health interventions (1,722) and Wellbeing Plans (762). This cannot be explained by the higher overall population size of the deployment site alone, particularly given the geographical and staffing challenges outlined below. However, the overall number of beneficiaries equates to a reach of approximately 3% of the over 65-year-old population. This is likely an effect of Community Navigator numbers in comparison to the size of the deployment site's population.

Of those beneficiaries within Ayrshire and Arran, 504 fully completed the evaluation. A description of that population is given in Figure 11.

mPower deployment site Ayrshire and Arran

504
Evaluation Participants

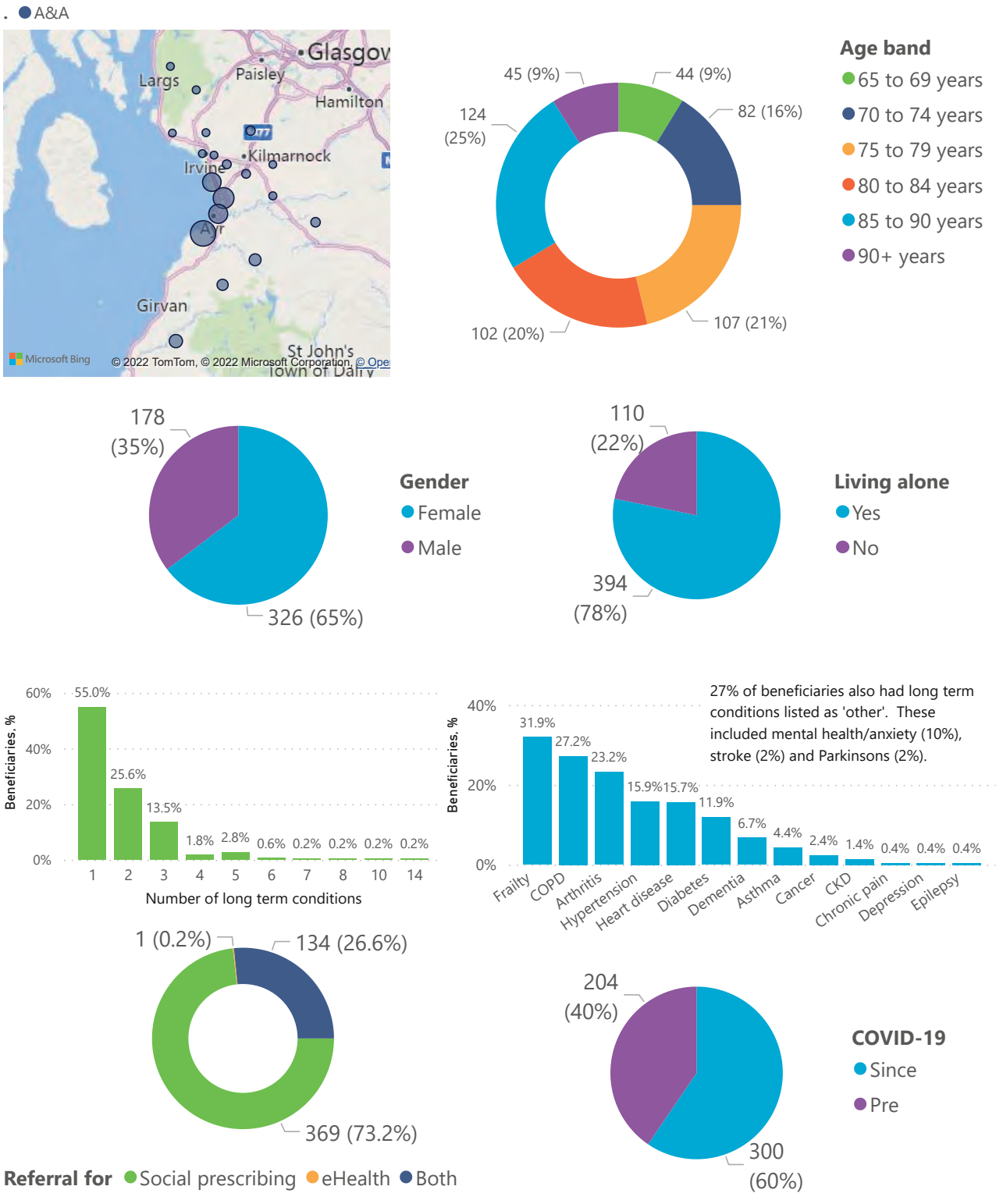


Figure 11 Description of mPower beneficiaries who consented to take part in the evaluation in Ayrshire and Arran. Data collected from August 2018 to December 2021.

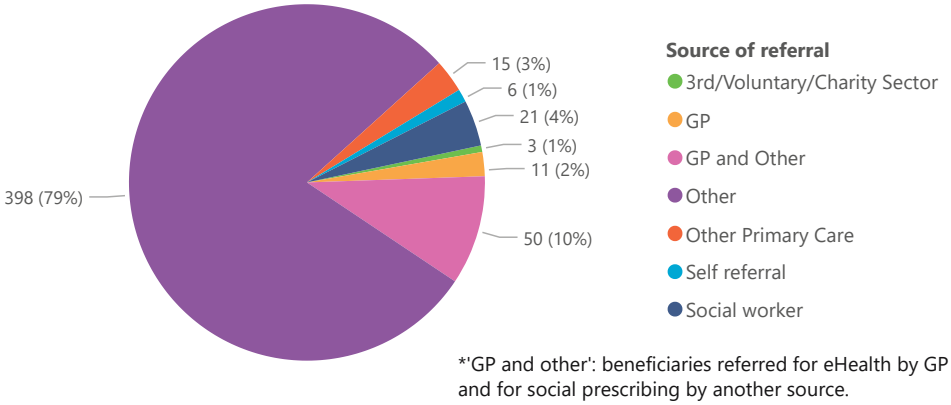


Figure 12 Breakdown of referral sources for mPower evaluation participants in Ayrshire and Arran.

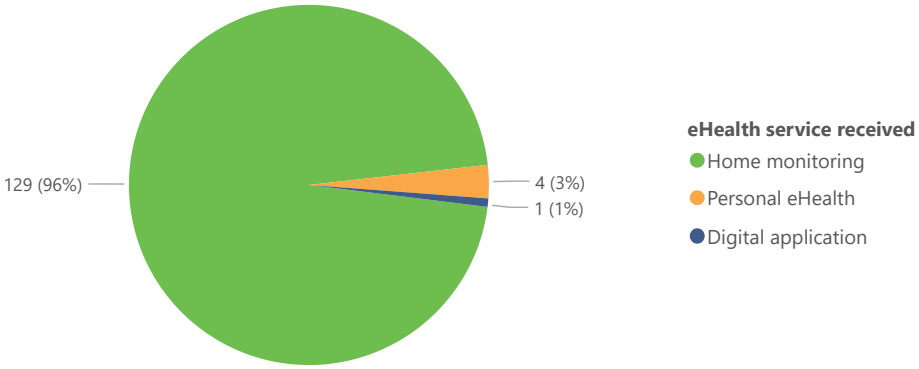


Figure 13 Breakdown of eHealth serivces received by mPower evaluation participants in Ayrshire and Arran.

eHealth service type	n	%
Alert	84	63
CUI	41	31
Telecare	3	2
Ability Net	1	1
Call Blocker	1	1
COPD A&A app	1	1
Crossword app	1	1
IT assistance	1	1
Telehealth	1	1
Total	**134**	**100**

Table 9 Details of eHealth service types received by mPower evaluation participants in Ayrshire and Arran.

The local team acknowledged that variation within the deployment site could be challenging:

> *"So it's quite a spread. They are the main towns, there's a couple of wee-er towns, the actual geography, the most of the land area isna occupied or it's wee villages and massive farming area… it's wee pockets of villages and houses and former workers cottages... And yes, so quite spread and most definitely significantly rural. (Local mPower staff)"*

As initially only one Community Navigator was in post at the start of the project, they were not able to equally deliver the service to all areas of the deployment site due to limited capacity. The focus was therefore initially on South Ayrshire. However, more Community Navigators were employed subsequently, enabling an expansion of the service, although it should be noted that the service still covered a comparatively large area.

As in other deployment sites, the local team identified isolation and loneliness as key challenges for the area. This is connected to broader societal changes and may particularly affect older people:

> *"Isolation and loneliness is one of the main reasons for referral, I think we've got – a sort of tsunami, we've got an ageing population… the family home has changed, the dynamics have changed… and that structure of your family being there to look after you and pop in every day isnae happening. (Local mPower staff)"*

This demonstrates the value of the services mPower offered in meeting the needs of the community.

Context of COVID-19

The mPower team in Ayrshire and Arran did not get redeployed during the pandemic. However, they moved from being part of the Intermediate Care Team to the local mental health unit, which meant a shift in health and social care contacts and therefore referrals. The team also reported that not being physically in the office meant that fewer referrals from contacts they were used to speaking to informally were taking place.

Social Prescribing and eHealth

A Link Worker scheme, with Community Link Practitioners based at GP practices, was operating in the area. This posed an initial challenge for mPower:

> *"In Ayrshire and Arran we have up to forty Community Link Practitioners… So I was coming in with a role… they seemed to think the same job. But I could see it as obviously being totally different because their service was very much signposting whereas we're much more deep-diving. (Community Navigator)"*

However, on establishing the distinct approach to service delivery offered by mPower as a holistic social prescribing project, the Community Navigator was able to establish mPower as offering a service meeting needs on a broader spectrum. This was further reinforced by mPower being part of the local mental health unit which meant social prescribing referrals for over 65s automatically came to them, while anyone under the age of 65 was referred to a Link Worker.

The findings of the eHealth readiness assessment survey indicated the presence of a level of trust between patients and healthcare professionals to share clinical information; willingness by patients and healthcare providers to use ICT; and a culture of embracing new technology. Healthcare professionals were indicated as having a stronger belief in the perceived need for eHealth than patients; and while patients were thought to perceive a need for eHealth, this again didn't apply to Virtual Clinics.

There was a relatively strong belief in the presence of leadership through a champion; and eHealth development involving healthcare professionals, but not patients, which could negatively affect buy in. The surveyed eHealth technologies were felt to have relatively high user-friendliness, though training needs were unclear. Ayrshire and Arran was also reported to have the relevant ICT competences for eHealth implementation, but lacking the required financial resources for implementation.

A range of eHealth technologies were available in the area from the outset. These included home and mobile health monitoring, Florence, Telecare, NHS Near Me, and a range of NHS apps. The team worked closely with the local Technology Enabled Care team. Referrals to these pre-existing services were made by the mPower team if they identified a need whilst co-producing a Wellbeing Plan with beneficiaries. Furthermore, in 2021, Digital Champions became a part of the mPower team, further strengthening and connecting mPower with the local, already well established, digital teams. The deployment site was also able to collaborate with Alzheimer Scotland's ADAM product and support the use of Connecting Scotland devices for beneficiaries.

Health and Social Care Services

Creating connections with health and social care was aided by the fact that mPower staff were based within a hub with social work, integrated care teams and specialist nurses:

> *"I think being based within this hub at Prestwick is really key. I'm a seen presence within the intermediate care team, the social work team, the specialist nurses team and I think with them, utilising it and seeing how well it's working, other health professionals have tapped in. (Local mPower staff)"*

This enabled the Community Navigator, initially working without an Implementation Lead in post, to build relationships with relevant services who could refer beneficiaries to the project:

> *"I think that's been one of the strengths that I've had within this role, is that I didn't have any training, I came in basically with no lead and I basically had to make the job my own, very much so."*

Furthermore, their background of working within NHS in the area meant that they had pre-existing connections and skills to draw upon. They also attended meetings for various services to explain what mPower could offer, as well as using case studies to show how they were supporting beneficiaries. Another key component in building relationships with other health and social care services was establishing a quick and easy referral system.

However, securing GP buy-in was also a struggle for the Ayrshire and Arran team. Three GP referral pathways were set up but as the existing (non mPower) Community Link Workers were based within GP practices, referrals often went directly to them. This resulted in some referrals from Link Workers to mPower, as they identified it as a service that could meet the needs of the beneficiary.

At the start of 2020, a change in management personnel resulted in the mPower staff moving to the Mental Health Team. With home working being the norm, forming a new team could be challenging and also meant the loss of physically being in the same building as referrers they had established relationships with. As noted, informal conversations and physical reminders of the presence of mPower were conducive to frequent and appropriate referrals.

Community Resources and Transport

The Community Navigator initially made use of the South Ayrshire Life portal, a third sector organisation, to make contacts with community organisations. The team also drew on their local knowledge of the area and prior professional experience in the third sector to identify services to signpost beneficiaries to. While acknowledging that there were several community groups in the area, transport was a key barrier. Many beneficiaries talked about the difficulty of getting buses that would take them to the right place at the right time and back again, also acknowledging that it could be difficult to physically get on the bus. Many relied on relatives and taxis, neither of which are always viable options. One of the Community Navigators took beneficiaries to their first meeting at a community group, but continued attendance is not viable if no alternative transport options are available to the individual:

> *"I take them the first time but then who is going to take them the time after that and they've enjoyed it, yet they've no family. My Bus won't take them because they've got a rollator and they need help to get into the bus. Community transport doesn't work in their area and they are reliant on a taxi. So to get out and about, it's a fiver to get to the group, fiver back and then maybe four pound for their lunch. So fifteen pound."*

As prior research has shown, providing transport to the first meeting can ensure continued attendance (Husk et al, 2019). However, if other transport is not available or affordable, this is simply not possible.

In the advent of the pandemic, many third sector organisations ceased to offer services initially. Several services already had waiting lists pre-pandemic and Community Navigators struggled to find services to refer beneficiaries to:

> *"A lot of stroke clubs in Ayrshire they are not taking referrals in just now for new people. So it's very challenging on how people get peer support, when these services arenae back to full capacity and won't be back and even when they do open up, it's going to be a minimum or a maximum of four people in the room. And I think people that, especially with the good weather coming in, they are going to get frustrated knowing they canna go to a lunch club, they canna go to a stroke club, a memory clinic. That's going to really have a knock-on effect with a long-term condition as well and how they feel about managing it."*

Telephone befriending, helplines and wellbeing calls were seen as especially important to counteract loneliness during the pandemic. While some services moved to digital platforms, the local team noted that being connected digitally was not something that was a priority for beneficiaries, who were dealing with much more complex needs:

> *"I sometimes think it's maybe the nature of our referrals. There's a whole cohort of folk who have got the capacity to finance and the equipment to be able to regularly engage in that and they are all taken care of. But the folk that we're getting as beneficiaries… their priorities are referral pathways, so you are in reablement, you are in respiratory, you are in social work, so quite often there is (loads) of health inequalities in there. And they canna afford to feed theirselves or heat theirselves, they are in a health crisis, they've got financial problems, they've got whatever.*
>
> *Fuel payments, people struggling with regards to shopping and their prescriptions, so trying to sign them up to make sure they are signed up to home shopping, even if it's paying over the phone with their card, the likes of Morrisons and stuff like that. So it has been very much the necessities of just getting through rather than they are looking to connect to a group online about stroke, it really hasn't been about that; it's been about social isolation, loneliness, depression, feeling excluded, feeling isolated, that's very much what the referral sources have been for."*

Being able to afford equipment and being receptive to increasing digital literacy was therefore not always at the forefront of people's minds. It was therefore a priority to focus on more immediate needs. With the pandemic, there was an increase in meal and food delivery services, as well as prescription deliveries.

6.2.4 HSE Community Healthcare Cavan, Donegal, Leitrim, Monaghan and Sligo (CHO1)[7]

There are two areas within HSE CHO1 selected as mPower deployment sites: South Leitrim and Finn Valley. As the target data provided to the Project Board is not broken down by these areas, we cannot provide an assessment of progress towards targets at this lower geographical level. For the HSE CHO1 area as a whole, however, there have been 754 digital health interventions and 325 wellbeing plans delivered. These figures are higher than in the other Irish deployment site and is the second highest number of eHealth interventions in the island of Ireland by quite a long way. The figures indicate that the HSE CHO1 mPower project has reached approximately 14% of the area's over 65s population.

The quantity of completed evaluation questionnaires provided to UHI from HSE was impacted by an issue with the collection of appropriate consent from beneficiaries. Beneficiary evaluations could be retained by HSE but the consent form used by local mPower staff did not accurately and sufficiently describe the subsequent transmission, in an anonymised form, to UHI. As a result, evaluation data garnered by HSE in undertaking 871 eHealth interventions and 347 wellbeing plans does not inform this report. A limited dataset of beneficiary evaluations was transferred by HSE to UHI after the situation was rectified in June 2021. 380 eHealth interventions and 145 wellbeing plans occurred after June 2021.

What is presented in Figure 14 is the data from the 73 questionnaires we were able to use as part of the evaluation.

[7] During the implementation of mPower HSE Community Health Organisations were abbreviated to CHO1, CHO2, through to CHO8 and CHO9. Near the close of the project CHOs adopted a more geographic orientated nomenclature as shown in the chapter headings of this and the following HSE section. For consistency the report refers to the HSE project partners by the abbreviations used during the majority of the project implementation period i.e. HSE CHO1 and HSE CHO8.

mPower deployment site CHO1

73

Evaluation Participants

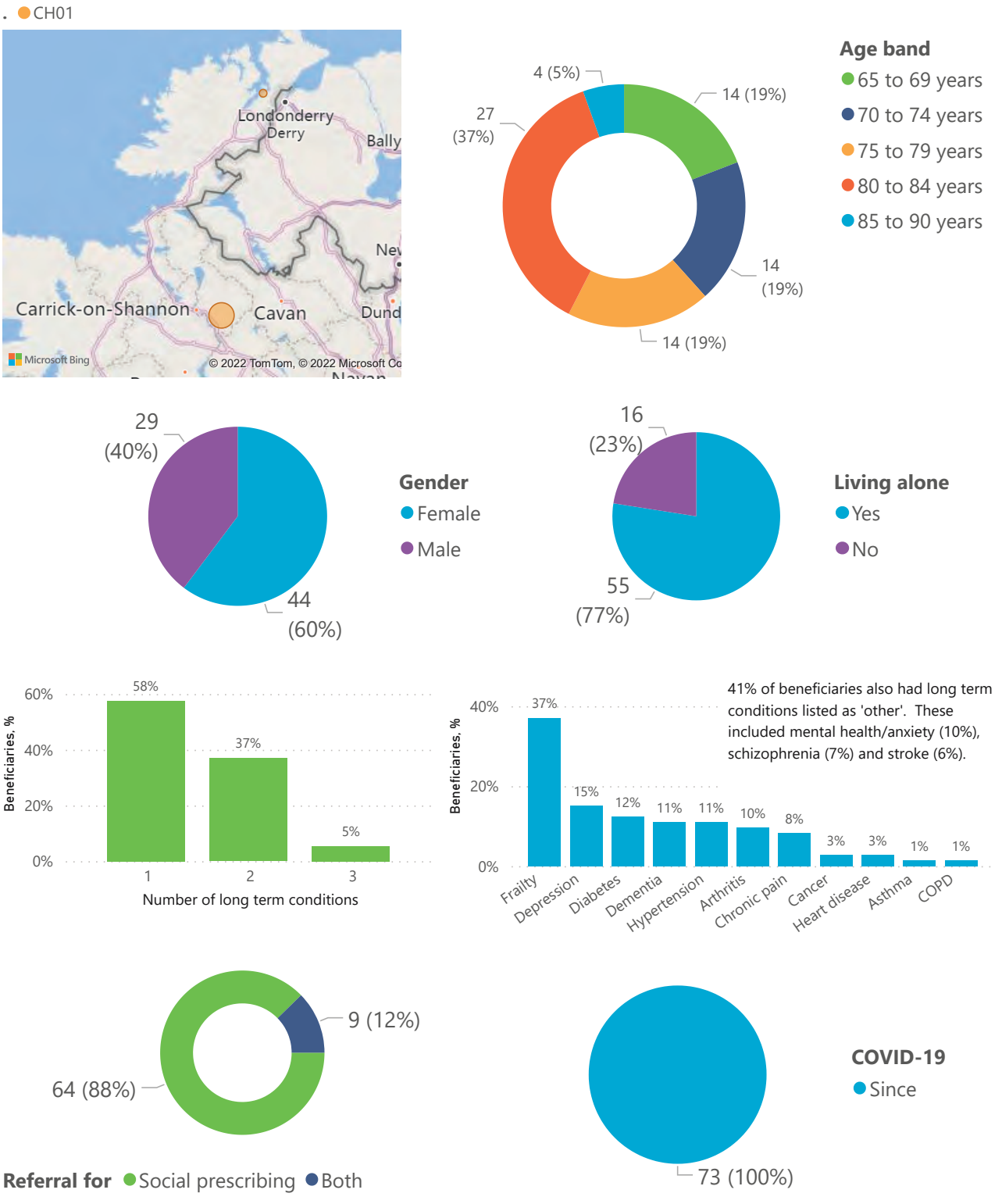


Figure 14 Description of mPower beneficiaries who consented to be part of the evaluation in HSE CHO1. NB Living Alone: two participants declined to say. COVID-19: all 73 beneficiaries consented to participate in the evaluation after the start of COVID-19, hence there is no 'pre COVID-19' content in the final chart.

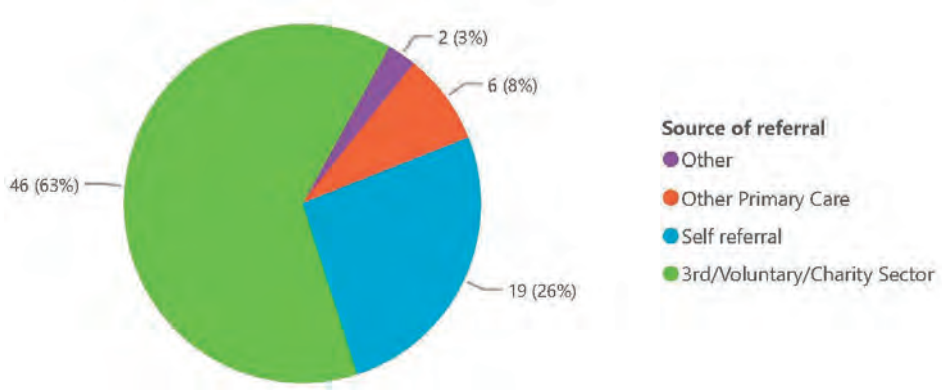


Figure 15 Breakdown of referral sources for mPower evaluation participants in HSE CHO1.

Questionnaires relating to the provision of eHealth interventions in CHO1 were not available for analysis as part of this evaluation.

HSE CHO1 - South Leitrim

South Leitrim is one of the two areas selected by HSE CHO1 as a deployment site. County Leitrim, which contains South Leitrim, is rural and has a dispersed population (Leitrim County Council, 2016) of 32,044 (Haase and Pratschke, 2017). This population contains 5,037 residents aged 65+ in private households, of which 32.7% live alone (CSO, 2018). South Leitrim's population of 11,752 comprises 19% aged 65+. It has a dependency rate of 63% (Cullen and O'Kane, 2018b). County Leitrim overall has a 2016 Pobal HP Deprivation Index of -3.2 for (Pobal, no date), and 32% of South Leitrim's population is Disadvantaged. In South Leitrim, 2% of the population self-report their health as bad or very bad (Cullen and O'Kane, 2018b). As in the other deployment sites, geography provided a challenge where limited resource was available:

> *"I feel that our areas were broad… Leitrim is quite an elongated county …I feel like it's a big area... I think travel time obviously impacts a lot on what you can and can't do. (Local mPower staff)"*

HSE CHO1 aimed to mitigate their geographic scale by sharing their Community Navigator resources between South Leitrim and Finn Valley. Despite this amendment, and as with the other sites, having one Community Navigator with finite capacity meant that not all areas of the deployment site were covered equally. It is therefore important to consider the resource relative to the area and population to be covered at the planning stage.

Context of COVID-19

COVID-19 compounded recruitment challenges in the area. At the start of March 2020, two of the three HSE Implementation Leads in post (one in CHO1 and one in CHO8) were new starters, in their first HSE roles. As COVID-19 response became the priority, and despite access to and guidance from an experienced Health and Wellbeing team in CHO1, the new starters sometimes felt isolated and uncertain about processes. Soon after starting the Implementation Lead was temporarily re-allocated to support the national and local eHealth effort. The relationships at the national level and the experiences gained during the period subsequently had considerable positive impact on the HSE's achievements in mPower.

eHealth and Social Prescribing

While two mPower teams worked within HSE CHO1, the eHealth readiness assessment questionnaires, collected in early 2018 and completed anonymously, concerned the

deployment site as a whole. The findings indicate a level of trust between patients and healthcare professionals to share clinical information; but uncertainty in the willingness of patient and healthcare providers to use ICT, and no culture of embracing new technology. This differs from the Scottish sites and may be related to the comparably lower figures in terms of eHealth beneficiaries seen in HSE CHO1, although still the 4th highest across the project.

The readiness assessment confirmed partners did not start the project from the same place. HSE CHO1 had significant scope for innovation, capacity building in the system and supporting staff to adopt digital health and care. Their lead-time for planning, identification, procurement, training and delivery of eHealth interventions would have differed from Scotland and may have impacted beneficiary numbers achieved.

Healthcare professionals were indicated as having a stronger belief in the perceived need for eHealth and home and mobile health monitoring than patients; and while patients were thought to perceive a need for eHealth, this did not apply to Virtual Clinics, in line with findings from other deployment sites.

There was also an indication of the lack of belief in the presence of eHealth leadership through a champion; and the lack of healthcare professional and patient involvement in eHealth development. In the HSE eHealth initiatives are a national shared service and a local (CHO1 located) champion, in the form of a General Manager for Digital Health, was only appointed in the final year of the project.

The surveyed eHealth technologies were felt to have relatively high user-friendliness, though training needs were again unclear. Respondents also felt that HSE CHO1 lacked the 'ring-fenced' financial resources for eHealth implementation.

The local team cited the delicate balance between satisfying project-wide requirements of mPower, meeting local needs to ensure buy in and maintain relationships, and the ICT infrastructure needed to successfully implement eHealth. This is something the local operational mPower team was not able to do without a wider service transformation and it is unclear what the position or responsibility of the local mPower team could and should be in this complex context, particularly considering that mPower was time-limited by its funding.

However, as with other deployment sites, receptiveness towards eHealth and technology increased during the COVID-19 pandemic, providing more opportunities to engage both healthcare professionals and beneficiaries with technology. While there was a desire among health and social care contacts to engage with technology via mPower, there were issues around having access to skilled eHealth personnel who were able to support:

> *"But I just keep persevering and saying, 'look there's a project here, there's an opportunity here, what can we do to help you, that meets our aims and objectives as well'. But it was about just being open and honest, 'look we've got a very short space of time, what's realistic and what could we do quickly that could make a big impact to the beneficiaries?' It was received well and then they wanted the clinicians' laptops, they wanted the digital equipment that wasn't part of our brief to provide. So every time you were hitting barriers because of my lack of knowledge and understanding of HSE processes and systems. But at the same time, because we'd made connections with ICT looking for this equipment, they were able to provide them with equipment that's already internal in-house (Local mPower staff)"*

Furthermore, the local team were able to procure interactive activity tablets for two community hospitals. These products came with various functions such as the ability to link in with clinicians and relay information about health and wellbeing as well as playing games individually or in groups. The team was also able to set up community digital hubs in the area and were involved in rolling out Attend Anywhere across the HSE. This demonstrates the ability of the local team to provide innovative eHealth solutions to beneficiaries. One local team member however explained how referrals to Attend Anywhere did not always lead to Wellbeing Plans as envisaged and planned:

> *"In hindsight maybe there was a lack of clarity on the pathway the service was provided by the Community Navigator and complicated by COVID-19. As a direct result of this the referrals were very limited to requests for Attend Anywhere and the opportunity to access the Wellbeing Plans was lost. The staff seen the service as a support for any issues relating to Attend Anywhere rather than a service that could support their patients. On a positive note any beneficiary supported by Attend Anywhere has reported a positive experience."*

While the support of the rollout of Attend Anywhere was successful and led to a high number of eHealth interventions, an opportunity to further support over 65s availing of the technology with a Wellbeing Plan was sometimes lost. Linking the video appointment to an 'additional' referral step for a Wellbeing Plan was not always possible due to the pressures of responding to COVID-19. Providing people safe video access to clinicians was fast paced and a priority at the time.

In terms of social prescribing, there were pre-existing social prescribing services in the area, funded through the same host HSE Health and Wellbeing team as mPower. Efforts were made at the design and initiation stage of the project to complement these services with mPower activity but no approval was gained from the EU funding body.

Health and Social Care Services

Health and social care services in South Leitrim were spread out, with key services for the region based in Sligo. The first Implementation Lead recruited aimed to leverage her existing relationships with the Health Promotion Team in Sligo and retained this as her base. Maintaining relationships across all health and social care services could therefore be challenging on a practical level as it requires a lot of travel. Again, the whole team attended a large number of meetings to try to ensure buy-in from primary care services. The local staff reported that the relationship building had been largely positive and worked well.

Interviewees reported that for a time there were no staff in post and, therefore, when posts were filled, relationships built by one postholder had to be re-established. This was especially difficult when the original postholder had strong personal connections with the Health Promotion team and Public Health Nurses which could not be so easily passed to the new postholder.

Staff retention issues had an impact on continuity of relationships and interruption of referrals. New postholders sometimes found the needs of people referred may have changed or the opportunity may have been lost due to changed health circumstances. This could result in misgivings of health and social care professionals who were unable to see their referral being acted upon, while being unaware of the issues around recruitment.

It is evident how different the working contexts in the deployment sites were, particularly between the three jurisdictions. It is important to acknowledge the workload in terms of relationship building and the impact this may have on service delivery.

Community Resources and Transport

The mPower team originally employed in South Leitrim were unfamiliar with the geographical area. Therefore, they had to build up knowledge of the community assets available. They acknowledged that while an asset map would be beneficial, it would require significant effort to keep it up to date as things change so rapidly within the community.

As noted in the section on the Western Isles, building and maintaining community asset maps is a time-consuming process and ownership of this work needs to be designated to someone with the capacity to do so. Local mPower teams felt they may not be best placed to take ownership of asset maps due to their workload and the time-limited nature of their posts. In the absence of an asset map, the Community Navigator built up their knowledge of groups in the area by identifying the needs of beneficiaries and then researching ways to meet these. Through this bottom-up approach, connections were built within public and third sector organisations such as Age Friendly Alliance, Gardai, Leitrim County Council, Leitrim Sports Partnership and the Education Training Board. The team reported this to be a beneficial approach, as it was based on user need and not staff assumptions.

Local staff noted that community transport in the area was improving, through the introduction of The Local Link service connecting the towns in the area and collecting rural residents on the way. Responsive services were also available, transferring people to health appointments.

With the previously stated difficulty in recruiting, especially for part time Community Navigator posts, HSE requested approval from the EU funding body to fill the post via their community organisation contracts. The process of gaining approval and to follow the necessary procurement and contract amendments was time-consuming. However, as expected by HSE, this provided a fruitful avenue for referrals as the postholder had extensive experience of working in the third sector in the region and was known by local organisations:

> *"And pretty much I used my own profile and my own organisation to say 'look, we're here, this is the new flag we're bearing, this is the new project we're running with', and people rolled in behind me."*

Ultimately, the Community Navigator being based within the third sector was a positive for the team and enabled them to get the referrals they needed.

HSE CHO1 – Finn Valley

Finn Valley is the second area selected by HSE CHO1 as a mPower deployment site. County Donegal, which contains Finn Valley, although having small urban centres in Ballybofey and Stranolar, is predominantly rural and has a dispersed population (Donegal County Council, 2017) of 159,192 (Haase and Pratschke, 2017). This includes 23,162 residents aged 65+ in private households of which 28.4% live alone (CSO, 2018). Finn Valley's population of 14,631 comprises 15% aged 65+. County Donegal has a dependency rate of 59% (Cullen and O'Kane, 2018a). It has a 2016 Pobal HP Deprivation Index of -6.4 (Pobal, no date); and 41% of Finn Valley's population is Disadvantaged. In Finn Valley, 2% of the population self-report their health as bad or very bad (Cullen and O'Kane, 2018a). As with the other deployment sites, rurality, along with

weather conditions, could be challenging for the Community Navigators and could also impact the ability of beneficiaries to engage with their wider community:

> *"The rurality is obviously a challenge… now at the minute the weather is good, if the weather is bad I probably wouldn't get out to some of the houses that I would be going to. But that's something that everybody meets around these parts..."*

Context of COVID-19

The local team worked as part of the National Virtual Health Team to support the rollout of Attend Anywhere across Ireland. This was a significant undertaking:

> *"In the National Virtual Team we were having meetings on bank holidays, we were having meetings on Saturday because it was all hands to the deck."*

The activity with the National Virtual Team delivered eHealth beneficiaries for the project. However, the HSE CHO1 team felt they compared poorly to other partners, who were not redeployed and, able to leverage COVID-19 responses for the achievement of wellbeing targets.

eHealth

Finn Valley also faced issues with implementation of eHealth. The key barriers were issues around procurement, as well as broadband and connectivity in the area:

> *"And some of the areas are internet black spots so you are not going to get eHealth maybe in some of the homes and then a lot of people who live on their own don't have internet in their home... I suppose a lot of the clinicians are really waiting on the eHealth side of it so we're going out and meeting with them but there's a kind of… anticipation that we'll be coming with something with us, eventually. And that's putting pressure on us, as people on the frontline because the whole project has been sold as delivering eHealth solutions. (Local mPower staff)"*

Approval for eHealth procurement had been secured at a national level at the start of the project with an expectation that identification of specific needs would be at a local level. As noted elsewhere in the report, the project staff were expecting a suite of solutions to already be available:

> *"That's the anticipation; that there will be eHealth solutions there for them [primary care practitioners] and that they will be able to use that to meet their patients and that their patients will benefit by not having to travel to [another town] or whatever. So we're at that sort of tipping point… where we need to… be actually putting that talk into action and saying, 'right, okay, we're going to deliver for you.' (Local mPower staff)"*

Furthermore, securing buy-in for eHealth among clinicians was hindered by concerns around responsibility of monitoring any resulting data:

> *"That person, patient, feels confident that 'the nurse or the clinician is getting my data and if anything happens and it goes up or whatever, they will be onto it right away.' … And so that poses problems and for the clinicians…they can't be monitoring results and things like that there, 24/7. So the lack of a centralised type of hub is a big issue for us, in terms of data when it is collected. (Local mPower staff)"*

The pandemic resulted in a major shift in attitudes towards eHealth among health and social care staff. While buy-in had previously been a challenge, the local team were asked to support the rollout of Attend Anywhere and to develop and deliver training modules for this:

> *"In Ireland, mPower was the only avenue for Attend Anywhere … and I suppose we were seen as…the go-to person… the HSE formed a national virtual team on the back of COVID, to look at how we can support services, see patients virtually and so there was eight members in that team and four of them were mPower staff... We were looking at policy, process, training, resource requirement, things like data protection and needs assessments and… we did a lot of work on the training side… Just lots of resources. It was a masterpiece of work… there's over a hundred virtual waiting rooms behind CH01, all the different services and I think earlier in the year we reached 100,000 Attend Anywhere consults. So we went from none."*

It was recognised that this would not have been possible had it not been for the pandemic and that it seemed to have resulted in a culture shift locally where: 'people are realising this is here to stay... they see it as business as usual and also there's an expectation there from the service user'. This considerably helped the team to deliver on eHealth.

Health and Social Care Services

Finn Valley mPower staff found relationship building with primary care to be a key issue:

> *"I would have a lot of community knowledge and local knowledge but then there's the intricacies of, say, the HSE, that I'm new to and it can be very difficult navigating your way through these things and trying to find out what you can do and where you could maybe signpost them to within the HSE and nine times out of ten, I'm signposting them to other organisations, as opposed to HSE or community organisations. (Local mPower staff)"*

This meant that considerable investment was necessary to establish productive relationships with colleagues within Primary Care to secure referrals and signposting to the project. It should also be noted that mPower in Finn Valley did not have the clinical remit to refer beneficiaries to health services, unlike some other deployment sites. This could further hinder relationship building with primary care. However, the local team aimed to build relationships by attending various meetings with primary care staff:

> *"Because we weren't getting a lot of referrals so I did want to develop a trust relationship with clinicians that maybe I didn't know personally and I was going to quite a lot of meetings, just so they know me because if they are going to refer a patient to me, they need to know who I am… they need to know I'm actually a person that's going to try and help."*

The Community Navigator acknowledged that while the reception at meetings was generally positive, a persistent approach was needed to remind busy Primary Care staff of the existence of mPower and the benefits associated for older people in the area. This consistent approach was subsequently translated into referrals.

Despite the engagement resulting from supporting Attend Anywhere, referrals from health and social care remained slow. This partially was related to the added pressure on staff as a result of COVID-19. Project staff also believed that better visibility for mPower could have been achieved by being fully embedded within the health and social care team, where they could more easily seen as a referral options for statutory health and care professionals.

Community Resources and Transport

Transport was also a challenge in Finn Valley. The main towns of Ballybofey and Donegal were well serviced but rural transport was lacking. However, some social clubs offered transport to activities that they organise:

> *"Transport is a massive issue for people. You know, getting out, doing the simple things in life, if you don't have the car… you are really, really isolated… It's very, very difficult, even for the local day centres and that, if they don't have some kind of transport, they are very lucky, I suppose, in a way, that Rural Link is doing that for them but there's only so many places they can serve us if they have set runs. (Local mPower staff)"*

At the beginning of the pandemic, most community groups the local team were able to refer beneficiaries to had temporarily closed. The local team reported that most groups were not at a point where they were able to adopt digital technologies to keep in touch with their clients. Furthermore, the cohort of clients often weren't sufficiently digitally literate to make use of such services, even if available.

Some groups made regular calls to members and one group put together a WhatsApp group that some mPower beneficiaries were a part of. It was also reported that a few groups were meeting over Zoom. For example, exercise classes were available. However, lack of digital literacy and internet access were also an issue in the area throughout the project. While efforts were made to help beneficiaries with this, it could be challenging both financially, and also because interactions were taking place over the phone which made it difficult for Community Navigators to instruct beneficiaries on the use of devices.

6.2.5 HSE Midlands, Louth, Meath, Community Healthcare Organisation (CHO8) - Drogheda and Carrickmacross

The mPower project was implemented within the two locations of Carrickmacross and Drogheda, within HSE CHO8. These locations are within the counties of Monaghan and Louth respectively. County Monaghan is predominantly rural, with just 37% of its population in urban areas (Monaghan County Council, 2019); and with 27.4% of its residents aged 65+ living alone (CSO, 2018). Carrickmacross' population of 5,032 comprises 11.7% aged 65+ (CSO, 2017a). County Monaghan has a 2016 Pobal HP Deprivation Index of -3.2 (Pobal, no date), and a dependency rate of 36.7% (Haase and Pratschke, 2017). County Louth's population is defined as 69% urban and 31% rural (Louth County Council, 2015); and 26.4% of County Louth's residents aged 65+ live alone (CSO, 2018). Drogheda's population of 40,956 comprises 11.2% aged 65+ (CSO, 2017b). County Louth has a Pobal HP deprivation score of -2.9 (Pobal, no date), and a dependency rate of 37.7% (Haase and Pratschke, 2017). In County Louth, 1.85% of the population self-rate their health as bad or very bad (Louth County Council, 2018).

The combined population of the deployment locations within HSE CHO8 is approximately 45,988. Of this population, approximately 5,176 are over 65 years of age. HSE CHO8 achieved 497 digital health interventions, which is lower than the 929 achieved in HSE CHO1. The number of Wellbeing Plans in HSE CHO8 (167) is also lower than the 325 in HSE CHO1. The number of Wellbeing Plans in HSE CHO8 is the lowest within any deployment site. However, as HSE CHO1 comprised of two separate deployment sites and therefore, two teams, this is not unexpected. Furthermore, HSE CHO8 had high turnover of staff with periods of posts being vacant, making local relationship building and scoping of community resources challenging. It is therefore noteworthy that there is a reach of approximately 13% into the over 65s population which is a relatively high proportion.

HSE CHO8 was impacted by the same issues around obtaining consent to share data with UHI as HSE CHO1. We were therefore only able to include 22 beneficiaries in the evaluation analysis, after the consent issue was resolved. This sample included no eHealth questionnaire data.

mPower deployment site CHO8

22
Evaluation Participants

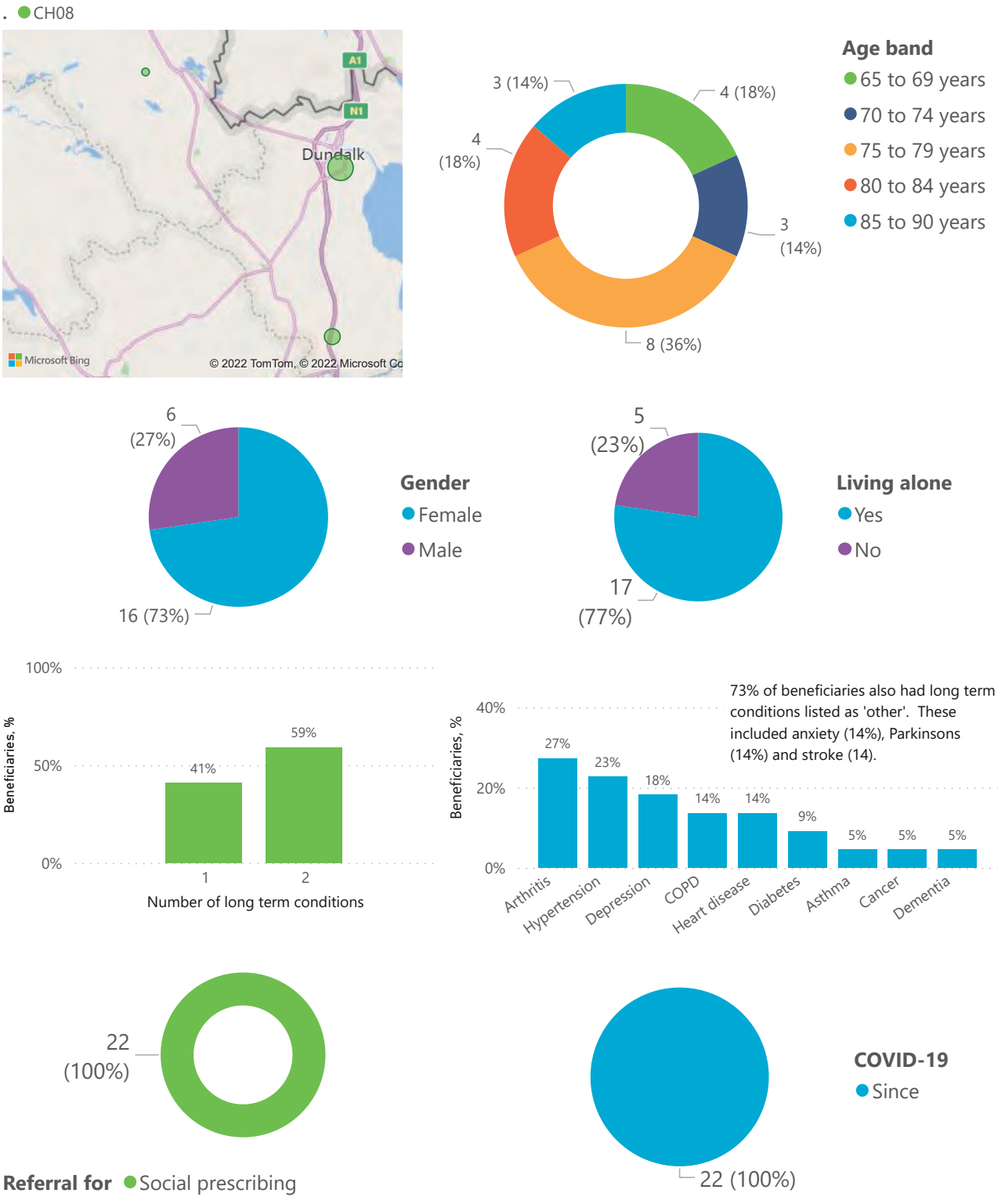


Figure 16 Description of mPower beneficiaries who consented to take part in the evaluation in HSE CHO8. Data collected from June 2021 to April 2022. NB COVID-19: all 22 beneficiaries consented to participate in the evaluation after the start of COVID-19, hence there is no 'pre COVID-19' content in the final chart.

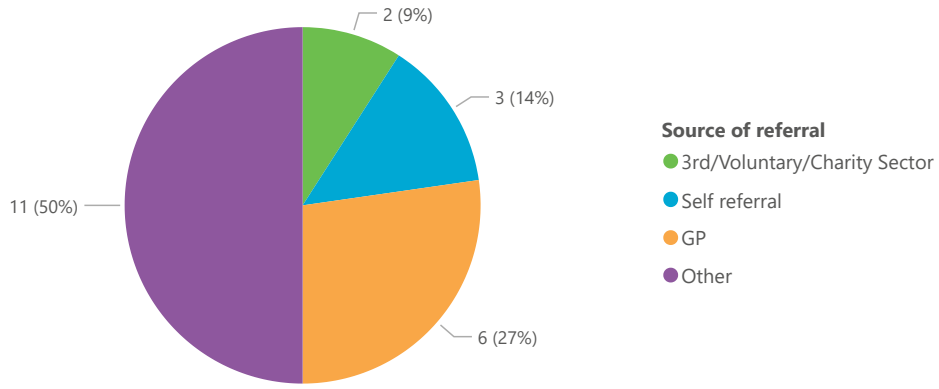


Figure 17 Breakdown of sources of referral for mPower evaluation participants in HSE CHO8.

Context of COVID-19

Before the onset of the pandemic, an additional Community Navigator was employed, based within the third sector organisation ALONE. They were not redeployed due to not being employed by HSE. However, another Community Navigator was redeployed to work on the rollout of Attend Anywhere across the Republic of Ireland. Redeployment had a significant impact on the number of Wellbeing Plans Community Navigators were able to complete during this time, even over the phone.

Social Prescribing and eHealth

Before the implementation of mPower, a social prescribing project called Cúltaca had operated in the area. Furthermore, during the time that mPower was being implemented, social prescribing became increasingly prevalent and valued in the area:

> *"In the last year, it's funny, it's definitely taken off. Even the term 'Community Navigator' is being used elsewhere, especially with mental health services, not so much the older population but a lot of the mental health services are trying to take it on board as a service. (Local mPower staff)"*

A local team member reported that occupational therapy services in the deployment site viewed signposting as part of their work. mPower was therefore a welcome additional resource, taking some of the pressure off their service. However, this did not result in significant quantities of Wellbeing Plans.

Findings from the eHealth readiness assessment indicated a level of trust between patients and healthcare professionals to share clinical information, but uncertainty in patients' and healthcare providers' willingness to use ICT. This may be reflected in the lower numbers of eHealth beneficiaries within the deployment site compared to the Scottish sites but emphasised the extent of the opportunity for mPower in HSE CHO8.

Healthcare professionals were indicated as having a stronger belief in the perceived need for eHealth than patients; and while patients were thought to perceive a need for eHealth, this again did not apply to Virtual Clinics.

Respondents were uncertain regarding the presence of leadership through an eHealth champion; and neither healthcare professional nor patient involvement in eHealth development was observed. The surveyed eHealth technologies were felt to have relatively high user-friendliness, though training needs were again unclear. Respondents felt that HSE CHO8 lacks the financial resources for eHealth implementation.

As eHealth readiness assessment findings suggest, HSE CHO8 faced similar challenges to HSE CHO1 in terms of procurement of eHealth. Local policies and procedures meant that there was a delay in obtaining the technology necessary for eHealth implementation. It is likely that this has impacted the numbers of eHealth beneficiaries obtained for the deployment site.

The local team reported that not being able to describe exactly what mPower can offer in terms of technology was a hinderance in securing buy-in for the eHealth side of the project, particularly as there was a lack of demand for eHealth from healthcare providers.

The importance of securing buy-in for eHealth by being able to show how it works in practice was seen as key. A member of the local team suggested that health services may be 'fearful' of new forms of service delivery that use technology. Being able to demonstrate how the technology works in practice may act to alleviate these concerns. Any uncertainty in terms of what can be provided through mPower could undermine this.

As already noted, the pandemic brought with it an increased demand of Virtual Clinic technology from health and social care services and mPower staff were on the forefront of this work. They also worked with Healthy Ireland on an initiative called HI Digital to bring technology to people who have never used it before.

Health and Social Care Services

The local team spread the word about mPower through talks and events such as an information day attended by healthcare workers. Again, engagement with GPs was difficult but the reasons for this were unclear, as they had initially responded positively to the project.

HSE CHO8 have faced similar issues to the two HSE CHO1 sites in terms of not being embedded within the local primary care team. This resulted in fewer natural opportunities to have dialogue with primary care workers. Links with services had not been established from the outset, making implementation more challenging. This may be reflected in the lower numbers of Wellbeing Plans that have been completed in this deployment site.

It appears that the Scottish and Northern Irish sites have benefitted from having their local implementation teams more embedded within local primary care services and multi-disciplinary teams and have, therefore, worked from a different starting point in terms of relationship building and support.

However, with a Community Navigator based at ALONE, they were able to make use of existing referral routes. ALONE was known for its befriending service and health and social care professionals, in particular social work, occupational therapy and hospitals, often referred patients there. The Community Navigator was then able to introduce the referred person to the mPower Wellbeing Plan. However, it was acknowledged that referrers did not necessarily view their referrals as being for mPower:

> *"We [ALONE]'re known for befriending, that's our big thing. We do support coordination, but we also do befriending so most people go 'oh this person is lonely, I'm going to refer them into ALONE for a befriender', I have spoken to people about what the Wellbeing Plan is and they do like the idea of it and they can see the benefit of it. I don't know how front of mind it is for them though when they are talking to an older person. The referral for the befriender is much simpler."*

Community Resources and Transport

The local team reported that there were several voluntary organisations in the area relevant to mPower, such as District Support for Older People. However, it was broadly viewed that community organisations for older people often work in silos, which made integrating into the landscape challenging for mPower staff. The local team initially worked to address this by seeking to bring community groups together, with mPower also around the table.

A Community Navigator identified transport as the main issue in terms of services in the area:

> *"I find the biggest challenge isn't in terms of finding a solution for someone, it's getting them to that solution so you know, they might say 'I'll join a book club but I've no way of getting there', you can look at things like taxi service but finances might be restricted and mobility might be an issue."*

The community transport that was available was for hospital appointments, and where public bus services were available, beneficiaries were not always physically fit or confident enough to use them.

As in other deployment sites, much third sector activity ceased with COVID-19. A Community Navigator reported that services such as Meals on Wheels were operating, delivering food to some of their beneficiaries. Some social groups were also doing phone calls with service users but there was a distinct gap in availability of the activities beneficiaries would normally be referred to.

6.2.6 Western Health and Social Care Trust - Fermanagh

Fermanagh was the locality chosen from the Western Health and Social Care Trust (WHSCT) as the mPower deployment site. The Western Trust contains extensive rural communities and a small number of densely populated urban areas (WHSCT, 2018); and its population of 302,204 comprises 15.7% (47,471 people) aged 65+ (NISRA, 2019a). The Fermanagh and South Tyrone Assembly Area has a population of 108,495, of which 17,441 are aged 65+ (NISRA, 2019b). These areas are larger than the actual mPower deployment site but we do not have figures at a lower geographical scale. Five of the top ten most deprived Super Output Areas, by Access to Services in NI, are in the Fermanagh and Omagh Local Government District (LGD) (NISRA, 2017). Over a fifth (21.85%) of Western Trust's population has a long-term condition or disability that limits their day-to-day activities (NISRA, 2013a). The self-rated health for Fermanagh and Omagh's LGD2014 reveals 4,413 people have bad health and 1,145 people have very bad health, equating to 3.90% and 1.01% of the LGD's 113,161 residents respectively (NISRA, 2019c). Northern Ireland's WEMWBS score overall is 51.4 (DoH, 2019).

Fermanagh recorded 227 digital health beneficiaries and 368 Wellbeing Plans completed. The number of digital health interventions (227) is much lower than in the Southern Trust (929) and the number of Wellbeing Plans lower by 69. The number of digital interventions in this deployment site is the lowest of any of the areas. Its total number of beneficiaries gives a population reach of approximately 3% (although this is likely to be slightly deflated by our lack of local level population data).

Of the beneficiaries in the Western Trust, 95 completed the evaluation questionnaire and the make up of this sample is shown in Figure 18.

mPower deployment site
Western Health and Social Care Trust

95
Evaluation Participants

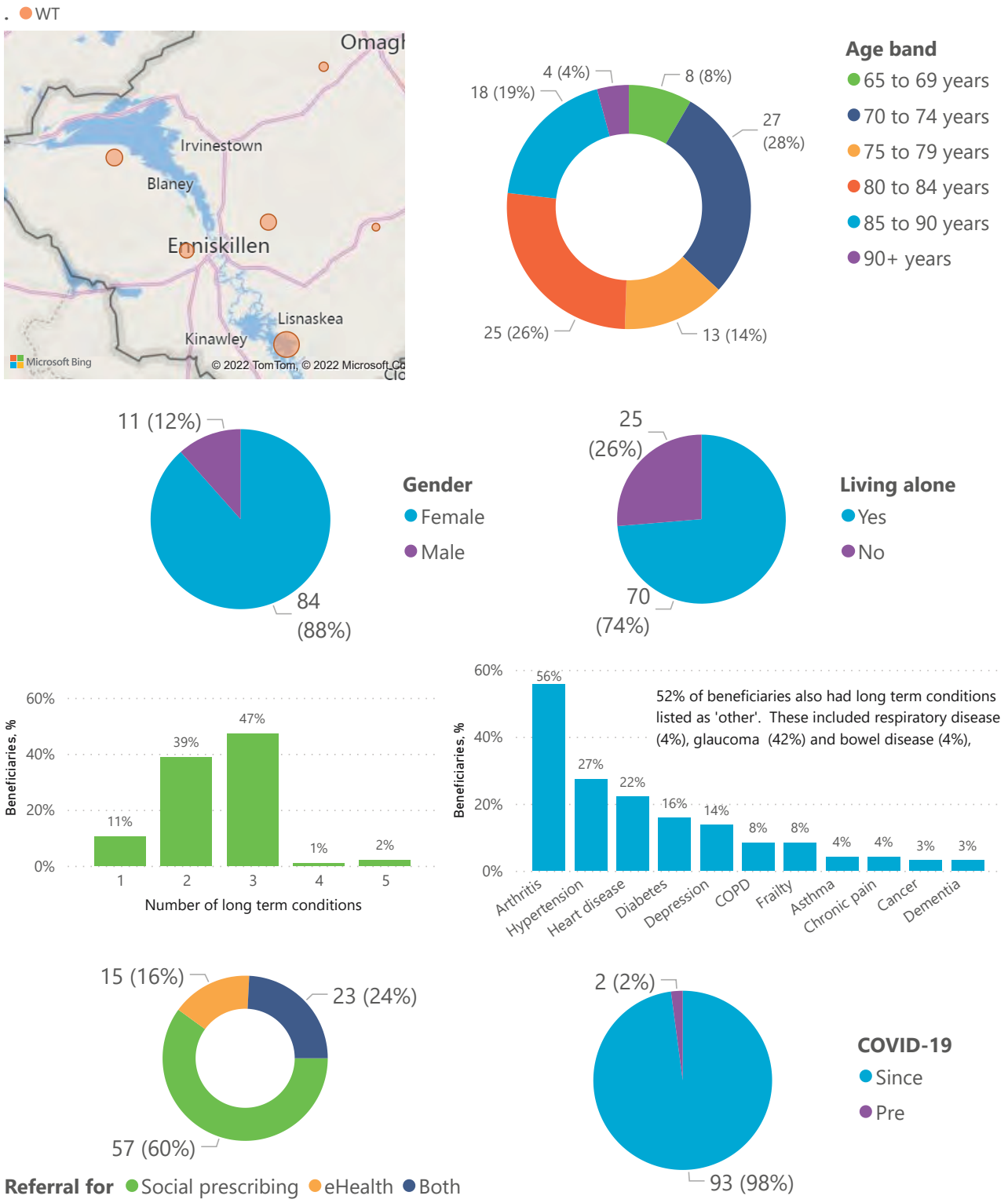


Figure 18 Description of mPower beneficiaries who consented to take part in the evaluation in Western Health and Social Care Trust. Data collected from March 2019 to January 2022.

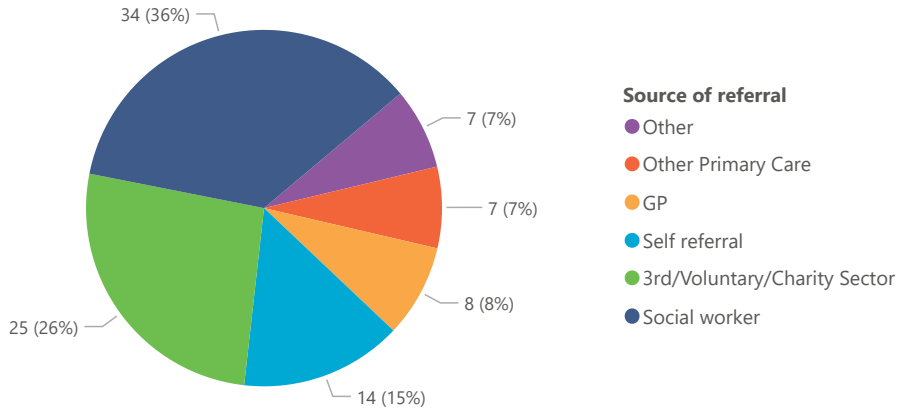


Figure 19 Breakdown of sources of referral for mPower evaluation participants in Western Health and Social Care Trust.

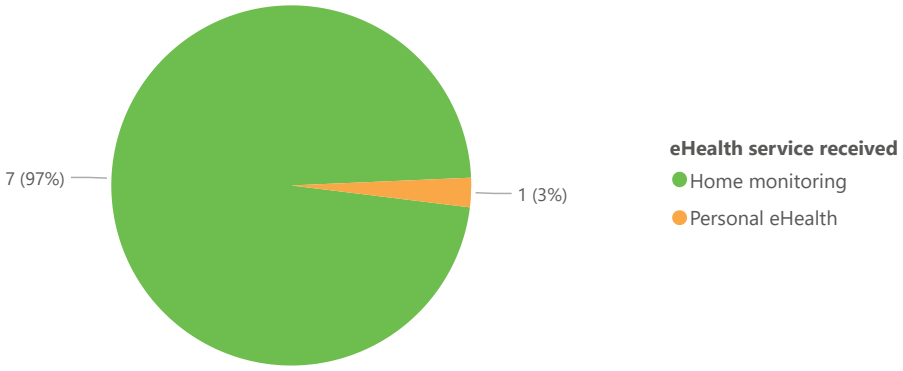


Figure 20 Breakdown of eHealth services received by mPower evaluation participants in Western Health and Social Care Trust.

eHealth service type	n	%
FLO	22	57.9
Lifeline	14	34.2
Personal alarm	1	2.6
WhatsApp support	1	2.6
Total	**38**	**100**

Table 10 Details of eHealth service types received by mPower evaluation participants in Western Health and Social Care Trust

Context of COVID-19

The two Community Navigators in the area were redeployed to social work teams. They reported that a lot of the work was in the capacity of a social work assistant and that many parallels could be drawn with the work they did as Community Navigators:

> *"So although you were doing social work you were also doing the navigator role; so you were putting people in touch with food provisions, that might have been down the local shop getting deliveries… The same with prescriptions and medications, the same with getting rural transport to deliver some free of charge... And then talking to them about what befriending services were out there. So you were kind of wearing two hats, quite a lot."*

Perhaps unsurprisingly, when the Community Navigators moved back to working on mPower full-time, the transition was not a clear cut one:

> *"It wasn't a straight cut that you just finished social work assistant one day, mPower the next day. And there was still a few phone calls you get… In some cases there was an overlap, which was involving people through social work and through mPower so that was grand, because I could have one conversation and kill two birds with the one stone."*

While the majority of contact with beneficiaries during COVID-19 took place over the phone, Community Navigators were also periodically able to make home visits, wearing appropriate PPE.

Existing eHealth and Social Prescribing Services

CoH-Sync and a Big Lottery funded social prescription service both operated within the locality. Similarly to Wigtownshire, mPower and existing programmes worked together to direct referrals to the appropriate service:

> *"This was done through meetings and inviting them [CoH-Sync and the Big Lottery programmes] to join the mPower Health & Wellbeing working group which was established with the local GP practice…. Having a structured agenda enabled us to discuss and agree clear referrals pathways… mPower would take the over sixty-fives and the GPs would refer all other age groups to the other Social Prescribers. I felt that it was important from the beginning that mPower was seen to support local community organisations and involving them in the Health & Wellbeing monthly meetings encouraged relation building and closer working arrangements. (Local mPower staff)"*

This highlights the importance of linking in with other services as well as primary care in order to ensure that mPower is effectively embedded within existing structures.

Findings from the eHealth readiness assessment indicated a level of trust between patients and healthcare professionals to share clinical information; but uncertainty in patients' and healthcare providers' willingness to use ICT, and no culture of embracing new technology. This may be reflected in the lack of eHealth beneficiaries within this deployment site.

Healthcare professionals were thought to have a stronger belief in the need for eHealth than patients; and while patients were reported to perceive a need for eHealth, this was not the case for Virtual Clinics.

The findings indicated a relatively strong belief in the presence of leadership through a champion; and eHealth development involving healthcare professionals, but not patients.

The surveyed eHealth technologies were felt to have relatively high user-friendliness, though training needs were unclear. Western Trust respondents had some confidence in its ICT competences for eHealth implementation but lacked the required financial resources.

Interview participants also indicated that delivering eHealth interventions in Fermanagh was a particular challenge, due to infrastructure and services not being in place:

> *"Respondent: It [eHealth] is not available for use within our catchment area yet. It's difficult when you speak to clinicians and they are eager to get involved in eHealth initiatives and there is a long delay in it being operational. Momentum can easily be lost.*
>
> *Interviewer: So how do you go about procuring that?*

> *Respondent: Well I can't procure it, as they are National projects being rolled out, I cannot go outside the established framework. I can only work to have full access to it once they become available. However we have been waiting months and months and each time it seems to be one step forward two steps back, but we are advancing. (Local mPower staff)* "

This demonstrates the difficulties in implementing a project without the ability to draw on pre-existing technologies or to procure these as part of the project, which makes meeting targets particularly difficult.

However, with COVID-19, there was a shift in receptiveness to eHealth among health and social care:

> "*There's really been a massive shift... Because everybody has, in the last couple of months, just had to do it. Whereas before it would have been – really looking at 'well what's the added value of doing this' and trying to make time for it. Whereas there was no other choice and people had to do it and they've just got on board. For example, one of the pathways that I'm working on is with district nursing and tissue viability. And the tissue viability nurse has been telling me that previously 95% of their consultations were home visits and that they reduced that to 15%. So we've been talking about it and she just said it totally changed their service. (Local mPower staff)* "

The mPower team were able to support a range of health and social care teams in moving to a service more focussed on eHealth solutions:

> "*When mPower is here, when we initiate something, it gets it off the ground, both from equipment support but also in terms of managing that change-management piece and the service improvement and monitoring.* "

Health and Social Care Services

In Fermanagh, GPs were receptive to the idea of social prescribing and eHealth:

> "*The GPs within in our catchment area have shown great interest in social prescribing and they have a very good understanding of how it works and the benefits... It is important to a new project like this to be able to identify key champions. A GP within the practice is definitely one of these champions… This GP also recognises the benefits of using eHealth Technology in their practice which they feel would benefit their patients particularly older people in that by using VEC to link in with Consultants in one of the major hospitals older people may not have to travel long distances for appointments and could be seen locally. (Local mPower staff)* "

The local Community Navigator maintained a regular presence at the health centre to make sure that GPs, nurses and reception staff were aware of mPower. The Implementation Lead also regularly met with various health professionals and attended multi-disciplinary meetings with the local GP practice. The relationship building process was largely positive and local health care staff viewed mPower positively.

While physical presence was no longer possible at the onset of the COVID-19 pandemic, the redeployment of Community Navigators to social work strengthened their ties to the service and resulted in closer contact and thus, referrals. Connections with a wide range of other services were also achieved through the support in implementing eHealth that mPower provided locally.

Community Resources and Transport

The local team reported that there were several community groups operating in the area. The Community Navigator built connections with these by introducing themselves and their work, initially via email but also in person. Physically going along to activities was key in establishing relationships. Relationships between mPower and community organisations, such as the Southwest Ageing Partnership, were considered key to creating a legacy from mPower:

> *"Sustainability is an essential goal of the organisation, once the project is finished, the improved working relationships and shared learning will hopefully continue to build and support the role of social prescribing in empowering older people to continue to self-manage (Local mPower staff)"*

Again, having to do extensive asset mapping at the outset was a challenge and time consuming. In terms of transport, social car schemes existed, organised by the Healthy Living Centre, where volunteers drove people to appointments and activities. Of course, this was not always available. While there were public buses running in the area, using these required the beneficiary to be able-bodied.

As with other deployment sites, there was a lack of face-to-face community sources to refer beneficiaries to at the onset of the pandemic. However, a lot of services were available over Zoom from the Healthy Living Centres. The local team reported varied success in engaging beneficiaries with services that were online. A key service for the local team was a local befriending hub who were able to provide telephone befriending. The positive outcomes resulting from this service will be discussed later in the report.

6.2.7 Southern Health and Social Care Trust – Newry and South Armagh

Within the Southern Health and Social Care Trust (SHSCT) mPower deployment site, activity was concentrated in the localities of Newry and South Armagh. Newry aligns with Newry, Mourne and Down DEA; and South Armagh aligns with Slieve Gullion DEA. Newry, Mourne, and Down DEA's households are defined as 58.6% rural and 41.4% urban (NISRA, 2018). Southern Trust's population of 383,541 comprises 14.7% (56,245 people) aged 65+ (NISRA, 2019d). Out of the total population of 119,966 people in the Newry and Armagh Assembly Area, 17,705 are aged 65+ (NISRA, 2019e). Four of the top ten most deprived Super Output Areas, by Income in NI, are in the Southern Trust area (NISRA, 2017). Of Southern Trust's population, 19.64% have a long-term health problem or disability that limits their day-to-day activities (NISRA, 2013b). Self-rated health in Newry, Mourne and Down LGD2014 revels 6,929 people have bad health and 1,860 people have very bad health, equating to 4.04% and 1.08% of the LGD's 171,533 residents respectively (NISRA, 2019b). Northern Ireland's WEMWBS score is 51.4 (DoH, 2019).

The Southern Trust recorded 929 eHealth interventions and 437 Wellbeing Plans completed. Both of these numbers are higher than those recorded in the Western Trust and the 929 digital interventions is the highest in Northern Ireland or Ireland. They have reached approximately 2% of their over 65-year-old population (although this figure is likely to be slightly deflated by our lack of local level population data). Of the beneficiaries in this area, 129 completed the evaluation questionnaire and the characteristics of this sample are shown in Figure 21.

mPower deployment site
Southern Health and Social Care Trust

129
Evaluation Participants

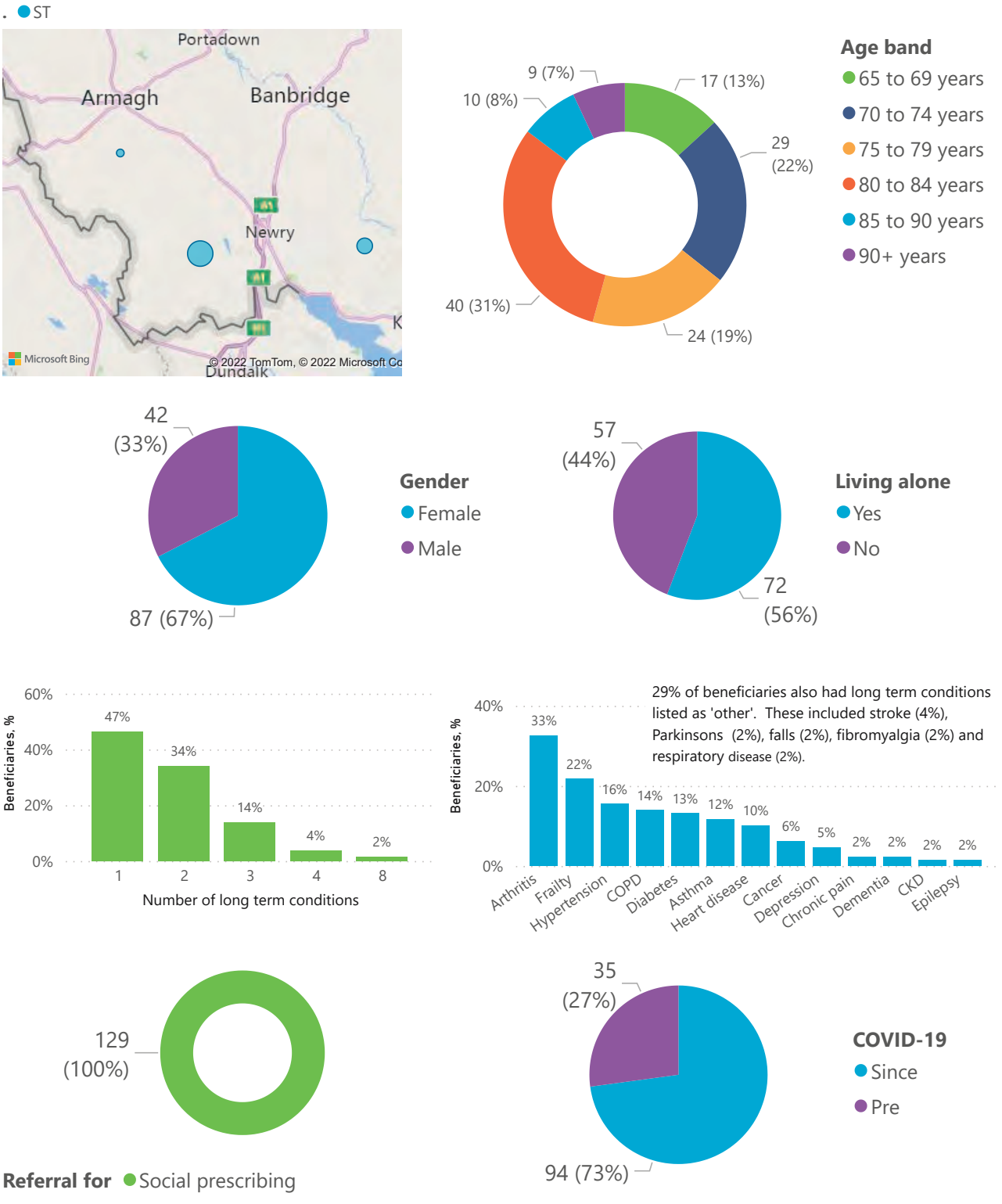


Figure 21 Description of mPower beneficiaries who consented to take part in the evaluation in Southern Health and Social Care Trust. Data collected from March 2019 to December 2021.

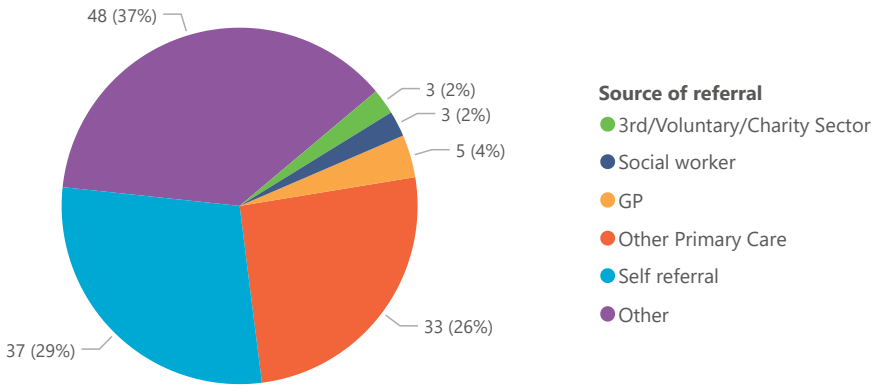


Figure 22 Breakdown of referral sources for mPower evaluation participants in Southern Health and Care Trust.

Only one Southern Trust beneficiary who participated in the evaluation was referred for eHealth and they were provided with a personal alarm.

Context of COVID-19

While the local mPower team was not redeployed, they volunteered their time for the COVID-19 helpline that was set up within the Promoting Wellbeing team for the first five weeks of the pandemic. Anyone with a social, medical or financial need was able to call the helpline and this resulted in a large number of referrals for the mPower team:

> *"We had an opportunity there to talk with the rest of the call handlers and basically say 'if they are over sixty-five and living in this area, you can refer them straight to us', so that was great to be able to have that understanding with people. So if you got somebody who was over sixty-five, they would attend to their immediate need, so the immediate need might have been getting a prescription, so they would sort that out for them but then refer them to us for the follow-up. And that resulted in a huge, huge increase in our caseload for beneficiaries."*

eHealth

The findings from the eHealth readiness assessments suggested a level of trust between patients and healthcare professionals to share clinical information; patient and healthcare providers' willingness to use ICT; and a culture of embracing new technology.

Healthcare professionals were indicated as having a stronger belief in the perceived need for eHealth and home and mobile health monitoring than patients; and while it was reported that patients perceive a need for eHealth, this did not apply to Virtual Clinics.

There was a relatively strong belief in the presence of leadership through an eHealth champion; and eHealth development involving healthcare professionals, but not patients. eHealth technologies were felt to have relatively high user-friendliness, though training needs were unclear.

Respondents were uncertain about ICT competences for eHealth implementation, and availability of required financial resources. This uncertainty was also reflected in the interviews with the local team, particularly at the outset of the project:

> *"In time, digital interventions will become way more part of how the system works but it is certainly the more innovative and therefore the more controversial component of the study. Like that meeting with social workers, half of them thought this was almost… offensive to their way of working. It's not that I don't see what they are saying, it's a concern that you are taking the humanity out of care, so it's coming from a really good place. It's reiterating 'we're not taking anything away'."*

The difficulties in securing buy-in for eHealth are connected to wider issues around culture change which can take time. This demonstrates that a fuller transformation of health services cannot rely on the mPower team implementing change in isolation.

Despite these challenges, a relatively high number of eHealth beneficiaries were recorded. In the absence of readily available eHealth solutions, the Community Navigator favoured an approach similar to that of the Western Isles, where beneficiary needs were met with more diverse forms of technology:

> *"Not everybody is a candidate for a digital intervention… it's not like 'give everyone a free iPad', the majority, I'd say well over half of the people I meet, have them already. It's the other half … who hadn't really thought about it or…and then when I started to talk about the benefits of technology, it's 'oh yeah, I never thought about that, free telephone calls, who would have thought I'm spending a hundred pound a month calling me sister?' And see where we live here, if I want to phone somebody fifteen minutes into the south, it's costing me an international call... And you know, this whole idea of what they are doing in Scotland with the iPads and Alexas and all that, we need that here now. I have beneficiaries ready to go, who it would change their lives, change their lives, you know? And for whatever reason… we can't do the same things."*

The Community Navigator therefore identified needs among local beneficiaries and how these could be met. In border areas, technology could offer a way for beneficiaries to increase their connections with friends and family across the border. However, this was not possible to implement initially in the Southern Trust, resulting in some frustration. This shows how approval processes and operational differences between partners can hinder outcome achievement.

As has been seen in other deployment sites, health and social care were also much more receptive to eHealth solutions after the onset of the pandemic than before. This resulted in a situation where mPower, having previously been ahead of the curve when it came to eHealth, slightly fell behind as services rapidly moved online. However, in time a gap was identified in the ability of service users being able to engage with the new digital services:

> *"But then obviously the gaps started to emerge, that a lot of these services have offered online service but many of the patients don't have the ability to get on themselves. I suppose what I've been focusing on now is to support those services to support those patients to get online. (Local mPower staff)"*

The local mPower team were also able to provide all care homes within the deployment site tablets with pre-loaded resources:

> *"Not just for the residents but also for the staff: health and safety but also ideas for exercise and social things that they could do. So spoke with a local museum, got a recording off the museum, all sorts of different exercise… web-cams, under the sea, on top of mountains, in forests, in zoos, city-scapes around the world, live feeds that people could tune into… Some of the art packages that they could access or download, enabled people with really, really limited mobility to create wonderful art... So I suppose most importantly of the whole thing was the ability to have social contact with their family members outside."*

This demonstrates that finally having the ability to procure devices and using innovative and creative resources could provide wide-ranging benefits for both care home staff and residents.

Community Resources and Transport

Local staff referred to a large amount of community groups operating in the area, citing a *'very vibrant community and voluntary sector'.* While their reception to mPower was again largely positive, one member of local staff felt that mPower had not been set up with the third sector in mind, hence resulting in them feeling 'left out'. This was slightly problematic in terms of building rapport without being able to provide the means to build capacity within (by channelling resource to) the third sector, alongside referrals to it. Previously established relationships with the community sector by local staff worked to somewhat offset the impact of this. It is uncertain whether building third sector connections would have been more problematic if this had not been the case. Capacity and support of the third sector therefore needs to be carefully considered at the design stage of social prescription projects.

Transport was also an issue for the area. While community transport was available, the cost was often prohibitive for beneficiaries:

> *"In the ideal world, I'd take some of mPower's money they have every year and subsidise people's travel or community transport. (Local mPower staff)"*

The local team reported that a wide range of third sector organisations were offering their services online during the COVID-19 pandemic. However, the extent to which beneficiaries were willing to engage with online services varied.

Health and Social Care

The local Implementation Lead had experience in engaging with GPs and was able to use this knowledge effectively in their mPower role. By virtue of being based in the same building as the Promoting Wellbeing team, staff were also able to maintain key relationships with referral sources. Beyond this, posters were distributed to offices of key services to remind staff about mPower. The Implementation Lead also organised cross-service meetings to promote the project. They acknowledged that while primary care staff indicated that they view mPower in a positive light, the leap to making referrals could be difficult due to time pressures and working patterns that could be hard to shift. Referral processes therefore needed to be as streamlined as possible.

As already noted, the COVID-19 pandemic brought with it increased opportunities to connect with other health and social care services, resulting in a large number of referrals. Furthermore, many of the staff had a background in health and social care and were able to draw on pre-existing connections to generate referrals: 'I have to say, I have never been without referrals. Ever.' However, it was reported that referrals from social work and occupational therapy, as well as GPs, dried up at the start of the pandemic, due to them no longer being able to see patients face to face.

6.3 Approach to Service Delivery

This section gives an overview of the mechanisms of service delivery employed by the local mPower teams across deployment sites. It considers how eHealth and social prescribing were delivered to beneficiaries, as well as the importance of the relationship between beneficiary and Community Navigator in achieving outcomes. It also discusses the changes that took place as a result of the onset of the COVID-19 pandemic.

6.3.1 eHealth

As the preceding section demonstrates, the availability of eHealth solutions varied between the different deployment sites. Where eHealth was available, referral pathways had often been established prior to the launch of mPower and local teams recognised that disrupting these processes would not necessarily be beneficial:

> *"I spoke to the tech team and… I was thinking, well Florence is being delivered by the specialist nurses… And I'd spoken to a couple of specialist nurses… 'yes, we use Florence and we're fine, thank you very much.' And I'm thinking 'well is it my job anyway to be taking Florence off them and saying, 'well I'll do it'. (Local mPower staff)"*

Some teams found that a meaningful way to integrate mPower eHealth delivery was to design new Florence protocols and provide support to beneficiaries already availing of this technology. This was seen to add value.

Community Navigators directed beneficiaries to existing apps, such as My Diabetes My Way. They also supported beneficiaries in the use of various other apps they already had on their phones or tablets.

In Ayrshire and Arran, support in the use of Computerised Cognitive Behavioural Therapy (CCBT) was offered, as a big reason for drop-outs from the programme among older people was not knowing how to use the service. Many Community Navigators were also able to refer beneficiaries for telecare services. The existence of these established eHealth technologies/ services has provided the Scottish mPower teams with referral routes that were not present within Ireland or Northern Ireland when the mPower project began.

Some deployment sites explored the use of NHS Near Me beyond the primary and secondary care context, to connect people remotely to various groups and classes, either from home or a community centre. This would reduce travel time and enable people to have access to groups that are not available in their area, as well as enable people to attend activities virtually during COVID-19 in some cases.

The mPower team in the Western Isles explored several other eHealth options that extend beyond the three original mPower eHealth categories. One example is implementing Whzan[8] in care-homes. Whzan is a form of Telehealth technology that allows clinicians to set parameters for clinical readings specific to the patient. These act as a baseline, and readings which fall outside the parameters will generate an alert. This is called a NEWS Score (National Early Warning Score) which is a clinically recognised system. However, despite the statistically robust evidence of such technology, the team encountered push back in terms of responsibility for responding to data recorded:

> *"We went in, in January and left the equipment with them and they were going to give it a try… I knew that the care home themselves… are not responsible for the medical care, so they were slightly reticent about what would they do with the information they were getting… but they were willing to give it a try. And then thought, 'well, we will be working closely with our GPs' so we… had a review meeting with the GP surgery and I thought, 'right, I'd better mention it' so I said, 'we've taken Whzan, we've left it with them, we've set all the residents up, it gives you a really good measure of the three key measurements'…So I sent the GP an email and I just said, 'Have you had a chance to think about it?' And he wrote back and said, 'Yes, I have and we – the people in the home know their patients, we know their patients and so we're not interested'… it's like every time you think you've opened a door, two shut, and you are just constantly trying to think, 'right okay, which is the relationship or the issue that I need to deal with at this particular moment in time.' (Local mPower staff)"*

[8] For further information, please see: https://www.whzan.com/public/Home.aspx

This demonstrates how even when the appropriate technology is available, barriers to buy-in can be difficult to overcome and relationships with health and social care services can be challenging to maintain.

Other forms of eHealth offered included: providing video conference technology to care homes and community trusts to enable people to keep in touch with friends and family and to attend GP appointments remotely; supporting patients from small, part-time GP practices to attend Virtual Clinic appointments supported by a nurse on days when a GP is not in their surgery; and supporting beneficiaries to use technological devices they already have, or lending them tablets or Alexas to try before deciding if purchasing one would benefit them. Beneficiaries who did not have access to larger supermarkets were also supported to use online shopping to achieve a more varied diet.

These novel approaches to delivering eHealth interventions to support self-management and mental wellbeing can be beneficial because, as literature suggests, social and communications technologies can reduce social isolation and lead to better self-rated health (Chopik, 2016). The flexibility of the mPower approach has allowed us to gather evidence on the benefits of implementing a broad definition of eHealth that encompasses more than health or health-related technology.

In those deployment sites where eHealth technology was available, local teams reported that many of their beneficiaries who took part in an eHealth intervention had done so because it had been identified as potentially beneficial to them as part of a Wellbeing Plan discussion with a Community Navigator. It was less common for a beneficiary to talk about being referred directly into an eHealth intervention, without having done a Wellbeing Plan first. This is perhaps not surprising as the mPower teams were at least initially rarely in a position to deliver eHealth interventions themselves. One Community Navigator articulated their approach to service delivery and view of how eHealth and social prescribing interact within the project:

> *"Social prescribing can run alone but I don't think eHealth can run alone itself… Social prescribing is the main frontier that you are dealing with and eHealth just comes to underpin it, to further help and support [the beneficiary]."*

Throughout the development of the localised mPower services, and, as we have seen, during the COVID-19 pandemic, a range of new eHealth solutions emerged. While developments had taken place prior to the pandemic, its onset was a turning point when it came to implementing and mainstreaming these:

> *"In terms of COVID, I really do think COVID was the catalyst that actually brought about the adoption of eHealth solutions in Ireland. We weren't really getting much engagement from clinicians here at all and suddenly then they phoned, they were ringing me – people that I'd talked to way back, to see if I could get them this [technology]. So that tipped the scales, very much so. (Local mPower staff)"*

While initially, local mPower staff were often cautious and expected the shift in interest in technology to be a temporary one, driven by necessity, all pointed towards a wider culture shift that they were a part of. An example of the use of technology during COVID-19 was providing care homes with iPads:

> *"We wanted to try and help, you know people looking in windows at parents, stuff like that, so we found the money to get iPads and that enabled us to get every care home in our area, give them a pre-loaded pad with information, not just for the residents but also for the staff: health and safety but also ideas for exercise and social things that they could do. So spoke with a local museum, got a recording off the museum, all sorts of different exercise for all different varieties of different people and video-cams and web-cams, under the sea, on top of mountains, in forests, in zoos, city-scapes around the world, live feeds that people could tune into… art packages that they could access… livestream in music and videos, comedians… we had the libraries app… So I suppose most importantly of the whole thing was the ability to have social contact with their family members outside."*

Several deployment sites also set up Community Digital Hubs. These were spaces where generally, older people, could attend Virtual Clinic appointments. Beyond this, they aimed to improve people's health, wellbeing and digital literacy by exploring various digital tools and help people connect with friends and family remotely. They also aimed to reduce digital inequalities by providing people with access to digital devices and internet connectivity. The hubs continued to run beyond the mPower project, thus contributing to its legacy:

> *"I think some of the legacy around, particularly the Community Digital Hubs that have just got off the ground in our area, are you know, the way forward connecting older people and communities to health services, to digital opportunities. (Project Board member)"*

Another technology some deployment sites availed of was ADAM (About Digital and Me), an Alzheimer Scotland initiative partially funded by mPower. It is a digital platform that, through a series of questions, helps citizens as well as families and carers to identify technology that might be beneficial to their health and wellbeing:

> *"mPower funded the six pieces of kit through the ADAM Framework and it was a Flipper universal TV remote, which is a sort of simplified television remote, a Doro mobile phone, the Amazon ECHO Show, a companion pet that came as a cat or a dog, a dusk-till-dawn night light and a dementia-friendly clock. (Digital Navigator)"*

As the ability to provide digital services and support through mPower increased, some sites felt having Community Navigators specifically focussing on digital support to be beneficial. While their role and approach mirrored that of Community Navigators, they were able to offer more specialised technological support:

> *"We'd discuss the digital side with them and see what they were looking to do, whether it was looking to have any help with digital equipment they already had or if it was an ADAM assessment. Going to people's homes, set up the equipment, make sure they are confident in using it. Organise, phoning them back to get feedback on it. Some of the kit can take a short while. But for iPads and the Amazon ECHO Shows, you could probably spend a good hour or so there, just making sure they are confident and you've tested everything. (Digital Navigator)"*

Depending on the technology available in the area, Digital Navigators provided beneficiaries with the equipment, as well as support in using it.

Digital Navigators also worked closely with the Connecting Scotland programme, managed by SCVO, which provided digital devices to citizens lacking connectivity, kit and confidence in technology use.

6.3.2 Wellbeing Plans and Social Prescribing

Both interviews with, and observation of, Community Navigators revealed that they took a flexible and adaptable approach to putting together Wellbeing Plans with beneficiaries. Depending on the needs and circumstances of the beneficiary, the process could either take a more formal structure, with the Navigator going through the plan and questionnaires systematically; or a more flexible structure, were answers to questions in the plan were generated through informal conversation. The ability to adapt the approach in line with the needs of beneficiaries demonstrates the considerable skill set Community Navigators possessed.

The mPower Community Navigators went beyond signposting to community activities and referring to eHealth by offering a holistic, person-centred service, considering the unique circumstances of each beneficiary:

> *"You don't know who is going to come through the door and you don't know what you are going to be faced with and I think it's about being flexible with that and if the patient is not ready to have a Wellbeing Plan or not… You've got that model of mPower there and it's great and you've got the Wellbeing Plan… but it's how you make it work in your area and how it works best."*

Community Navigators found themselves identifying beneficiary needs that did not neatly fall under community signposting or eHealth. Local teams have thus helped beneficiaries sign up for services such as meals on wheels; have contacted safety officers to assess the safety of homes; have chased other services that have not contacted beneficiaries as promised; have provided help in making sure beneficiaries have the cheapest energy and phone suppliers; have encouraging decluttering of homes; have provided beneficiaries with memory boxes; and have provided information on benefits and other potential support and services that beneficiaries might make use of, amongst many other things. In the Community Navigators' own words:

> *"I have a look at every aspect that I could signpost to: statutory, community, voluntary, health service and then just general support that I might be really searching on the internet."*

And

> *"I see it more as a catch and release programme, so we're here to do a Wellbeing Plan that's holistic, patient-centred care, focusing on what that patient wants. Very much it could be small things like getting the bins put out, help getting a blue badge, going to a PIP assessment, accessing their works pension… helping them get a dog walker and a cleaner…"*

An example of how Community Navigators worked with the evolving needs of a beneficiary comes from a beneficiary who had been receiving letters from HMRC saying that he owed a lot of money. The Navigator discovered that the beneficiary had not been able to act on these

letters as he was not literate. She directed him to the local money advisory body; contacted his family, with his permission, to ask them to support him; helped him obtain proof of his illiteracy and finally, signposted him to a class where he could learn to read and write. This clearly demonstrates the multiple layers of social determinants of health/wellbeing that mPower Community Navigators had the power, skills and will to act on.

Despite the holistic approach to social prescribing, Community Navigators found it important to assert certain boundaries for their role:

> *"I always say I'm not the three Cs: I'm not a carer, a cleaner or a counsellor… And be realistic with them because it's their Wellbeing Plan."*

This approach ensured that the focus is on self-management supported by the Navigator – not led by them.

As the literature suggests, Community Navigators can act as 'boundary spanners' (Baker and Irving, 2016) who develop collaborative relationships with various other services. Local mPower teams saw their role as connecting primary care services, the third sector and communities. This was a natural outcome of the process of establishing the mPower service:

> *"I believe there's a role within mPower to try and develop services or make them more connected together as well as in the community… It's about the longer-term sustainability and, okay, we will be here for a while but at the end of this there's still going to be a route into the different services that you need."*

The networks created through the work of local mPower teams could therefore ensure sustainability beyond the project itself.

This flexible and holistic approach to social prescribing acted as a foundation for the way the service had to evolve during the COVID-19 pandemic. Local staff from all deployment sites observed increasingly complex referrals. Beneficiaries had multi-faceted needs – from the most practical physical needs in terms of food and housing – to complex mental health needs. All deployment sites worked to connect beneficiaries with services such as food delivery, community pharmacy services, and supporting them with various benefit claims. For Ayrshire and Arran, this meant that promoting digital literacy often had to take a backseat:

> *"For our service, the referral routes and pathways we've established, with the likes of social work, with frailty clinics, the intermediate care teams, this isn't people who are looking for lunch clubs and stuff like that; this is people that are needing help with attendance allowance, that are very lonely, very isolated, their mental health is at breaking point and for me to say, would you like a tablet as part of your Wellbeing Plan? That's the last thing on their priority, do you know what I mean? (Local mPower staff)"*

This poses the question whether those with the needs appropriate for social prescribing were referred to the service. However, it's important to consider that in the context of a pandemic, a change in needs can be expected and mPower as a service was able to respond to this, again demonstrating the person-centred approach adopted. Local staff also reported that some beneficiaries expressed that they couldn't ask for help for issues they considered to not be 'urgent' during the pandemic:

> *"There's a lot of people who – their mindset has maybe changed, whilst they want some support and help because of the pandemic, they maybe feel they don't have the confidence to maybe ask for that same level of help."*

There is therefore a risk that some people who may have benefitted from a service like mPower when not at a crisis point get overlooked and later require more extensive support.

Loneliness and social isolation had been from the outset recognised as the most pervasive issues for beneficiaries referred to mPower. COVID-19 further compounded these and as we have seen, the types of community resources Community Navigators were previously able to draw on to support beneficiaries were often no longer available. However, local teams were able to work to implement innovative solutions to support beneficiaries.

Teams in the Republic of Ireland and Northern Ireland noted that connecting beneficiaries to online church services was not only important for wellbeing, but could also provide an inroad to increased interest in digital technologies:

> *"This wee lady here… lives with her husband, they are quite isolated, we got them connected online as well so they are now watching Mass every week, which they love, they can see their local Mass every week. The wife is using the libraries online, she's not buying any of… her sewing magazines anymore, she's able to get them all online and loves it. They were in quite an old house and their heating wasn't great so they've got a grant through to get their boiler replaced and their heating upgraded, so they are delighted with that. And I think there's a perception that everybody is connected to somebody in health and they know about all these things that they can get but a lot of the time that's not the case; I've loads of clients that are not connected with anybody in health."*

This quote demonstrates the boundary spanning role that local mPower teams took on during the pandemic as well as before. The service was able to connect beneficiaries digitally in a person-centred manner, led by the needs and interests of the beneficiary, while also connecting to other relevant services such and health and social care and housing.

Close ties with the third sector during this time were also key. In the Western Trust for example, the local team worked with a third sector organisation to put together wellbeing packs for beneficiaries:

> *"So we talk to [beneficiaries] about – if you were going to your groups, what would you be doing in your groups? Some would say they might be doing knitting, some would be doing craft projects, so we've been lucky enough to… send out wellbeing packs to them. The men all want outdoor activities, but it's not like movement or physical activity, it's about doing something or creating something or building, so they are getting little bird houses sent out that they have to build and paint... The same for people who are at home and looking at the library deliver book boxes to them because they aren't able to get in."*

Cultivating an understanding of the complex needs of beneficiaries in a context when limited services are available requires a complex skill set. Community Navigators also talked about how, with the limited social support available, they had to strike a balance between supporting the beneficiary while not taking on the role of befriender. This meant accumulating increased knowledge of what's available and crucially, increased creativity to create new resources, such

as the tailored wellbeing packs designed in collaboration with the third sector. Other examples included a pen pal exchange with a local school; linking people up with a service that gives them a quick good morning call; daily planners and exercise and diet booklets; and providing beneficiaries with pictorial guides on how to use WhatsApp and Zoom to help keep in touch with family, something that was highly valued at a time when family visits were not possible.

Table 11 shows the number of actions beneficiaries agreed to take as part of their Wellbeing Plan, with the majority agreeing to 2-3.

Number of actions agreed	Number of beneficiaries	%
0	4	0.4
1	139	15.3
2	294	32.4
3	253	27.9
4	66	7.3
5	56	6.2
6	38	4.2
7	28	3.1
8	14	1.5
9	7	0.8
10	5	0.6
11	3	0.3
12	1	0.1
Total	**908**	

Table 11 Number of Wellbeing Plan actions agreed by beneficiaries at initial appointments.

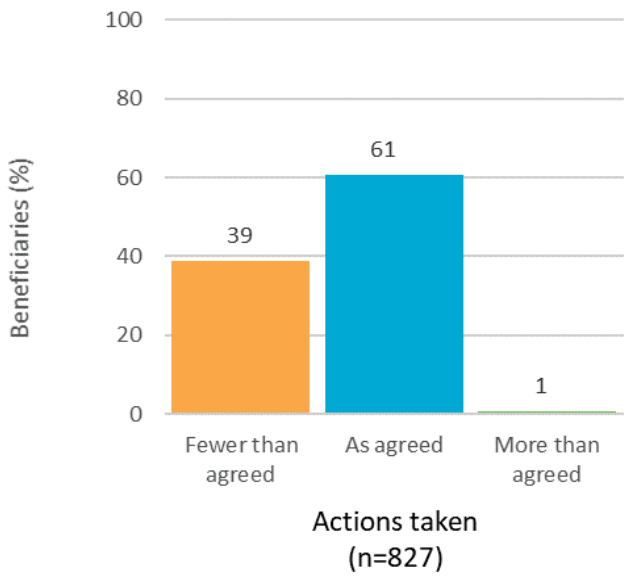


Figure 23 shows the proportion of beneficiaries who took as many of the actions as agreed, fewer than agreed and more than agreed. We can see that the majority, 61%, took the actions they'd agreed on with 39% taking fewer than agreed. These findings indicate higher take up than other studies, for example that of Loftus et al. (2017) who found that only 41% of social prescribing beneficiaries followed through with the agreed activities and actions.

Figure 23 Breakdown of whether Wellbeing Plan actions agreed were taken by the time of follow-up appointments.

6.3.3 Welfare of Community Navigators

As the previous section has indicated, the role of the Community Navigator went beyond signposting and referrals to eHealth. The local mPower staff had very different backgrounds in terms of their professional history. Some had worked within health and social care services in different positions, while others had vast experience in the third sector. Each of these backgrounds brought a wealth of knowledge and experience that was being utilised in their day-to-day work. However, some concerns were raised about the welfare of Community Navigators, both relating to lone working, and coping with challenging disclosures.

Local teams were often reliant on the Navigator keeping in touch with the Implementation Lead when they were seeing beneficiaries to ensure safe lone working. This could be a challenge if their working patterns differed. More generally, the role of the Community Navigator was not as clearly defined and governed as clinical or regulated roles:

> *"If you look at any of the other teams who are out negotiating in the area, the public health nurses are all - they have to be massively qualified… so a lot of the things with clients and meeting them, a lot of it is your life experience, your gut, making sure you are safe… how do you handle yourself, when do you know to get out. (Local mPower staff)"*

All Community Navigators did receive induction training for their local organisation and the specifics of the role form the central project team. Indeed, some Community Navigators on the island of Ireland were able to avail of role specific training from another Interreg VA project CoH-SYNC. While no negative incidents were reported, this was a concern raised by several participants. Community Navigators also encountered people in very difficult situations which could be emotionally taxing:

> *"I find it quite difficult… People are disclosing things to me about their lives that are just heart breaking and they get upset and I really fear how I leave people… I can't just get through it by asking the questions on the Wellbeing Plan… there's some shocking stuff. And I try and not open up anything more than what's being actually told to me, I try and empathise with them but, you know, some of it is just – it's crazy."*

The lack of formal debriefing systems with others in similar roles, working in the same area, was a key issue for some. While more informal debriefing did take place within teams and between sites, local staff would have benefitted from connecting with others familiar with the area and the issues people there faced. This echoes recommendations elsewhere in the report around imbedding mPower in primary care and MDTs. In this instance it may have had led to additional supervision benefits.

6.3.4 Role of the Implementation Lead

The Implementation Leads acted as the foundation that ensured Community Navigators were able to support beneficiaries and meet their needs:

> *"I view my role as an enabler for the Community Navigator in that, if there is something that needs to be done in the background to make their job easier, in maybe the form that needs to be filled in, that more business end of it, I see that as the Implementation Lead role."*
>
> *I think my role is more trying to embed it, open up networks, talking to people, promoting mPower, embedding it into the business per usual. Even in terms of the wellbeing referrals and obviously the eHealth, identifying key flows and that…and connecting with ICT."*

Implementation Leads worked to establish referral pathways and make connections. Often, they played a key role in enabling Community Navigators to offer beneficiaries eHealth solutions, something which was often cited as difficult due to procurement challenges. Implementation Leads also worked to establish wider initiatives, such as providing tablets to care homes and trialling the use of various technologies in their deployment sites, such as ADAM and ARMED.

While Implementation Leads and Community Navigators had different roles, they worked very closely together. For example, Community Navigators also played a key part in making connections with health and social care and the third sector and promoting the service. Community Navigators and Implementation leads were therefore very much a team:

> *"Well, we all operate very well as a whole unit and as a team. And there's lines between the roles but it's very, let's go for the word 'integrated' because we need to know what each other is doing."*

Implementation Leads reported that the job was not quite what they expected. Rather than implementing a service, they were generally actually setting a service up:

> *"If we had a plan it would have been simple. So we were strategically planning plus operationally planning and then project planning."*

This proved very challenging, particularly for those who started in their roles when their local mPower service was at its infancy. Implementation Leads with limited background in health and social care and new to the area they were working in also faced many barriers as they weren't as familiar with the local and institutional culture and had to accumulate a lot of knowledge in a short space of time to be able to establish the service. This indicates that it's important to make the scope of the role clear from the outset and, if the goal is to set up a new service rather than implement an existing one, ensure this skillset is prioritised when recruiting.

6.3.5 Relationship between the Community Navigator and Beneficiary

One of the key themes to emerge from the data is the importance of the interaction between the Community Navigator and beneficiary. Beneficiaries reported several aspects of the mPower approach to interaction that they felt were positive, including meetings taking place in their homes; the amount of time Navigators spent with beneficiaries and, most importantly, the manner in which Navigators interacted with the beneficiaries. These three elements (home, time and manner) were recognised as the core benefits of the mPower approach by beneficiaries themselves, primary care staff and third sector representatives that we spoke to. The support provided by Community Navigators is also acknowledged as being key to social prescription services in the literature, providing continuity in care and reducing isolation (Elston et al, 2019).

Local mPower staff viewed the home setting as key in making beneficiaries feel comfortable and building trust:

> *"I think the home visits work well, I think the way that the Community Navigator is able to spend the time helping people… I think they [beneficiaries] feel as if somebody is really listening to them… they [the Community Navigator] feel such a sense of responsibility as well... More so than if it was over the phone or something like that, so that kind of bonding is there."*

This was also appreciated by beneficiaries, as many expressed that they were more relaxed and able to think things through than they would have been in a setting such as a GP surgery.

This was also due to the fact that Community Navigators were able to spend more time with beneficiaries than most other healthcare professionals. Most beneficiaries emphasised the value of Community Navigators not appearing to be in a rush when visiting them: *'She was nae in a rush, it wasn't a case of 'right, hurry up and get oot'.*

Community Navigators usually cited spending an average of an hour to an hour and a half with beneficiaries, particularly for the initial assessment. While it was acknowledged that this was partly due to the length of the paperwork, such as the Wellbeing Plan and questionnaires, the length of time spent with the beneficiary was mainly due to the fact that they simply wanted to speak to the Navigator*: 'it builds trust too because you are not just rushing in 'how are you today?' going through the motions and then out the door again' (Local mPower staff).* Subsequent visits could be slightly shorter, as a rapport had already been established. This approach was viewed by beneficiaries as different to their experiences with primary care staff:

> *"You feel more comfortable and more relaxed with her. You don't feel the pressure of, that you have to talk about everything quickly and get it out of the way quickly."*

Other benefits of the home setting and the time spent with the beneficiary included being able to see the circumstances and context they live in:

> *"I think when you're in their home you see the true aspects of their life. Because somebody can come to an appointment and say 'I'm fine, everything is ok…' then you go in and the house is an absolute pig-sty and it's chaotic… and you know they are not living the best life possible. (Local mPower staff)"*

Beneficiaries were also more easily able to talk about what mattered to them:

> *"You can see that they've not had that opportunity for a little while to maybe tell somebody about something that they are really interested in… I had someone that insisted that I came out and looked in their garden to see, and they were so proud, and it was just having that ability to bring that into a conversation that it wouldn't necessarily have come up in another setting. (Local mPower staff)"*

Some beneficiaries knew Community Navigators and/or their relatives prior to their involvement with mPower. This is perhaps not surprising considering the rural focus of the project. While this can raise issues in terms of professional boundaries, beneficiaries who brought up pre-existing connections expressed that these helped them be more at ease. As one beneficiary put it:

> *"No, it takes a particular person to break the ice, it's not an easy job to do… to come and then talk to older people... Especially up here, they know your parents and your grandparents and everybody else in the family."*

In some cases, Navigators were also able to draw on their personal experiences and connections with long-term conditions experienced by beneficiaries, which again contributed to building a sense of trust and understanding. As one Community Navigator explained:

> *"And I open up as much as I want about my personal life as well and I think that can sometimes be good for them, because if you can make that relationship and show that you've maybe experience similar to them."*

Having knowledge of the Community Navigator or a prior connection to them, however tenuous, was described by Community Navigators as a vehicle to increase trust.

Beneficiaries also talked positively about the ways in which they saw Community Navigators actively search for opportunities that may benefit them, such as making inquiries about potential community groups they could attend and regularly keeping in touch to update beneficiaries on progress, even if no suitable activities were available. This gave beneficiaries a sense of someone willing to work for their benefit and keeping them in mind: *'What she says she's going to do, she does.' (Beneficiary). The trust that Community Navigators were able to build with beneficiaries enabled them to open up about various factors affecting their lives. This extended well beyond health concerns:*

> *"There's not anything I couldn't talk to her about, you ken. (Beneficiary)*

And

> *"She's very helpful and when she comes in here, I treat her like one of the family, I treat her like one of the family and tell her all my ups and downs. I don't hide anything from her. (Beneficiary)"*

Beneficiaries also appreciated the level of detail Community Navigators went into when speaking to them, and their ability to refer back to previous conversations so that they did not have to keep repeating themselves (something that they felt they had needed to do in previous interactions with health and social care professionals). The level of detail in the work of Community Navigators gave beneficiaries the sense that they would be able to pick up on issues others may not:

> *"I would hope maybe that, if she come the day…'oh I see you are growing a beard now. 'I haven't shaven the day at all.' 'Why have you not shaven?' That's the kind of thing she would say back… Ken?…'you haven't washed your face this morning. What's wrong, are you having problems with your shoulders?' She wouldn't' say 'you are dirty, you are needing your face washed.' 'Is your shoulder bothering you the day?'… There's something about her, she gives you confidence, you ken? (Beneficiary)"*

The overall manner in which Community Navigators dealt with beneficiaries was very highly valued by all participants interviewed. Community Navigators reported using *'open-ended questions, affirmations and reflecting back onto [beneficiaries] what they've told you'*. Communication skills are therefore important. The combination of setting, time spent with beneficiary, the broad focus of the interaction and the ways of interacting employed by Community Navigators led to positive experiences for beneficiaries:

> *"I've only seen her twice, but it's as if you've known her for years, she's very friendly and talks to you as if you are not just a patient, but somebody she knows."*

Community Navigators were described as '*nice', 'very approachable', 'a good giggle';* having *'a really nice manner', 'cheery'*; having *'a way with old people', 'encouraging';* always *'having ideas', 'here to help', 'more enduring than most', 'interested in me'; 'she listens'* and *'interested in trying to support'*. Beneficiaries could see the value of the service:

> *"Yes, many an old person would love to have someone like [the Community Navigator] to come in and say 'is there anything you would like to do?' And I'm quite sure a lot of elderly people are lonely and I class myself as being very lucky. That somebody is interested."*

As outlined earlier, the form of interaction between beneficiaries and Community Navigators changed during the pandemic. The main difference, brought up by all local mPower staff, was the fact that home visits were largely no longer possible. Of course, meetings taking place in a home setting was identified as a key component in building trust and rapport and being able to get a holistic overview of the needs of beneficiaries:

> *"80% of communication is non-verbal so you are not getting the same cues as you would have if you were in that environment. It's like you are missing so many cues because people are just telling you what they want to tell you, over the phone. So you are missing the wee signals if they've got dishes in the sink or old food lying about, if they are unkept or unclean, things like that, you are not getting the true picture really what's happening in the communities. (Community Navigator)"*

It was also more difficult to support those hard of hearing over the phone:

> *"If somebody's hard of hearing, you become quite basic in your language as well, so that's difficult, I would say. And… you end up speaking to a family member instead and then you're not getting their answers directly, you're getting 'my dad's fine with that' and actually you want to ask dad himself, you know? (Community Navigator)"*

Phone support was also difficult at a time when there was an increased focus on supporting beneficiaries to become digitally connected: *'Teaching technology over the phone is an absolute nightmare, it takes hours of time to do very little, it's really bad.'*

Reports on the length of time spent on the phone with beneficiaries compared to face to face varied. While some felt that calls were often shorter as being on the phone could be tiring for the beneficiary, others reported calls often being longer due to the increased amount of time it took to build rapport and open up the needs and interests of the beneficiary.

Many also reported that beneficiaries' involvement with mPower was longer as they weren't always able to be referred to appropriate services and needed more support directly from the Community Navigator. This could also mean more frequent interactions than would have taken place in person.

A limited number of Community Navigators made use of video conference technology to speak to beneficiaries, although the uptake was not significant. Those who had done so viewed the experiences as positive ones as they allowed them to pick up on visual cues that can be lost over the phone.

Building rapport was key when engaging with beneficiaries over the phone. Many reported that beneficiaries could be more guarded and even suspicious, in particular during the first phone call. Some of the ways Community Navigators were able to engage with the beneficiary were firstly, mentioning who the referral came from to establish a connection to someone they know. It was also important to keep the conversation informal, often meaning not following the Wellbeing Plan but rather using it as a guide:

> *"'And do you mind if we go through a few wee things with you and see?' What was your typical day, what time would you sort of get up at, what time do you go to bed, how do you fill your day, do you find the day long? Medical conditions – what are you struggling with…you know, you can get this equipment or you can get that equipment, or that might make things that wee bit easier. A lot of them don't know. I think that's where you just take the guide from, they can see the benefit of having those couple of wee bits.. So I would use her [CN's mother] as an example quite a lot to people. It's…it sits a wee bit better with them, 'Oh, I never thought of it like that.' Or 'Well yes, that would be a good idea, especially when I'm on my own', so you are sort of using different wee examples to them and then I just find the conversation flows when they know that all you are doing is trying to get to help them and make things a wee bit easier."*

Another helpful way to build rapport with beneficiaries after an initial call was sending them a pack with leaflets and information about what mPower can offer them, along with a card from the Community Navigator. This could then be referred to in the follow up call once the beneficiary had had time to familiarise themselves with the materials. On the other hand, many beneficiaries were simply happy to have someone call them as they were isolated, making the interactions easier.

All Community Navigators spoke about the positives face to face interaction could provide, some even saying they wouldn't have applied for the role if they had known it would eventually be telephone-based. However, most saw the benefits of moving to a hybrid model when possible:

> *"I think before, I done everything face-to-face and I think now, I'm definitely going to go for the more blended approach and from the first appointment offer them - if they want face-to-face or if they want telephone and really respecting what that person wants. I would like one of the appointments to be in-house so I can see what I'm dealing with but if that's not what that person wants, then that's not what that person wants. And I think realising now, that you have to respect the individual. It's their journey, do you know what I mean – it's their journey."*

Beneficiaries described interactions with Community Navigators after the onset of the pandemic much in the same was as before the pandemic:

> *"It was just her personality, I think it was her niceness on the phone, her caringness and nothing seemed to be impossible for her and she didn't rush it, she had time for me and she listened carefully. You know, it's just all them wee things that added up at the time, when I was at my lowest. … She listened and more than her work, I felt she was nearly – I never seen the girl, I wouldn't know what she looked like if she came to the back door but she seemed nearly like a friend… the work they are doing is really appreciated and wanted and needed, by people like me.*
>
> *I think reflective listening. Whereas the practice nurse is a practical suggestion: you will do this whereas the Community Navigator is wanting to know, be aware of where I'm coming from, what I want to say."*

This is testament to the adaptability and flexibility of the service, as well as the complex skillset of Community Navigators to meaningfully engage with beneficiaries, despite changing circumstances. It demonstrates that Community Navigators were able to maintain a person-centred service even if interactions were no longer in-person.

The relationship between the beneficiary and Community Navigator is at the foundation of the generation of positive outcomes from mPower. It cannot be separated from the impact of taking part in social activities or benefitting from eHealth interventions. For many beneficiaries, it was this interaction, in and of itself, that is the most consciously valued part of the project. What they valued the most was being able to talk about their health and wellbeing in a holistic manner; to spend time with someone who does not focus on just one health issue but has the time and skills to speak to them about all aspects of their lives and how these affect their health and wellbeing. This is also what makes the service unique. However, it should be acknowledged that, particularly in a context like the COVID-19 pandemic, there was a risk that the Community Navigator could take on the role of a befriender, resulting in the beneficiary becoming overly reliant on the interaction itself.

As previous research has indicated (Skivington et al, 2018), an approach to social prescribing that entails *'intense and continuous involvement of CLPs [Community Link Practitioners] in individual case management'* can call into question the sustainability of such programmes. While filling in some of the gaps resulting from budget cuts in health and social care, social prescription needs to be well resourced to be able to provide a holistic service that is able to appropriately support as many people as possible.

6.4 Acceptability of Service Delivery Model

6.4.1 Beneficiary Safety

This section discusses the safety of mPower beneficiaries, from the perspective of mPower staff, healthcare professionals and the beneficiaries themselves. It focuses on the balance between duty of care and self-management, how safe beneficiaries self-managing in their homes felt, and how eHealth and social prescribing may contribute to patient safety.

The question of duty of care and self-management can be complex. As one primary care representative remarked:

> *"Self-management. I mean, I would encourage people to be independent. But I think with the neurological conditions, you have to be careful because you do have a duty of care and if you get something slightly wrong…"*

The evidence base highlights that careful consideration needs to be given to who social prescribing and eHealth interventions are suitable for. Elston et al's (2019) study, for example, on the impacts of social prescribing implies that such interventions are most appropriate for those around the middle of the Kaiser Permanente risk stratification pyramid, i.e. supported self-care. Those at higher risk of emergency admissions may not be the most appropriate group to target.

A third sector representative highlighted the importance of carefully considering safety implications on an individual basis, alongside the policy drive towards increased self-management:

> *"And I think there is a lot of folk who are in the community and it's some of these government policies to encourage folk to live independently as long as they can at home, it's the fine line of when that becomes unsafe for that person to live at home."*

Beneficiaries themselves also cited safety concerns regarding self-management at home. They often related this to a lack of railings and ramps as many were waiting for home assessments to have safety measures put in place. This hindered them from doing certain day-to-day activities, such as going out for a walk. Cleaning was also an often-cited concern, as beneficiaries did not always feel safe enough to clean thoroughly; in case they had a fall or accident. Those with fewer safety concerns explained that they had friends and family around them to check on them and help, while living alone could be more challenging. One beneficiary expressed concern about a surgery he needed as he lived on his own and was not sure how he would manage in the recovery period:

> *"The orthopaedic surgeon in Stornoway… he was telling me. 'Oh', he says, 'you'll need a hip operation sooner rather than later', he said … But I feel so, so remote, as I was telling [the Community Navigator] – that I'm on my own. It's a big operation to have, you know? It's steep going up the stairs… I'm musing on that one."*

Safety concerns may therefore result in delays in essential treatments. This further highlights the need to reach people who live alone and do not have extensive support networks to support them to self-mange better, if appropriate.

Safety of eHealth

Overall, beneficiaries using Telecare, such as Care Call (Wigtownshire), Faire (Western Isles) and Pobal Seniors Alert Scheme (HSE CHO1) felt safer as a result of technology being made available to them. This also extended to their family and friends, who often encouraged them to have Telecare installed for peace of mind, sometimes despite initial resistance from beneficiaries. However, the system generally alerts a nominated person (as opposed to the health services) so the functionality is often dependent on the beneficiary having someone who is willing and able to take on that responsibility and is living close-by. Two beneficiaries with no family nearby specifically cited the difficulty of using alarms in the absence of such people. Furthermore, the technology only worked in the home and not outside it. One beneficiary lamented not being able to go out into the garden and feeling secure (see also: Acreos et al, 2015). Overall though, telecare was viewed positively by local mPower staff, who had observed the increased safety, independence, control and peace of mind it had brought to beneficiaries, benefits that are cited in the wider literature (e.g. Stoke, 2017).

Florence was also viewed positively by beneficiaries in terms of safety. An example of this are two beneficiaries, husband and wife, who had mixed up their medications. As a result of this, an mPower Community Navigator set up Florence medication reminders for them which they found to be helpful and reassuring.

Primary care representatives expressed some concern about the safety of Virtual Clinic appointments, because such technology may result in something being 'missed':

> *"And I think because, speaking by a VC…means, I don't think people are used to it and have actually relaxed on VC necessarily. There's very much a thing in primary care of seeing the person in the flesh is going to be a much more natural situation and you are going to pick up…much more on all the cues."*

Again, this suggests that Virtual Clinic technology may be more appropriate in the context of secondary care. It also supports the conclusions drawn by Greenhalgh et al (2018): when judged to be clinically appropriate, and a relationship of trust between patient and clinician has already been established, the use of Virtual Clinic technology can be safe and effective.

As we have seen however, Virtual Clinic technology was mostly embraced by health and social care during COVID-19. While this was initially out of necessity, it became clear that a culture change was taking place where Virtual Clinics, while not replacing face to face appointments, was a helpful addition or alternative to these.

Safety of Referrals to the Third Sector

No beneficiaries expressed concern over their safety in terms of attending the activities Community Navigators signposted them to. However, one third sector representative acknowledged that ensuring safety is key for organisations:

> *"There's a number of issues in there, I think one is the organisation having the policies and procedures in place. [Third sector organisation] isn't a care organisation, we're not part of Care Inspectorate, we draw a line at the end of our services… We don't take folk on trips who need support so we know our limitations, we know our expectations of volunteers."*

For Community Navigators, communication with primary care referrers was key to understanding the potential physical limitations of beneficiaries. One Navigator explained that she would always speak to the referrer, if from primary care, to ask for details of any potential physical limitations a beneficiary had, prior to recommending an activity for them. This demonstrates an awareness among local staff of the need to assess risk and appropriateness of signposting to the third sector. However, communication with clinicians was not always possible, particularly if the referral to mPower came through a different route.

Two primary care representatives expressed the belief that beneficiaries themselves are generally aware of any physical limitations that may make certain activities unsafe for them:

> *"I'm not aware of any bad experiences… I think it's only positive stuff I've heard so far on it. But yes, I think if the patient is consenting and they know what they are going for and everything then I don't see why not. In some ways it would be no different than the doctor suggesting to go."*

There was also widespread acknowledgement that health was not only clinical and to support the health of citizens required the involvement of non-clinical stakeholders:

> *"Health is not just solely clinical, mental health is not about just clinical anymore. Mental health always encompasses everything from a social element to the recovery being person-centred. And [social prescribing is] very much for me a person-centred approach so yes, it's very relevant in that person's recovery."*

In summary, while stakeholders were aware of the potential risks associated with signposting, good communication between all involved and the judgement of beneficiaries themselves resulted in mitigation of any safety concerns.

6.4.2 Recommending mPower to Others

Beneficiaries were asked whether they would recommend the use of mPower to others and if so, what kind of people they would recommend it to.

The response was overwhelmingly positive. Beneficiaries explained that they would recommend the service to older people who wanted to become or stay active, who are lonely and 'in a rut', who have physical difficulties, whose isolation has led them to not being aware of what is happening and available in their communities, and those who need practical advice on accessing specialist services. Beneficiaries expressed the value of being able to talk confidentially about all aspects of their life to a Community Navigator. The importance of reaching those that are hard to reach was also highlighted. As one beneficiary put it:

> *"[I would recommend the service to] people that are on their own that have got no help. These are the ones that have fallen through the cracks because they don't have a social worker or anything… The thing is, those people… are bound to have an illness at some time so they are bound to go to the doctors, so I think you should start from there… they should look up the patients and how often the patients come, get somebody to do that."*

Interestingly, the beneficiary highlights the important role primary care could play in referring beneficiaries to mPower. It was indeed envisioned that this would be taking place but GPs were cited as the most difficult to engage with the project as referrers. Those that are more isolated and thus, potentially harder to reach, were identified by beneficiaries as the ones most in need of the service. Without referrals from primary care, it is likely that some of these people did not get access to social prescribing.

Overall, the beneficiaries interviewed for the evaluation would recommend mPower as a service to support self-management to others, based on their own experience. This indicates that beneficiaries had a good understanding of the purpose and aims of the project and were able to observe the positive outcomes for themselves.

6.4.3 Meeting Needs

Local mPower staff generally thought that the service was meeting the needs of beneficiaries. One mPower staff member emphasised how important the connections with, and availability of, third sector services and community groups are, but also highlighted the importance of working as part of a wider team:

> *"I think if we are keeping people over sixty-five fit, if we're keeping them connected with the proper services and we're tackling loneliness… And the good thing is, as part of this team, it's not just us that's doing that."*

Considering both wider culture chance in service delivery, and outcomes for individuals, the participant demonstrates an understanding of how mPower could not operate in isolation from other relevant health and social care services, nor the third sector. It should however be noted that cross-service collaboration was more challenging in some deployment sites than others, as we have seen in previous sections of this report.

The context in which mPower was implemented determined the extent to which beneficiary needs were being met in each deployment site. In some areas, there were few appropriate services or community groups to refer a beneficiary to and other areas reported struggling with the availability of eHealth. These two factors meant that certain needs identified among beneficiary groups were not met. However, the Community Navigator visits themselves were seen as very much meeting the needs of beneficiaries:

> *"I think that's the strength of it, we're very person-centred…like we don't go out with an agenda…I think that's the really good part of how the service is evolved, is that we literally just go out and listen to whatever they [beneficiaries] tell us. (Local mPower staff)"*

Local staff cited the flexibility of the mPower approach as key in meeting needs – Community Navigators were able to meet the needs of the individuals in their particular communities, considering their individual needs.

Beneficiaries also expressed that the project was meeting their needs. The flexibility and adaptability of the service was again key to this. As one beneficiary explained:

> *"I had a CPN (Community Psychiatric Nurse) for a short time but then they put [the Community Navigator] onto me and they were doing the same type of – giving me the same type of advice. So the CPN stood away, which I was so glad… it was fine but no like [the Community Navigator] at all… She's the best one I've ever had, she helps with anything, you know… she's so good with mental health… and paperwork [for the welfare fund] that I need... she sees to that for me, makes the phone calls if needed."*

This quote illustrates how extensive the service provided could be. However, it is worth considering whether the boundaries of the role could be more clearly identified as providing psychiatric support and acting in the capacity of a case worker were not anticipated as being part of the role from the outset.

There was a shift in beneficiary needs from the onset of the COVID-19 pandemic, initially as people were struggling to access services related to more fundamental needs:

> *"It has been very much the necessities of just getting through rather than they are looking to connect to a group online about stroke, it really hasn't been about that; it's been about social isolation, loneliness, depression, feeling excluded, feeling isolated, that's very much what the referrals have been for. (Local mPower staff)"*

Community Navigators were able to assist beneficiaries with arranging meals and food to be delivered to them for example, as many felt too anxious to go out and do so themselves. They also sometimes helped beneficiaries understand COVID-19 regulations and guidelines as these could change quite rapidly and frequently.

Facing multiple practical and emotional challenges at this time led to some beneficiaries having increasingly complex needs:

> *"The ones that are coming through now, when you have COVID added in and maybe new feelings of isolation and loneliness and not being able to access things just day-to-day that things are building up and the complexities are increasing. (Local mPower staff)"*

This put local teams in a difficult position as services they could refer beneficiaries to were limited, both in terms of health and social care and the third sector. However, the resilience and creativity in finding solutions for beneficiaries that was evident pre-COVID-19 pandemic, meant that Community Navigators worked hard to provide beneficiaries with what they needed.

Loneliness and social isolation were of course compounded at this time. As one beneficiary explained:

> *"It's been awful, you are afraid to go to somebody's house! You don't want to go, I used to visit the woman up the road maybe once a week and she'd come down to me and we'd go for a wee run or do something but there's none of that now."*

This isolation in turn could lead to an increase in physical and mental issues:

> *"So there's that whole mental stimulation that's not really happening for people. They are tending to be sitting in front of the tv and letting it all come to them. So there's a lot of issues with people, because they are not getting out, they are not developing themselves in terms of their physical abilities or mental abilities and that is just having a knock-on effect. (Local mPower staff)"*

Both physical and emotional challenges could result from beneficiaries not leaving their house as often as usual. As mPower worked to empower beneficiaries to make meaningful connections with their community, the lack of options to do so was extremely challenging. However, as we will see, positive outcomes could still be achieved.

6.4.4 Reasons for not engaging with the service

The level to which beneficiaries were able to engage with the Wellbeing Plan actions as intended could vary. Often, physical limitations prevented beneficiaries for taking the actions they would like to:

> *"So at the moment, I'm waiting for…I know [Community Navigator]'s trying to fix me up with meeting clubs but I just can't…at the moment, I'm physically incapable of doing it. I want to meet people but I just canna do it."*

This raises the question whether mPower consistently met the aim of supporting people's self-management in a preventative fashion, or whether some of those referred to the service needed more clinical support before being able to engage in a meaningful manner. The barriers could be related both to physical and mental health:

> *"This is one of the difficulties that I have about…there are days when I have to go out to Stornoway and I really don't want to, for no good reason except that's the way I'm working at that time, these things are a bit of a struggle. I'm not sure what would change that but I do think that not having any requirement, if you like, to do things is not good for me. (Beneficiary)"*

While Community Navigators could encourage people to attend activities it was ultimately up to the individual to act on the Wellbeing Plan. It is worth nothing that it is important for social prescribing services to have good links with local mental health teams to be able to refer beneficiaries not ready to engage with a project like mPower to the appropriate service.

6.5 Beneficiary Outcomes

Our qualitative evidence shows that beneficiaries experienced mPower positively. The benefits that they described related particularly to reductions in social isolation, increases in sense of empowerment and increases in digital literacy. Around 20 to 30% of all beneficiaries who completed the evaluation questionnaire experienced some form of positive change between baseline and follow-up time points.

Data collection included data related to management of specific long-term conditions. For beneficiaries where depression was listed as one of the specific long-term conditions being monitored through participation in mPower there was a statistically significant impact on loneliness, life satisfaction and physical health.

When data is broken down by long-term condition and deployment site, it can be seen that the proportions of beneficiaries reporting positive improvement is much higher than average for certain long-term conditions and in certain deployment sites. This section of the report gives a descriptive overview of the beneficiary outcomes observed in both the quantitative and qualitative data analysis.

6.5.1 Confidence and Empowerment

Existing evidence on the outcomes of social prescribing suggests that it can lead to increases in self-esteem, activation and confidence (e.g. Chatterjee et al, 2018 & Elston et al, 2019). The analysis of our interviews with beneficiaries, and with local mPower staff across the deployment sites, supports this and suggests mPower beneficiaries experienced increases in confidence and empowerment as an outcome of their interaction with the project.

A specific event (caring responsibilities, a move, or physical injury/setback) was often the catalyst for beneficiaries engaging with mPower. Life changes could result in being socially and/or physically inactive for a period of time which, if prolonged, could negatively impact on confidence. An example of how mPower increased beneficiaries' confidence is a lady who, having been a carer for her spouse, found herself in a new phase of her life after his death:

> *"She was really wanting to focus on herself and get back to things that she used to really love doing… she was really trying to get the most out of her life and knowing she had a condition that was going to impact and get worse and going to have its own implications, she really was just trying to see how can she take that control."*

Through guided conversations, the Community Navigator was able to explore with the beneficiary the hobbies and activities that she was interested in doing. This helped the beneficiary to focus on her needs and wants and to identify ways to meet these. This process led to the Community Navigator signposting the beneficiary to an art group (something she used to enjoy and wanted to get back to). She was also signposted to a community group that offered computer classes as the beneficiary had a laptop but not the confidence or skills needed to use it:

> *"She wanted to be able to still be independent and do things like her car insurance online… her family was helping her with things like that. But she was like, 'No, I want to be able to do that and I want to be able to keep on top of that.' So that was quite a nice outcome for her, going to the art group, starting back a hobby that she used to enjoy and again it gives her that therapeutic, calming and just time out, relaxation that she got from doing her artwork that she really enjoyed. (Community Navigator)"*

Studies have shown how participatory art programmes can result in improved mental wellbeing (e.g. Redmond et al, 2019), which was also an important outcome for the beneficiary. Furthermore, she was able to become more independent through increased confidence in using her computer, enabling her to manage certain day-to-day tasks herself, rather than having to rely on family. This is an example of how technological interventions beyond the traditional definitions of eHealth can lead to positive outcomes in terms of self-management.

This example also illustrates how mPower beneficiaries could often come to Community Navigators due to a significant change in their life circumstances that decreased their confidence of self-esteem. The guided conversations and Wellbeing Planning could help beneficiaries to find new ways to structure their lives. Often, like the lady referred to above, beneficiaries found it difficult to know where to start in terms of making these changes – the time spent with the Community Navigator, and the guided conversations with them, could be what they needed to provide them with both the practical information and the emotional support and encouragement necessary to feel that they are able to take the first steps on the pathway to change.

Although Community Navigators deployed a suite of methods to encourage the generation of feelings of empowerment, guided conversations and goal setting were seen as particularly important ways of eliciting this outcome. One Navigator explained that setting goals and timelines was key in motivating and empowering beneficiaries as they then had a challenge to meet. A conversation with the Community Navigator could provide the imperative previously missing and enable the beneficiary to take the first step:

> *"I do think that not having any requirement, if you like, to do things is not good for me… when I was working…I don't like letting people down or something… so I felt I ought to be there. Whereas the problem with things that you are perhaps choosing to do… For me, I think it [speaking to the Community Navigator] was one of the factors in helping me…begin to do this business of doing something rather than waiting for inspiration to strike. For me, personally, I think that was very important. (Beneficiary)"*

While the beneficiary needed to be prepared to take action for themselves, a sense of obligation, however 'artificial', could provide the push to become more active which could lead to increased confidence and the ability to take part in things outside of those agreed with the Community Navigator. However, sometimes simply finding out about activities, and how to get to them, could provide the final push needed for a beneficiary to take action:

> *"She helped me a lot…Things I wouldn't think myself and she was persuading me- she was telling me how to get there and all the rest of it. She'd phone herself as well and booking things for me, she helped me a lot. And she's leaving, I'm going to miss her! She's so cheerie. Other girls come but, ach, they just do their business, they are not as cheerie. (Beneficiary)"*

This quote also demonstrates the importance of the interpersonal relationship between beneficiary and Community Navigator as discussed earlier in the report.

As previously discussed, transport could be a key barrier to engaging with activities. The Community Navigator in Ayrshire & Arran took the approach of driving beneficiaries to their first meeting of their chosen activity. However, after this they had to rely on other forms of transport. As a third sector representative explained:

> *"I think when a few people have engaged in that service, they maybe thought that [the Community Navigator] or somebody should be bringing them all the time…I know it's discussed with them… you need to make your own way and she'll say, before she takes them away again, if you want to come back you have to make your own way here. There's a bus stop. And she tells them all the different ways that they can come down. But I think it's just, again, going and actually taking that step to go themselves. One of the wee ladies hadn't been for a wee while and it was a neighbour that said 'you need to go out, get in the car, I'll take you, you are going.' Because there was nobody there really to encourage or to go."*

For some beneficiaries, being driven to the first meeting was enough to build their confidence up to attend future meetings. For some however, a further push to attend was needed, or a lack of (accessible) transport options prevented them for engaging further.

Beneficiaries also reported how their confidence was improved not just by attending the activity itself, but also the practices they built around attending:

> *"It makes me feel I've been out, you know, because I make the effort tae dress a wee bit smarter, a wee bit o' tinted moisturiser on and I feel that I'm getting a bit back tae myself again and each time you get a setback, it makes it worse, you know?"*

Many other beneficiaries echoed a similar sentiment: having a reason to go out and socialise was a way to get back to what they used to enjoy, thus improving confidence and self-esteem.

Many beneficiaries also cited how taking physical activity classes had improved their confidence. The improved mobility resulted not only in better physical health but also empowerment:

> *"And the way I see it is…part of the problem is confidence… ken I think … I really do believe I feel better with the exercise. And you are not on your own, you see, if you are lonely… so whether that…maybe changed a wee bit of my brain, I don't know."*

The beneficiary acknowledges that the change was not merely a physical one, but that in having an impact on his loneliness, his mental wellbeing also improved.

At the onset of the pandemic Community Navigators were limited in what services they could signpost beneficiaries to, particularly as group activities were generally no longer taking place. Many beneficiaries also had a loss in confidence due to being fearful of leaving the house in case they contracted COVID-19:

> *"I belong to a couple of women's groups and that all stopped completely and – it's the isolation, I think, the part was you were seeing somebody and having a cup of tea with them and having a chat and comparing how each other were feeling and what we were doing. Now there's none of that."*

Community Navigators were therefore limited in what they were able to signpost beneficiaries to in order to combat decrease in confidence and empowerment. An example on how to increase confidence was wellbeing packs that were put together in collaboration with a third sector organisation. These could enable beneficiaries to both feel more in control, safer and mentally stimulated:

> *"The pack was, as I say there was coloured pencils and stencils and things, I done a couple of them. And there was one about making phone calls, how to order groceries online and the man rang me and told me Iceland was very good because they don't charge and all. And there was other ones about activities and keeping fit and keeping active and that."*

As briefly noted earlier, empowerment was also encouraged by helping beneficiaries to become more digitally literate. Although this does not fall under the original categorisations of mPower eHealth interventions, it was recognised by local teams as something beneficiaries needed, and it could lead to wellbeing and empowerment when supported by Community Navigators:

> *"Showing people how to use their mobile phone, something really simple. I had a gentleman who has a mobile phone… but he didn't know how to use it…So this man visits his wife, who is unfortunately in a care home, and he has to ask the staff to phone a taxi for him to get back to his house. And he wanted to use the mobile phone to do that himself… I showed him how to do it…. And he does that himself and he's found that makes a huge difference. So for that, it's the smaller things which matter."*

The importance of increases in digital literacy was highlighted during the pandemic and provided Community Navigators with more opportunities to support beneficiaries in using digital technologies to keep in touch. It's always been acknowledged that digital isn't something that all beneficiaries would be willing to engage with but there is an indication that in some cases this changed as a result of the pandemic when keeping in touch without being digitally connected became much harder:

> *"Now I've graduated to the iPad, I'm getting very technical! Oh I use it quite a bit, yes. I'm on Kindle and I get my books through Amazon… emails as well. And I would be on Twitter as well, keep in touch with what's happening… I used to be afraid of it (technology), I'm not a bit afraid of it now! (Beneficiary)"*

In summary, Community Navigators were able to harness various methods to elicit confidence among beneficiaries and to empower them to take actions that improve their wellbeing, even during the COVID-19 pandemic. These outcomes are a result of creative and person-centred ways of delivering the service, in which the broader needs of beneficiaries were identified and addressed, beyond signposting.

6.5.2 Loneliness and Social Isolation

Reduced loneliness was reported in 20% of beneficiaries who completed evaluation questionnaires, with the majority (72%) of beneficiaries reporting loneliness levels unchanged.

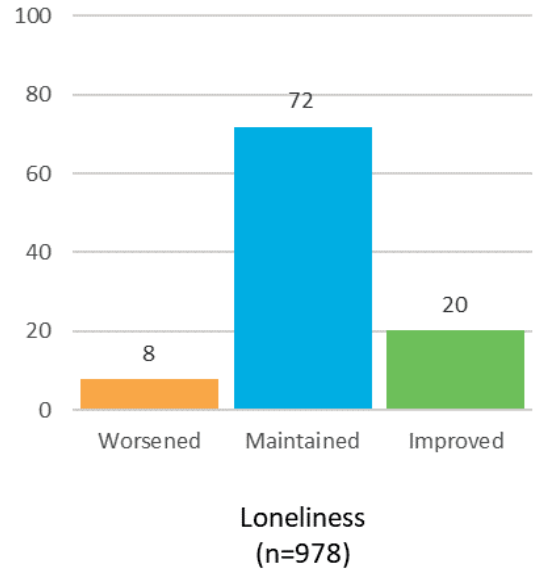


Figure 24 Changes in loneliness after participating in mPower for evaluation participants across all deployment sites.

Of those who reported no change, 36% stayed rarely or never lonely, and 34% stayed lonely some of the time.

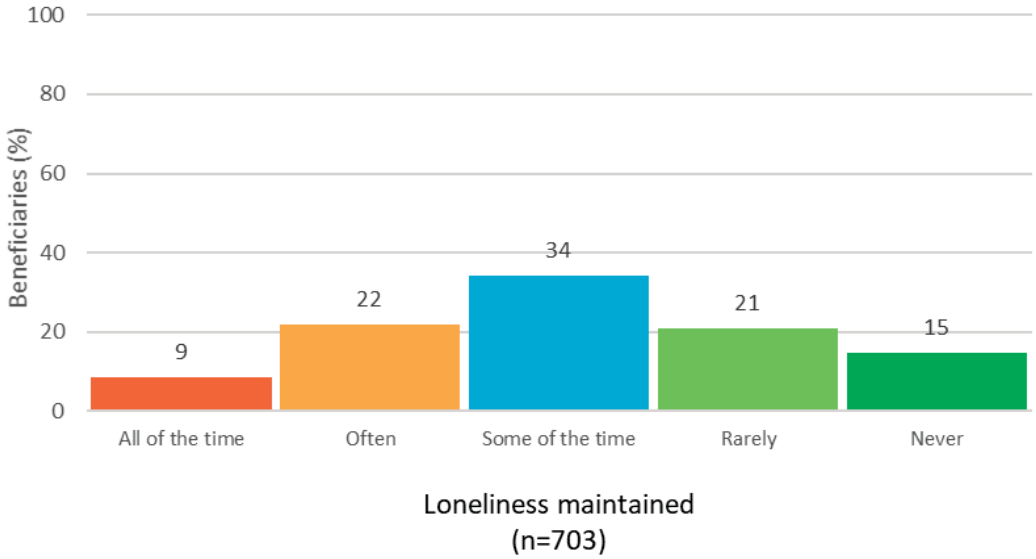


Figure 25 Breakdown of loneliness levels for evaluation participants where loneliness levels were mantained. Bars represent the percentage of evaluation participants where initial and follow-up levels were the same as per the axis category labels

Figure 27 demonstrates that maintenance of loneliness levels did not decrease after the onset of the pandemic, showing the impact that mPower had during this challenging time. 20% of beneficiaries also saw improvements since the pandemic started, the same proportion as pre-pandemic.

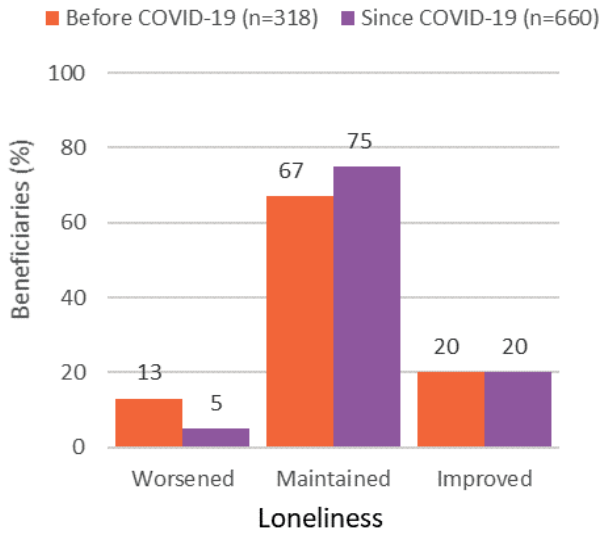


Figure 26 Changes in loneliness for evaluation participants completing follow-up appointments before and since COVID-19 public health measures were introduced.

Breaking down the data by deployment site, shows that several sites had higher than the average of 20% of beneficiaries reporting decreases in loneliness: the Western Trust (52%); HSE CHO1 (48%), Western Isles (32%) and Dumfries and Galloway (28%). The largest number of those seeing no change are within Ayrshire and Arran (85% of their sample).

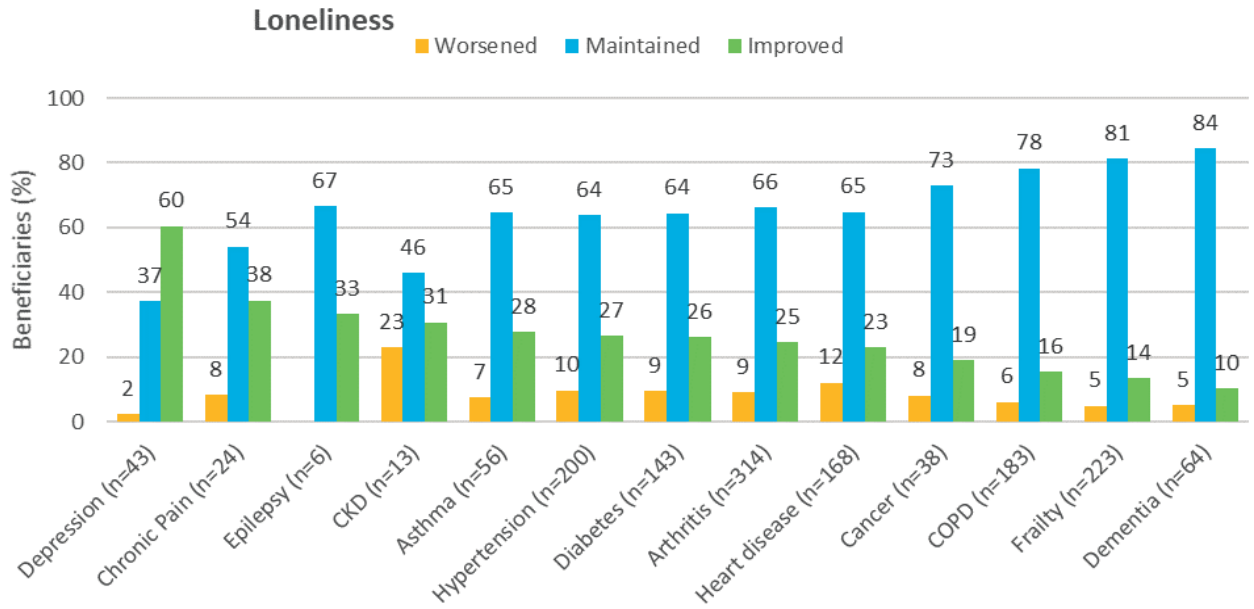


Figure 27 Changes in loneliness for evaluation participants in mPower by deployment site.

There was a statistically significant decrease in self-perceived loneliness for beneficiaries with depression at 60%. Breaking down the data by other long-term conditions (figure 28) shows higher than average decreases in loneliness for chronic pain (28%), epilepsy (33%), CKD (31%), asthma (28%), hypertension (27%), diabetes (26%), arthritis (25%) and heart disease (23%).

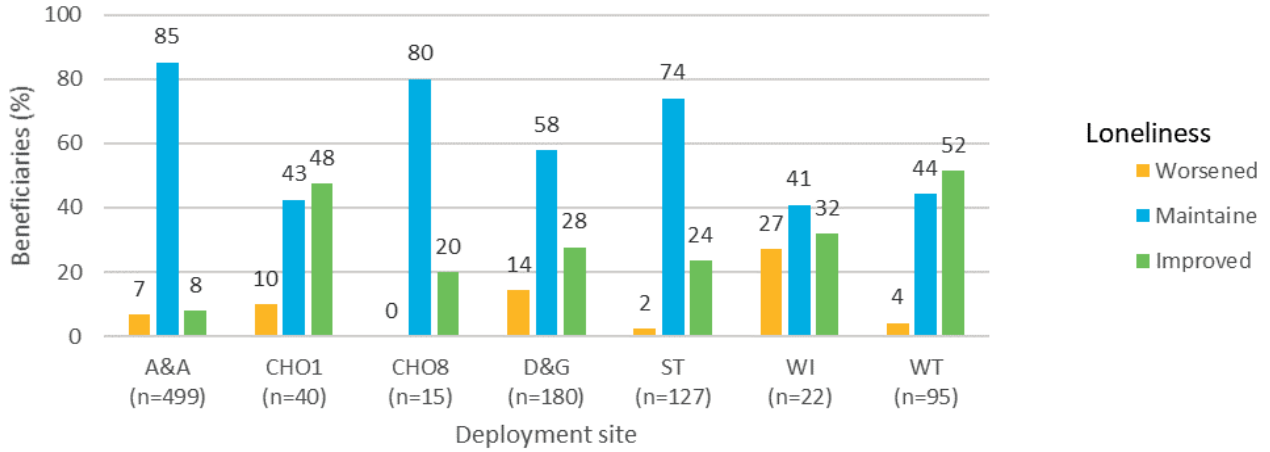


Figure 28 Changes in loneliness by long term condition for evaluation participants in mPower.

The outcome most frequently discussed by qualitative interviewees was indeed reduced loneliness and isolation. This supports findings from other studies (e.g. Evans et al, 2019; Waddington-Jones et al, 2019) that suggest that a reduction in loneliness is a key outcome of social prescribing. For mPower beneficiaries, the reductions often came about as a result of taking part in an activity they enjoy within a group setting:

> *"They've got a garden up there [a community garden] and last year… the weather was so beautiful, they had an all day picnic and the nurses even went to it. So again, you're meeting people. Although I love my garden…it's the social side that's essential to me."*

Taking part in social activities also simply allowed beneficiaries to have a bit of fun and to be playful:

> *"Interviewer: And what do you get out of going to the lunch club?*
>
> *Respondent: Just blethering and having a bit of a laugh, especially with Paul, he's a comic in itself. He thinks I'm awfy quiet. I says 'I suppose that's because I've naebody to talk to at hame, just my dug' and she can answer back, the cheeky rascal. (Beneficiary)"*

Often, the resulting increase in social connections from attending one group led beneficiaries to attending other groups, thus expanding their social circles even further:

> *"A lady came who was new to the area and she didn't know anyone and she came, I think twice [to the exercise class], and didn't see her again because everybody in the group had taken her in and said 'come to this group, come to that', she was too busy to come back! So that's… absolutely fine. So it does stop people being socially isolated. It really does. (Third sector representative)"*

Another beneficiary, whilst physically unable to play the sports that he used to enjoy, found great pleasure in being able to speak to others about the things he was passionate about and that used to be part of his daily life:

> *"Respondent: That's what I'm missing, I would love to kick a ball or something or just keepy uppy but I just canna do that any mair.*
>
> *Interviewer: And what do you do at the football memories meetings?*
>
> *Respondent: Oh, we talk about Kilmarnock Football Club, and what I used to – the team I used to play for, I miss all these things, sitting in here… I had a past."*

Beneficiaries also reported the value of peer support provided by specific groups. On being confronted with a diagnosis, a person can feel quite lonely and speaking to others in a similar situation may be helpful:

> *"I think with the Parkinson's group… it's obviously helpful to share experiences…It's just a new learning experience was – unsettling, Parkinson's, a completely new situation for me, so, anything to help to cope with it is welcome."*

Attending meetings therefore not only provided social connections but also practical and emotional support. However, the connectedness experienced by some beneficiaries seemed unavailable to others:

> *"Respondent: I can't talk about the World War because I wasn't in it. And nobody knows about London or….*
>
> *Interviewer: Are a lot of people local, originally from around here?*
>
> *Respondent: The bulk are born here, all know each other. They'll sit there and say 'do you ken Mrs such-and-such' and I haven't a clue what they are talking about. This shop used to be there, that shop used to be there. It wasn't when I was here."*

This beneficiary found it difficult to make social connections at community groups as he was slightly younger than others attending the groups and not originally from the area. A key way to connect with others socially is seeking common connections and shared memories to create a sense of belonging. Beneficiaries not originally from the area they currently lived in, therefore, sometimes struggled to gain access to these spaces in a meaningful way. Beneficiaries also acknowledged a generational shift in ways of being, socially, and missed the regular social contact that they were used to in their youth:

> *"People just don't seem to mix…as we did, you know?... In the fifties and sixties… people would congregate in houses, you know, in the evening, just chat away, you know?... It's the social aspect…That's why they are 'befriending' and all this thing [social prescribing] comes in, you know? And I can see why people are wanting it."*

This wider shift in the ways that people socialise was often lamented by beneficiaries, particularly in the Western Isles. On a more individual level, isolation could also be the outcome of key life changes such as retirement. Many beneficiaries expressed the need of support in finding new social connections once work ceased to provide a natural space for this:

> *"But when you've been working, you miss the contact of the people… having people to talk to… I haven't constructed much of a social life."*

Community Navigators could provide integral support in beneficiaries finding new ways of being social. This required agency on the part of the beneficiary, as the social workplace environment was no longer available to them. Furthermore, the loss of local services in villages in rural and remote areas was also brought up by many participants, as these had offered natural spaces for locals to interact in. With the lack of local post offices and village stores, new spaces for social interaction had to be created.

Being signposted to group activities was not always appropriate for addressing isolation for all beneficiaries. Stakeholders in all deployment sites highlighted the demand for befriending services as a tool to combat loneliness:

> *"'I've never been one to go to groups and never been one to mix like that, in that sort of setting', sometimes they'll say, 'I don't feel I would fit in, it's not my cup of tea...' And I would say in terms of recognising gaps within the community… befriending services is one of the things that we can identify that there is a real lack of. (Local mPower staff)"*

This shows how important it is to understand the individual needs of beneficiaries and the approach most appropriate for them, but also the fact that a suitable service to refer to may not actually be available in every locality.

A further challenge to decreasing loneliness among beneficiaries was the acknowledgement that isolation may not just be about the lack of appropriate activities and transport:

> *"I thought isolation… meant you were isolated physically from what was going on but some of the isolation, it's mental isolation where there's barriers due to past traumas that it doesn't matter if the bus stops outside your door, it doesn't matter if you've got loads of places to go to that are ideally suited to you; it matters if you haven't slept that night because of the trauma of something that happened years ago. (Local mPower staff)"*

While counselling was not part of the Community Navigator role, it is important to establish pathways for referring beneficiaries to mental health services where appropriate. However, one of the key strengths of the mPower project was that Community Navigators were able to spend enough time to become acquainted with the beneficiary and build the trust needed for them to open up about issues such as loneliness that affect their wellbeing, and working at their own pace in finding ways to address these:

> *"It might even be that they don't really want to address the fact that they are feeling lonely but after having conversations… they might actually reflect and say, 'yes, I am quite isolated and I am quite lonely' and I think with the way the locals are here, you can be very proud. … at the first home visit, I've planted the seed, as such, and then they'll say, 'actually I do want to do something…I do feel quite lonely sometimes', but it can take a while for them to admit to it as well, that's always important too – to go at their pace."*

With the advent of COVID-19, Community Navigators saw increases in loneliness and social isolation, as was the case for the older population as a whole (Zaninotto et. al., 2022). As noted before, this took place in a context where third sector services were limited and health and social care services were focussed on the response to the pandemic. This is how some local staff described the situation, particularly in reference to loneliness and social isolation:

> *"The ones that are coming through now, when you have COVID added in and maybe new feelings of isolation and loneliness and not being able to access things just day-to-day that things are building up and the complexities are increasing.*
>
> *So there's that whole mental stimulation that's not really happening for people. They are tending to be sitting in front of the tv and letting it all come to them. So there's a lot of issues with people, because they are not getting out, they are not developing themselves in terms of their physical abilities or mental abilities and that is just having a knock-on effect."*

To tackle loneliness and isolation at this time required local teams to come up with creative alternative solutions. This is exemplified in the following quote from a Community Navigator, describing a very socially isolated individual during the pandemic:

> *"A wee mannie… he's a farmer, he's very rurally isolated, no contact really with anybody… and he was really missing being out and about, wasn't able to see his stock, wasn't able to go to any of the livestock marts. He got his landline in and we connected him with a rural support chatline, so he loves that. He has a call with them once or twice a week, it's all just farming talk and that. We got him papers, so he gets his farming papers delivered every week. He's not really online, he's sort of coming round to the idea now maybe a wee bit when he sees the benefits of having that connection... If we could even show him online some of the livestock marts… he's a sheep farmer, that's all he wants to see but he's not able to get out to see that."*

Before COVID-19, it's likely that he would have been referred to a lunch club or a day centre but the team were able to find him a telephone based service tailored to his specific interests, organise magazine subscriptions and through this, get him interested in the idea of trying to go online.

Pre-pandemic, the citizen technology solutions (e.g. mobile phones, tablets) offered by Community Navigators played an important role in tackling loneliness and isolation. This is similar to other studies that have shown a connection between use of communicative technology and reduced social isolation in older people (Baker et al, 2018; Chen and Schulz, 2016). mPower beneficiaries in remote and rural areas, for example, often had family far away and technology could help them keep in touch with them more:

> *"We had our beneficiary… who wanted to use his video camera to VC his family on the mainland… I think it really made a difference to his isolation because he wouldn't see people day-to-day but as soon as he went onto his computer… he could speak with friends on the mainland and I think that did have a big impact…because he felt connected to someone and he was seeing them as well. (Local mPower staff)"*

Beneficiaries were taught how to make video calls and send text messages in order to keep in touch with relatives more frequently, rather than just relying on phone calls. One Community Navigator taught a beneficiary who had recently become blind to use the voiceover function on her tablet so that she could continue to use social media and email to stay in touch with friends. This is another demonstration of the wide range of skills Community Navigators employ in their work.

The importance of being able to keep in touch with friends and family using alternative means was obviously heightened during COVID-19. Based on the qualitative data analysed, there is an indication that this made some beneficiaries who were previously reluctant to make use of technology more open to it. One example of this was a lady in HSE CHO8:

> *"So she is ninety-nine, she has an eighty year old daughter who lives in California, so she hasn't seen her for two years, obviously, and don't know how likely it is that they are going to see each other for the next while either, they are both quite old. So I got her a tablet, that didn't work too well, she struggled with it – not intuitive, WhatsApp is not intuitive at all… She has an Alexa, thankfully, both these people have one. So she just says 'Alexa, call my daughter', and she appears and it's marvellous. The first time it happened, oh listen – there wasn't a dry eye in the house, it was lovely. So she now, she can do that. We got lightbulbs yesterday so she's brilliant, she loves it, she loves the company of the Alexa but she's really – she finds it magic to be able to speak to a computer and for it to speak back to her. Sheer delight. (Community Navigator)"*

Technology could alleviate loneliness in various ways, by watching videos, listening to music or reading. As one beneficiary put it: *'You needen't be lonely when you have an iPad!'*

It should be noted that those who are the most isolated and lonely and, therefore, potentially the most in need of a service like mPower, can also be the hardest to reach. This was acknowledged by beneficiaries, local mPower staff and third sector representatives:

> *"You get some poor body stuck in the house who canna get out or they don't want to go out and they lock themselves in and before you know what's happened, they've been forgotten and slipped through the cracks. I'm lucky, I'm one of the lucky ones. Always have been, I think. (Beneficiary)"*

Local mPower staff, as well as third sector representatives, struggled with finding solutions to the issue:

> *"The big challenge is going to be – there's areas of high deprivation… … we need to be trying to reach people in some of the council schemes and that's still a big challenge for everybody in here. Every department... So that's where we really need medical professionals to be working with us… So we're really wanting to engage with those people. (Local mPower staff)"*

This highlights the importance of establishing where Community Navigators sit within their local health and social care services, to enable 'sitting at the right table' and making crucial primary care connections (as those most isolated may be in contact with healthcare professionals). As not all sites had this established from the outset, not only was recruitment of beneficiaries a challenge, but there was a potential that those most in need of the service are least likely to avail of it.

Finally, it is important to highlight that Community Navigators possessed a vast knowledge of what was available in the area. Beneficiaries often spoke about being isolated because they were simply unaware of what was on offer in the community:

> *"I can't thank her enough for what she's been doing for us. It's unbelievable, the help that was there that I didn't know was there. It really is".*

6.5.3 Mental Wellbeing and Life Satisfaction

Figure 29 Changes in life satisfaction after mPower for evaluation participants across all deployment sites.

Of those beneficiaries who completed the evaluation questionnaires, 18% saw an improvement in the measure of life satisfaction and 77% felt their levels of satisfaction had been maintained over the course of their interaction with mPower.

Figure 30 Changes in life satisfaction for evaluation participants completing follow-up appointments before and since COVID-19 public health measures were introduced.

The proportion reporting an improvement was 18% before and after the start of the COVID-19 pandemic. Interestingly, a slightly lower percentage (4%) reported any decrease in life satisfaction after the start of the pandemic than before (6%).

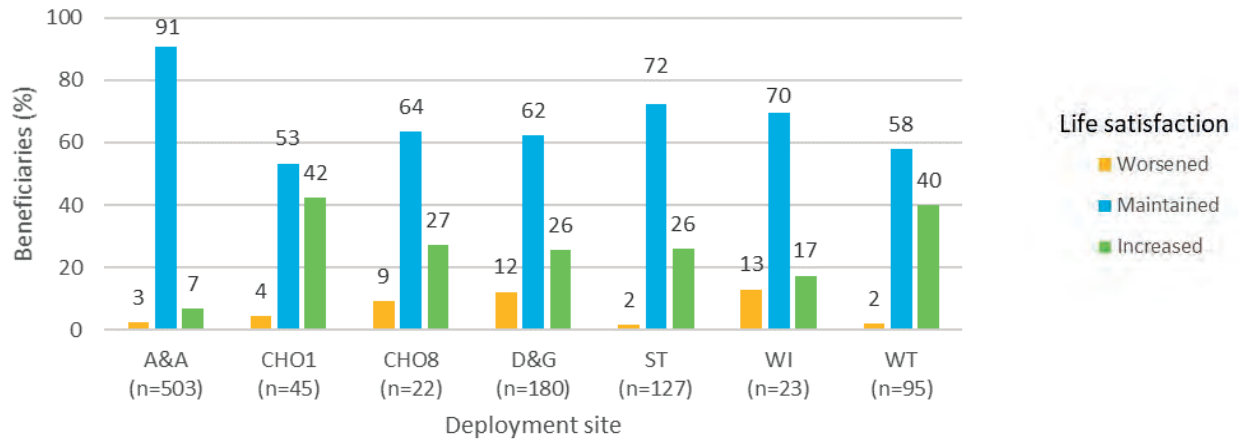


Figure 31 Changes in life satisfaction for evaluation participants by deployment site.

When we break the data down by deployment site, we can see that several of the deployment sites have higher than average proportions of beneficiaries who reported increases in life satisfaction: HSE CHO1 (42%), Western Trust (40%), HSE CHO8 (27%), Dumfries and Galloway (26%), Southern Trust (26%).

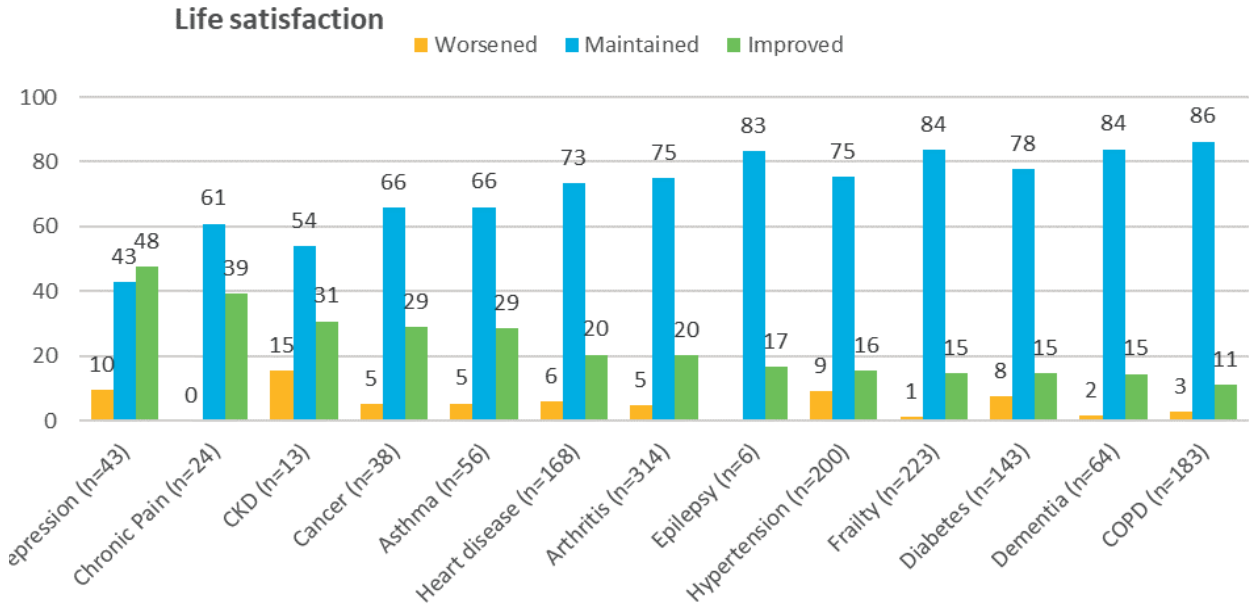


Figure 32 Changes in life satisfaction by long term condition for evaluation participants in mPower.

When we break the data down by long-term condition, we can see that several conditions also have higher than average proportions reporting a positive change in levels of life satisfaction: depression (43%), chronic pain (39%), Chronic Kidney Disease (CKD) (31%), cancer (29%), asthma (29%)

Low levels of mental wellbeing were often cited by interviewees as a reason people were referred to mPower. In turn, social prescribing and, in particular, contact with the Community Navigator, were cited as helping to improve beneficiaries' mental wellbeing. This is supported by the wider literature that suggests improved mental wellbeing is an outcome of social prescribing (e.g. Vogelpoel and Jarrold, 2014; Redmond et al, 2019). However, it must be acknowledged that the role of Community Navigators and community organisations in addressing more complex mental health needs is limited:

> *"I've one gentleman [who] goes to a choir now and he enjoys that. I'm trying to get him to engage with the local Men's Shed now too… it's definitely helping his isolation but again there's issues around depression… so he has a long way to go but it's putting steps in place for him where he can move through and maybe eventually become more independent that way."*

As noted before, connections with mental health organisations and services are important for local teams, although not all can directly refer beneficiaries to such services. There was also variation when it came to the extent to which Community Navigators provided direct mental health support. Notably, in Ayrshire and Arran, a Community Navigator took a very active role in supporting beneficiaries with their mental health. One beneficiary expressed that they had received more and better support from the Community Navigator than the Community Psychiatric Nurse they had interacted with:

> *"[I get in touch with the Community Navigator] mostly about how I'm feeling. That's the main one. And it's the most important to me... She has been a rock'."*

Life changes, such as retirement, could also lead to mental health changes. As one beneficiary put it: 'I had discussions with [the Community Navigator] over that [retirement]. Now, who am I?' While some beneficiaries were open about having been diagnosed with depression, others disputed the diagnoses they had received. Mental wellbeing issues were often described as 'frustration':

> *"Even that frustrates me… I couldn't walk down that road [cul de sac outside]. I could get there but the discomfort and pain… that's not me, ken. I've been pretty active most of my life and when you are not… It's frustration and all. A lot of frustration. In their words, depression."*

This quote demonstrates the connection between physical health and mental health. Being physically restricted can lead to reduced agency and therefore reduced mental wellbeing, as the earlier section on confidence and empowerment showed.

Signposting was not the only way that Community Navigators were making an impact on the mental wellbeing of beneficiaries. Mental wellbeing could also be improved by helping beneficiaries do things they deemed to be worthwhile and helpful to others:

> *"She wasn't really interested in committing to being a volunteer again…But because her faith was so important, I went and spoke with the volunteer coordinator in the social care trust. And based on our conversation, she developed a role in a nursing home which is only about a mile from where this woman lives, where she can go in and read bible and scripture to people who wanted that, who were unable to it themselves…but she also felt good for doing good, she was giving back and she was doing other people good so she started that, loved it. (Local mPower staff)"*

This example shows the diverse roles of Community Navigators, beyond signposting and social prescribing, and the person-centred approach to service delivery.

This became particularly important during the pandemic as signposting became more difficult due to limited services. To support mental wellbeing specifically, Community Navigators drew on skills and knowledge they had:

> *"For some people finding things to do during the day is very difficult. If they don't have tech or they are not interested in tech, I'm very limited in what I can suggest them to do. I do break the day into three parts. For somebody struggling with the day, I break it into three parts, that's what the daily planner is. And try and build a bit of mindfulness into it and tell them just think of one thing to do in each of those parts, that's different to the others. So if you have TV for the evening, don't be using it for the day time. And then try and get the walk in, if they can, or look at gardening, even if it's a window box. Look at bird-watching, birds. How to make a bird table. Little things like that but it is difficult."*

Beneficiaries would describe how being offered these alternative options to keep themselves occupied could have a therapeutic effect:

> *"I got a kit with some artwork, colouring in things. I started doodling a bit and it can be quite therapeutic. So what I've done, my front window, I put up these wonderful little bits of artwork and people pass by, my neighbours say 'oh, interesting.'"*

Volunteer calls were particularly important to many beneficiaries during the pandemic as they provided a social outlet and something to look forward to:

> *"They just changed my life, I think. And on a Tuesday you are looking forward or a Sunday, if you are kind of down, 'och sure, I'll be speaking to somebody', it's somebody different but it's not your own family, I think that's what it's all about. And they are not pushy, they are not saying 'you must do this, you must do that, you must go here'.*
>
> *They keep in touch, that's the main thing, just to see that I'm doing okay. And that I'm getting these volunteer calls which are very, very helpful because I can chat…I feel like I'm best friends with the people who ring me now, it just gives me that kind of outlook, otherwise I'd just be sat here looking at four walls most of the time, but it's great having volunteer calls, it's just like a friend to chat to."*

eHealth interventions were also suggested by interviewees to have the ability to improve mental wellbeing. One beneficiary, for example, was lent a tablet and WiFi box which enabled him to learn to use this technology. The Community Navigator showed him how to use YouTube to find music that he liked and he was observed to be overjoyed at being able to listen to his favourite artists whenever he wanted. The beneficiary himself explained that this had greatly improved his mental wellbeing and kept him occupied.

Another beneficiary suffered from sight loss, which prevented her from reading, something she was very passionate about. Her carer remarked that this was 'a very sore point' for her. The local Community Navigator therefore lent the beneficiary an Alexa:

> *"Carer: Like there was one hymn that she wanted to listen to, was Amazing Grace… and sure enough Alexa found it, and that appealed to my [name of beneficiary].*
>
> *Beneficiary: It was really out of this world.*
>
> *Carer: So that kind of thing she'd be able to download and we wondered about scriptures reading… and oh yes, she read or there was somebody read part of the Pilgrim's Progress and read it extremely well so I think if Alexa – it would be really very, very useful.*
>
> *Interviewer: And do you like audio books?*
>
> *Beneficiary: Yes."*

Having borrowed an Alexa, the beneficiary and her family had made the decision to purchase one themselves. It provided her with various ways of enhancing her mental wellbeing – from music to religious readings, to fiction and non-fiction audiobooks and puzzles.

Similar improvements resulting from technology were observed during the pandemic. One beneficiary described the joy of discovering YouTube on her tablet:

"She was still showing me YouTube searching and kind of different t'ings on it, so I did get the hang of it. And I got then about elephants and that - and I love watching elephants. And when the little baby ones comes along and they see the mother and you see the size of them and the size of the mother. You know, it's just wonderful."

While more research into outcomes of use of technology in this manner are needed, existing evidence suggests that higher technology use is associated with fewer depressive symptoms (Chopik, 2016). Therefore, when appropriate, alternative eHealth solutions could support mPower outcome achievement.

6.5.4 Self-management

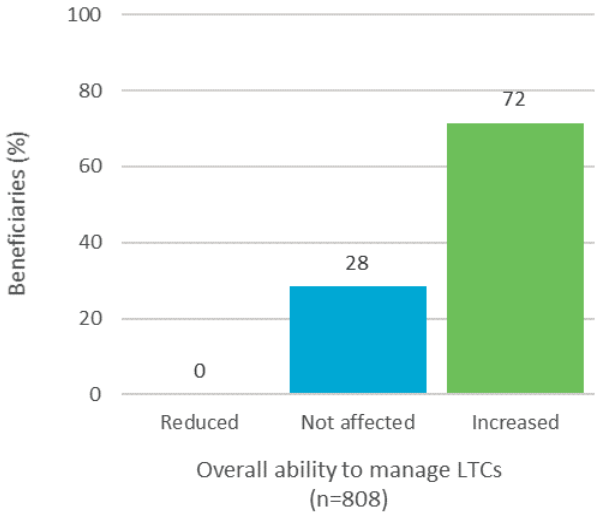


Figure 33 Evaluation participants view of their overall ability to manage long terms conditions after mPower. Single time point question asked at follow-up appointments only.

The evaluation questionnaire asked people their view of their overall ability to manage their long-term conditions after participating in mPower, with 72% saying that their participation had increased their ability to self-manage.

The proportion who felt mPower had increased their ability to self-manage rose from 68% pre-pandemic to 74% post-pandemic.

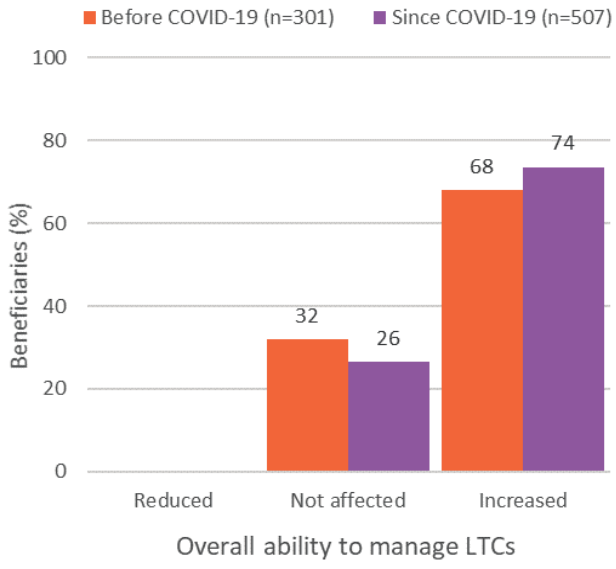


Figure 34 Evaluation participants view of their overall ability to manage long terms conditions after mPower by completion of follow-up appointments before and since the introduction of COVID-19 public health measures. Single time point question asked at follow-up appointments only.

Breaking down the data by type of long-term condition shows a particularly high proportion of people with CKD (91%) and chronic pain (81%) reporting an increase in their perception of their ability to manage their conditions. There are also above average increases for heart disease (76%), diabetes (75%) and epilepsy (75%).

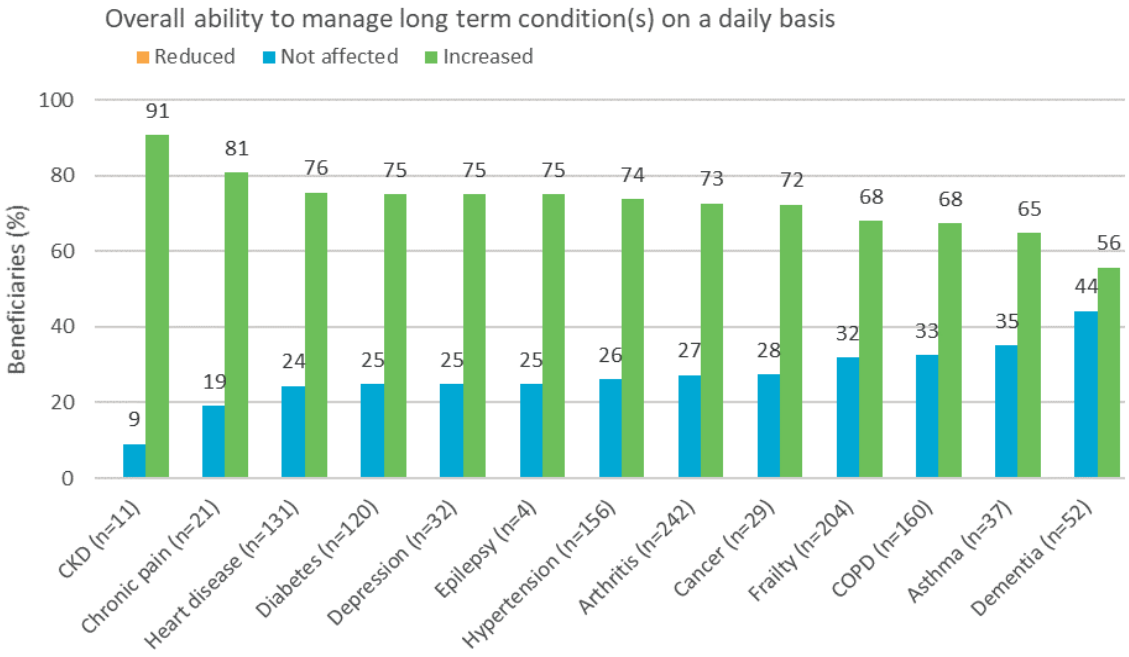


Figure 35 Evaluation participants view of their overall ability to manage long terms conditions after mPower broken down by long term condition. Single time point question asked at follow-up appointments only.

When looking at self-management by number of long terms conditions, there is not much variation, however, those with four or more long terms conditions reported the most increase, at 77%.

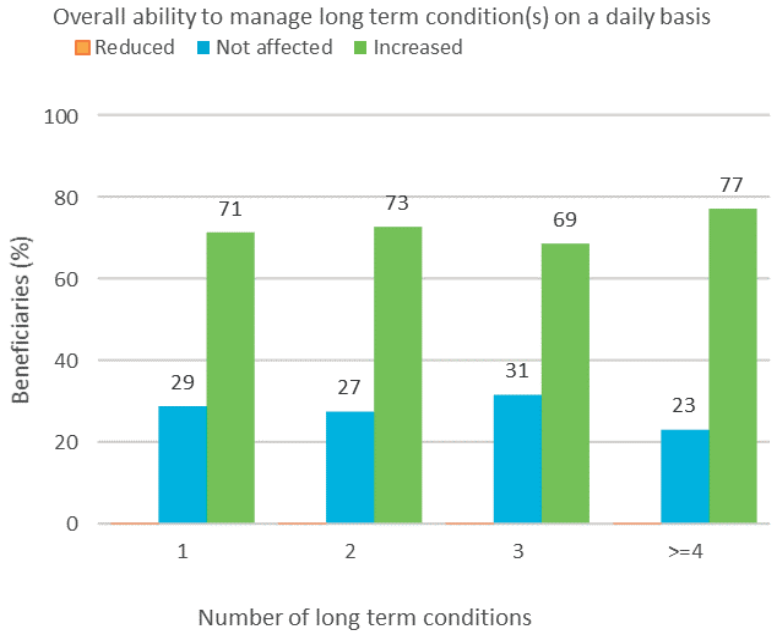


Figure 36 Overall abiity of mPower evaluation participants to manage long term conditions on a daily basis by number of long tem conditions.

When asked specifically about their perceived ability to manage individual conditions, the highest proportion reporting an increase was those with depression (44%), Chronic Kidney Disease (CKD) (40%), chronic pain (33%) and diabetes (29%).

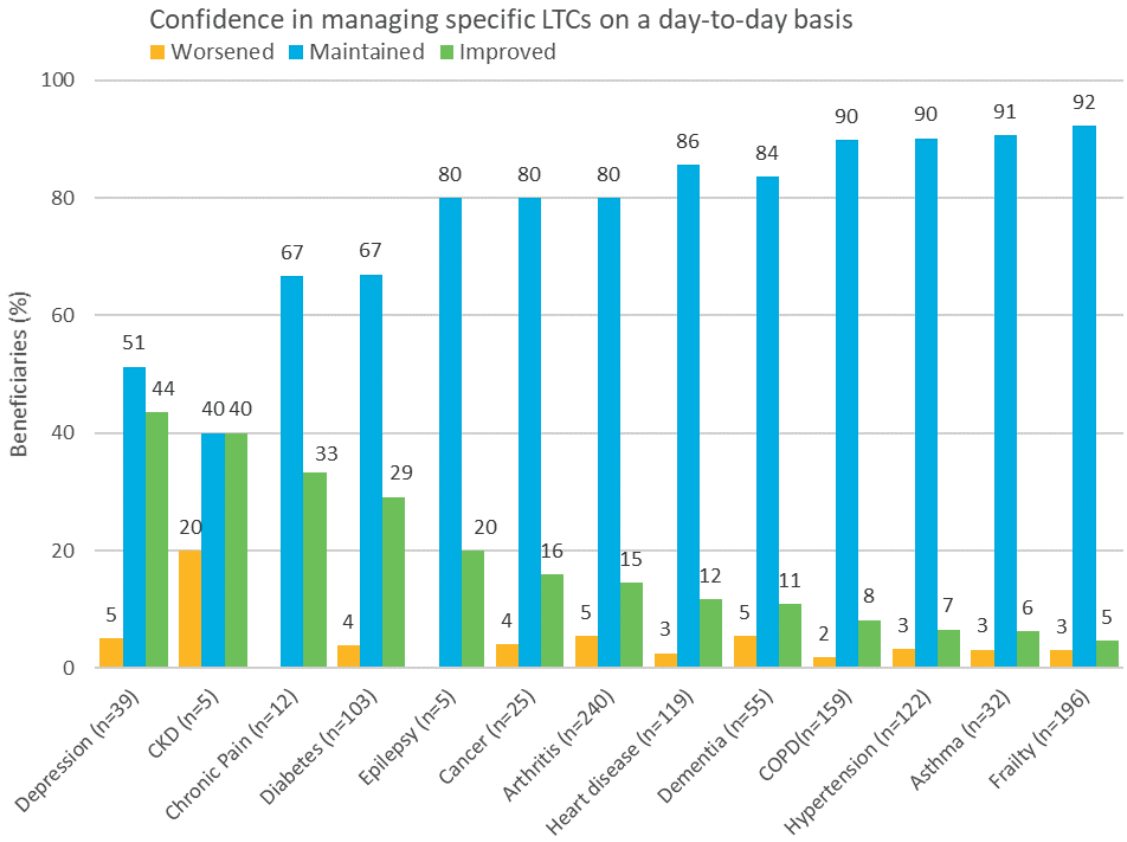


Figure 37 Changes in specific long term condition management for mPower evaluation participants across all deployment sites.

The ability and motivation to self-manage is closely linked to an individual's levels of empowerment, social isolation, mental health and physical health. As one mPower staff member explained, self-management could mean taking medication appropriately, eating an appropriate diet and undertaking regular exercise, but can also be seen more broadly as living one's life in a way that is personally meaningful and enjoyable, despite having long-term conditions. The holistic approach of mPower, therefore, contributed to increased self-management by enabling people to live well with their long-term conditions.

Taking part in group activities was viewed as particularly helpful for managing conditions such as depression and dementia. As one third sector representative put it:

> *"We have got some people who have the onset of dementia or they've got memory issues or they've maybe got depression, they've maybe got mobility issues and that kind of gets them down and they don't want to go out and about. But they know they can come here [the lunch club] and they are supported by everybody and the staff."*

One health and social care representative explained how social prescribing can complement clinical work to support self-management:

> *"Particularly now… when people have been isolated for so long – I suppose prior to the pandemic even, a lot of people weren't aware of what services were available out there, you know? …It's just good having [the Community Navigator] there. Because we are more clinical, we sort of overlook those services because it's really about, you know, clinic appointments and getting the person into clinic appointments. We don't think of groups out there like COPD Outreach and all that… when we're focussing on the very frail, complex clients, we do tend to have to focus more on the clinical end…"*

Different eHealth solutions also supported self-management. Medication reminders, delivered through Florence, were helpful for people who struggled to remember to take their medications:

> *"Because last week… I wasnae feeling well and the next day I says…– gosh, I hadn't taken the tablets, that's why I hadn't been well, my blood pressure –when I had put the band on, was away up. So…it's been very good, I have to say, very good getting that [Florence medication reminders] (Beneficiary)"*

This is in line with findings from previous studies that suggest that Florence medication reminders are most effective when they are meeting a need acknowledged and identified by the beneficiary (Cottrell et al, 2015b).

My Diabetes My Way was also cited as helpful in supporting self-management:

> *"I joined My Diabetes thing, which I thought was quite useful… It puts the onus of my diabetic problem in my hands, rather than somebody else's… I went back to the doctor and said, 'Hey, look it's gone high, what are we going to do? We going to do?' And it puts the onus back to me. (Beneficiary)"*

ARMED (Advanced Risk Modelling for Early Detection) is a falls prevention and self-management medical device that uses predictive analytics, wearable technology and health and social care data. This helps identify risks early to allow people to live independently for longer. ARMED was rolled out in some deployment sites with promising results:

> *"ARMED, it cannae stop people falling, for example, but it can indicate that levels of inactivity which maybe leads to people coming more frailer so therefore they are more susceptible but of all the reviews we've done so far, people's confidence to use the technology has increased, their ability, certainly from an mPower point of view, to manage their long-term conditions, hasn't greatly deteriorated, if anything it's either stabilised or in some cases for people, improved. And actually from an ARMED point of view, the number of falls has totally fallen (pardon the pun!) but the number of the people actually being hospitalised and actually fallen has just dropped off the cliff. And the feedback has been good in terms of – the users themselves have found real…those who wanted to talk about it, they've been quite happy with the device, should I say, they like even the simple things like be able to check their heartrate and how many steps they've done. (Community Navigator)"*

A number of technologies were rolled out in various deployment sites and it's not possible to provide detail on all. However, our qualitative findings overall support the conclusions of Cottrell et. al. (2015b) but also demonstrate that it is when a beneficiary has both the skills and motivation to use a technology, supported self-management is achieved. This outcome supports the wider mPower objective of culture change in health and social care.

Furthermore, our findings suggest that the use of technological solutions other than the three named mPower eHealth interventions (home and mobile health monitoring, apps and video conferencing) can play an important part in beneficiaries' ability to self-manage. More 'mainstream', off-the-shelf products have emerged as useful through the interactions between beneficiary and Community Navigator. For example, existing, reputable online resources could be helpful for beneficiaries in finding out more about their conditions, how to manage them, and what exercises may be appropriate for them.

In areas where access to eHealth technologies was limited, Community Navigators nevertheless found technological solutions that assisted beneficiaries in managing their own health. This ties in with digital literacy – in supporting beneficiaries to use tablets and smartphones, Community Navigators enabled them to have access to information sources enabling self-management.

As some services moved online during COVID-19, it was possible to offer beneficiaries various new digital services to support their self-management. One beneficiary described how she was able to connect to a COPD-specific class online:

> *"[The Community Navigator] set me up on a Friday, twelve to one, I get a fitness class for COPD. And that was great. I done that in my kitchen, you know. And speaking to the group and to the physio - the host - that was a good help."*

Finally, mPower staff, as well as third sector and primary care representatives, recognised the challenge in encouraging self-management of conditions, as this required a culture change that cannot take place overnight:

> *"The self-management piece is a massive gap to fill. Especially for the generation we're dealing with, over sixty-five that, you know, just … doing what they were told from a very young age; from church, from state, from everybody and the doctor was God…and to get that generation to go to self-management is a huge – is a big leap. (Local mPower staff)"*

Acceptance of self-management can, then, be seen as a culture change in which Community Navigators (as the direct link between beneficiaries and technology) play a pivotal role.

6.5.5 Physical Health

The evaluation questionnaire asked beneficiaries whether they had experienced changes in physical health after participating in mPower and 21% reported that their physical health had improved, with 71% saying it had been maintained.

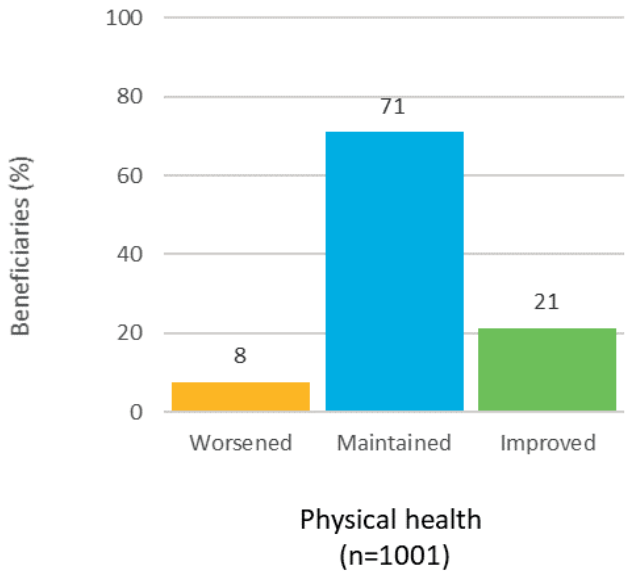


Figure 38 Changes in physical health after mPower for evaluation participants across all deployment sites.

For those who maintained their level of physical health, the majority remained fair, good or very good.

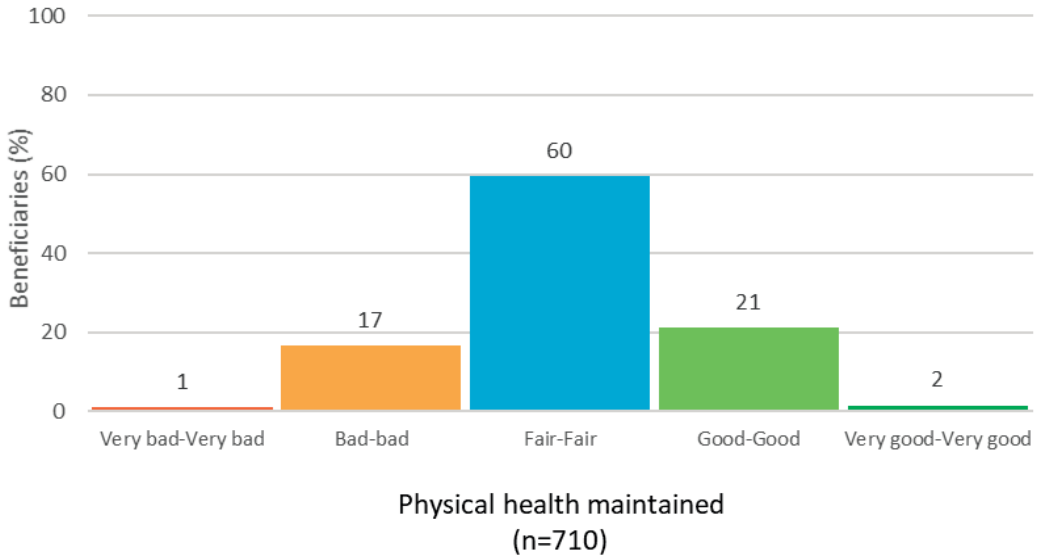


Figure 39 Breakdown of physical health levels for evaluation participants where physical health levels were mantained. Bars represent the percentage of beneficiaries where initial and follow-up levels were the same as per the axis category labels.

The proportions reporting improved physical health were higher pre-pandemic (25%) in comparison to after COVID-19 public health measures were introduced (19%). Interestingly, those who maintained increased from pre-pandemic (65%) to after the start of the pandemic (74%) and those worsening decreased from 9% to 7%.

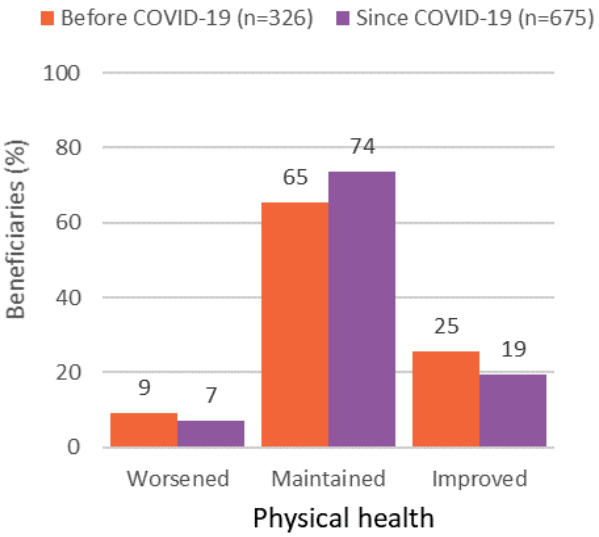


Figure 40 Changes in physical health for evaluation participants completing follow-up appointments before and since COVID-19 public health measures were introduced.

The reported proportions of beneficiaries experiencing improvements in physical health are much higher in some deployment sites compared to others. They are much higher in HSE CHO1 (48%) and Western Trust (48%); and much lower in Ayrshire and Arran (9%) and HSE CHO8 (5%).

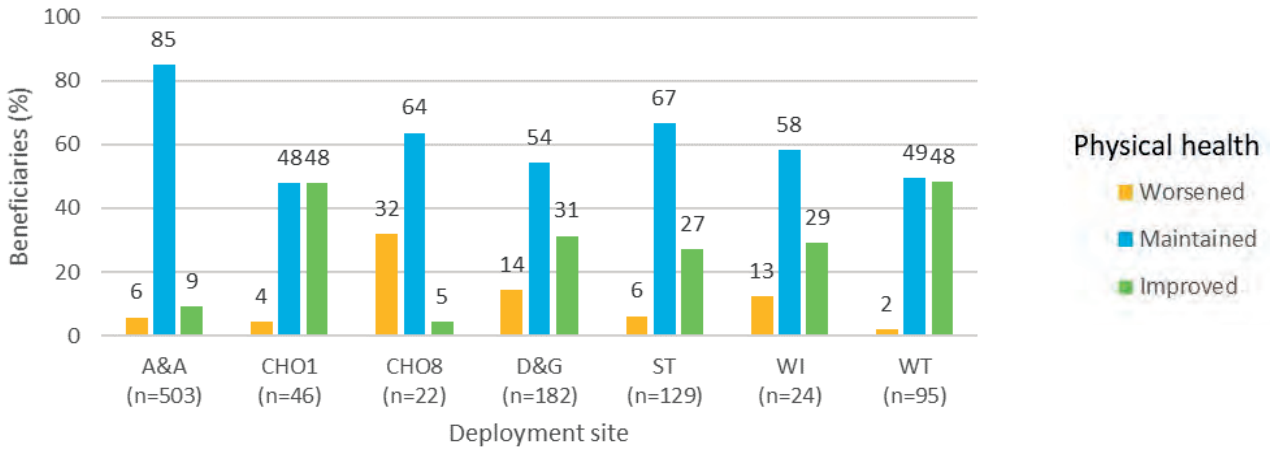


Figure 41 Changes in physical health for evaluation participants in mPower by deployment site.

When the data is broken down by type of long-term condition, we can see that the proportions reporting improved physical health are higher for CKD (54), chronic pain (38%) and depression (35%).

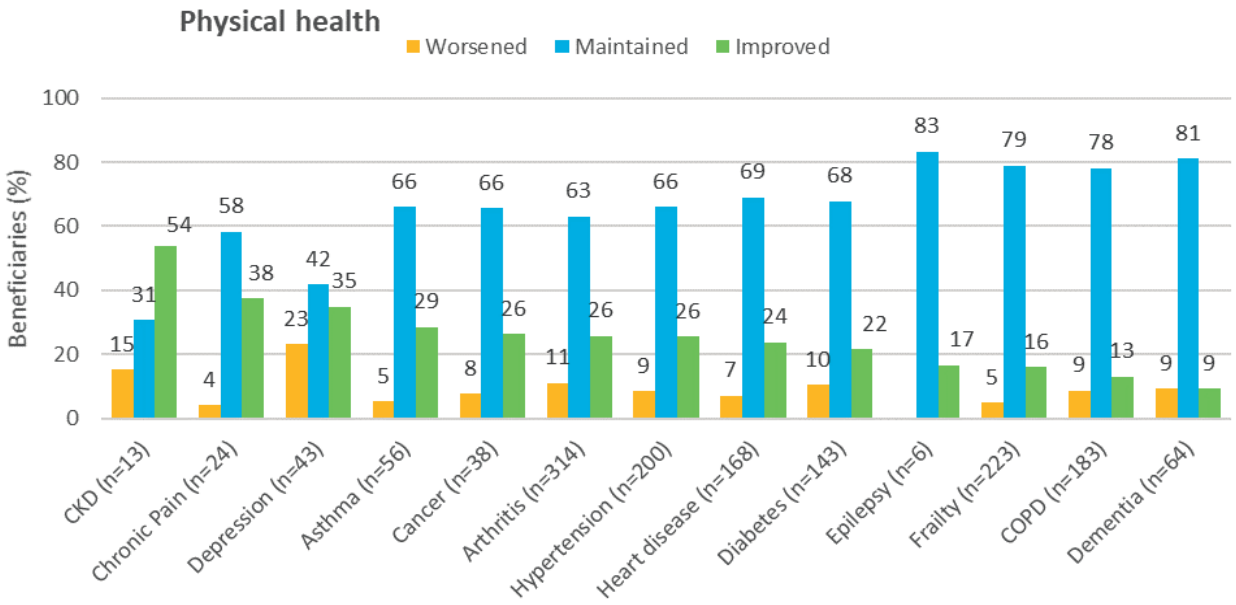


Figure 42 Changes in physical health by long term condition for evaluation participants in mPower

The qualitative data also shows that some participants reported improvements in physical health as a result of taking part in mPower. This is significant as the project specifically targeted older people. Community Navigators often directed beneficiaries to suitable exercise classes, such as Tai Chi or chair-based exercise classes:

> *"The people that come to Tai Chi will tell you about the many, many different benefits for them. Medically, it is quite easy to spot people with diabetes, it brings their levels down, their doctors are all pleased. People say it's the best night's sleep of the week, that actually it makes them more positive in daily life. And so it has many, many benefits apart from just keeping people moving (Third sector representative)"*

Community Navigators also provided beneficiaries with online exercise resources and exercise sheets so that they were able to exercise at home to build confidence:

> *"And as well as that, through NHS Choices and stuff like that, could give her actual exercises she could do in her house to build her confidence and her physical ability before she went out walking. I was saying you can do this, she was a fit and healthy woman, a bit of arthritis affecting her confidence. And she's absolutely flying around the place and she tells me now her life has changed completely."*

Many beneficiaries reported a decline in their physical fitness after the onset of the COVID-19 pandemic. Community Navigators worked to counteract this, by continuing to provide advice on exercise at home, as well as linking people to online exercise classes when available. They also provided beneficiaries with links to exercise videos as well as DVDs to improve fitness:

> *"Yes and she also sent a DVD of Mary Peters, Moving with Mary, and I found it good, I like watching it and I try to do what I can do with it and yeah, it got me up and got me moving because there wasn't much movement there in the beginning. (Beneficiary)"*

Community Navigators could also suggest walks in the beneficiary's local area that were suitable for their fitness level. Many also advised them on nutrition to improve their health:

> *"[We were] practicing the food and that sort of thing, to help with the diet. And to try and understand words like carbohydrate! So these mysterious words and how that can affect me so that was nice and getting leaflets about that. (Beneficiary)"*

These examples demonstrate the extensive and creative ways in which mPower helped support the physical health of beneficiaries, in line with the person-centred approach of the project.

6.5.6 Travel

One of the aims of use of Virtual Clinics as part of the mPower project was to reduce the travel beneficiaries had to undertake to attend appointments, particularly if travel was physically and mentally taxing. While no beneficiaries interviewed had used Virtual Clinics as part of mPower, there was recognition of the potential of the technology, even beyond a health care setting:

> *"I'm on the county committee for kidney patients and I had to miss the last committee meeting, being in hospital. I was mailing the secretary the other day saying 'I'll try and get to the next meeting, which is May, but some days I can't travel' and she threw in the idea of looking into the local NHS – it's not Skype but it's similar... So that will save me some travelling time."*

The beneficiary is making reference to the NHS Near Me platform. As he had mobility restrictions that meant he found it difficult to attend groups in person, the use of technology could have been beneficial for him.

Local mPower staff, as well as primary care representatives, also highlighted the potential of Virtual Clinic technology in remote and rural areas. This was particularly in the context of secondary care:

> *"There's some appointments you need to be there in the flesh [but if] it's a review appointment or just a talking appointment, that [VC]'s a brilliant thing. Some people, who especially don't have transport, it's a huge thing… So I always say secondary care is a brilliant one. And bits of primary care. (Primary care representative)"*

In terms of primary care, participants also highlighted how Virtual Clinic appointments could reduce travel for both beneficiaries and primary care staff, who sometimes had to conduct home visits with beneficiaries who were unable to travel to appointments. If used appropriately, mPower staff believed Virtual Clinic technology has the potential to help beneficiaries use the limited energy they have on *'doing things that they want to do'*.

A more unexpected example that increased wellbeing and reduced travel for a beneficiary was a Community Navigator enabling easier access to a mobile library:

> *"It's just been unbelievable… He just stops right at the gate [by my house]… Not only that but he's got a mobile lift, you know?... So I was gonna go up, 'oh, no, no, don't bother…', he said to me in Gaelic, he just pressed a button on the …just open the gate and straight into the van… (Beneficiary)"*

The Community Navigator asked the driver of the mobile library to stop closer to the house of the beneficiary due to his mobility issues. This made a great difference to both his physical and mental wellbeing as he found walking longer stretches difficult and enjoyed reading very much.

During the pandemic, the use of Virtual Clinics for health and social care needs became even more imperative. mPower were often able to support this work due to their experience. This in particular was the case in the Republic of Ireland where teams were a key part of rolling out the service across the region:

> *"I was redeployed to the National Virtual Health Team, although I suppose I was still trying to do our own work, so we was trying to deliver on Wellbeing Plans – I suppose eHealth side of it took over it very much so, because of that. And it was good, I felt it was beneficial for us. In terms of COVID, I really do think COVID was the catalyst that actually brought about the adoption of Attend Anywhere or eHealth solutions in Ireland, I don't think it would have happened as readily without COVID. We weren't really getting much engagement from clinicians here at all and suddenly then they were ringing me – people that I'd talked to way back, to see if I could get them this Attend Anywhere. So that tipped the scales, very much so. (Local mPower staff)"*

mPower played a key part in providing patients with access to health and social care services during COVID-19 via the use of Attend Anywhere. This also opened up new avenues and referral sources for the teams in the Republic of Ireland and raised the profile of mPower and eHealth in general.

6.5.7 Digital Literacy

45% of those beneficiaries who completed the evaluation questionnaire reported that their level of digital literacy had increased following their interaction with mPower.

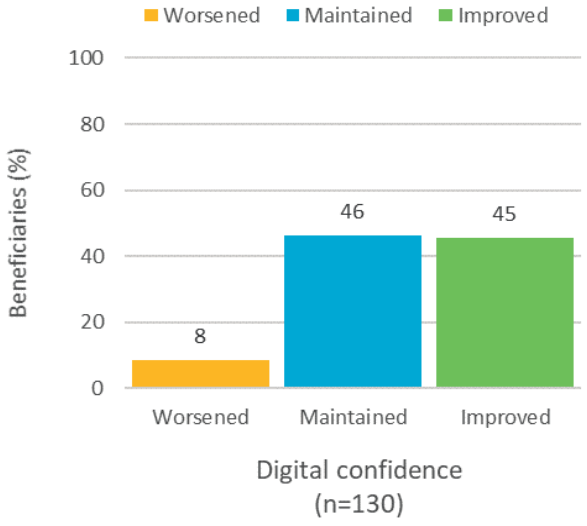


Figure 43 Changes in digital confidence after mPower for evaluation participants across all deployment sites.

The proportion was higher in the Northern Ireland deployment sites (65%) in comparison to the Scottish deployment sites (39%).

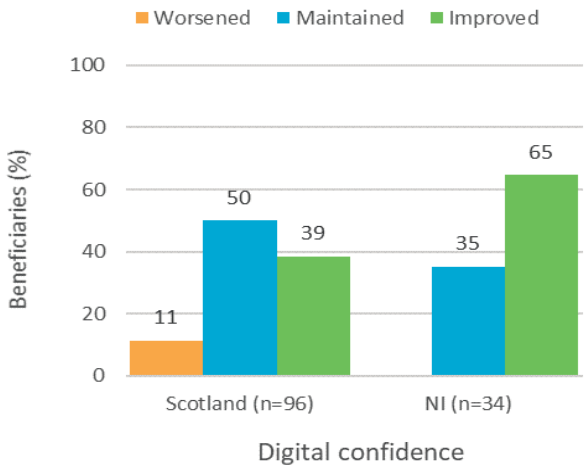


Figure 44 Changes in digital confidence after mPower for evaluation participants across deployment sites in Scotland and Northern Ireland.

Improved digital conference was reported by a larger proportion during the pandemic (49%) than pre-pandemic (41%).

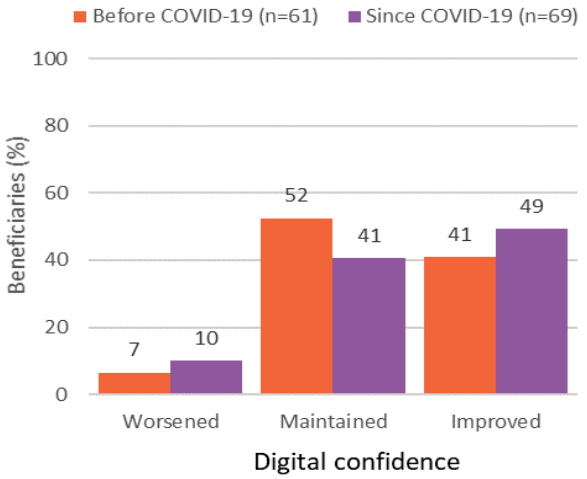


Figure 45 Changes in digital confidence for evaluation participants completing follow-up appointments before and since COVID-19 public health measures were introduced.

As previous sections have detailed, the qualitative data also shows how digital literacy has increased among some beneficiaries as a result of Community Navigators supporting them to use various forms of technology. However, not all were willing to engage:

> *"Well I can text but I've got away from it, I've changed phones and it's getting more technical and I've never been interested. I'm not interested in texting, I'd rather speak to you. Everybody is different. (Beneficiary)"*

This beneficiary used Florence for medication reminders but her husband responded to the messages received instead of her, due to her lack of interest in learning to use her phone. Local mPower staff acknowledged that for those who have not been brought up with technology, the prospect of using it can in fact be quite 'scary'.

Many beneficiaries however had a smartphone or tablet bought for them by relatives that they never or rarely used. Here, Community Navigators could both provide direct support in showing how to use the device, including written instructions, or referring them to local digital literacy classes.

As previously detailed, the ability to send text messages and use virtual conference technology to keep in touch with friends and family also had an important impact on beneficiaries in terms of loneliness and social isolation. This demonstrates how the different outcomes of the mPower project are closely interlinked and cannot necessarily be separated into distinct categories. Overall, the outcomes are often broader and more complex than digital literacy itself, and increased digital literacy can be a means to another end:

> *"I've been a teacher on a low level, in terms of showing someone how to use their online shopping, which really benefited their overall health and wellbeing, and to me that was eHealth because it benefitted their health. Identifying the gaps in terms of the beneficiaries and the gaps that they feel, I think, to technology rather than the actual gaps in the actual technologies that are out there. (Local mPower staff)"*

Some Community Navigators were therefore able to make use of existing technologies to achieve wellbeing outcomes for beneficiaries, through increased digital literacy. However, it was also clear that many beneficiaries were unwilling to engage with digital technologies, stating that it was 'not for them'.

The report has already discussed the increase in digital engagement as a result of COVID-19, noting that for some it was a catalyst to engage with technology as a way to keep in touch with friends and family and enabling them to access services such as the library and food deliveries. For many beneficiaries in Ireland and Northern Ireland, being able to attend Mass virtually was something that motivated them to engage:

> *"Mass is a big thing, and RIP.ie. with death notices online, so those are the two things that are getting people into technology. (Local mPower staff)"*

Technology could therefore meet some of the practical and social needs of beneficiaries, despite not being a replacement of face-to-face interactions. These practical considerations and needs could act as a 'hook' for beneficiaries to further explore the uses of technology and become more digitally literate:

> *"Never had a smartphone before, didn't know how to text, didn't know how to…now I'm on Facebook and everywhere and learning about it. I love it. Before I was in the dark ages, it was pencil and paper and the landline.*
>
> *Now I've graduated to the iPad, I'm getting very technical! I'm on Kindle and I get my books through Amazon. Emails as well. And I would be on Twitter as well, keep in touch with what's happening. I used to be afraid of technology, I'm not a bit afraid of it now."*

Community Navigators worked to identify what beneficiaries were interested in and based on that, worked with them to increase digital literacy:

> *"And if there's any other things on the laptop [the Community Navigator] would point out some different thing. Programmes that might be of interest, I was looking at the iPad this morning and my relative, who died yesterday, her granddaughter is in England and she put on some beautiful pictures on it and it was lovely to see that."*

Beneficiaries could, through this process, see the benefits and possibilities technology could provide them. Increased digital literacy therefore could contribute to wider outcomes, such as reduced loneliness, empowerment and general wellbeing:

> *"[The beneficiary] loves the company of the Alexa, she finds it magic to be able to speak to a computer and for it to speak back to her. Sheer delight. (Community Navigator)"*

6.6 Primary Care Attendance

The evidence on whether social prescribing reduces non-clinical primary care presentations is inconsistent (e.g. Elston et al, 2019; Loftus et al, 2017). No beneficiaries interviewed expressed that their primary care attendance had been reduced since taking part in mPower. In fact, most stated that they did not visit their GP very often, only for the regular check-ups:

> *"I hated the thought of an ambulance coming to the door and they're bound tae look at your records and see, 'I am not a person that gans forever, tae the doctor'…I don't go unless I've got an appointment for my bloods but I bet I havnae had an appointment tae see a doctor about my health."*

This may indicate that 'frequent flyers' were not always targeted for referrals. However, it is important to acknowledge that beneficiaries may not always self-report frequent primary care attendance.

During COVID-19, many beneficiaries expressed reluctancy to attend primary care appointments, generally due to not wanting to 'take up resources' when services were already stretched:

> *"A GP has maybe ten minutes and I don't like disturbing them unless it's something very, very urgent because they are just overwhelmed at the moment."*

Primary care representatives did see the potential in reducing non-clinical or 'unnecessary' GP appointments through the use of social prescribing and eHealth:

> *"eHealth… that can prevent a visit to your GP surgery, blood pressure monitors, all that kind of thing… And if it can prevent the frequent fliers from coming to want to have a chat with GPs, because they've got no one else to talk to, then if they can go to some kind of support group or be linked in with whatever social prescribing thing is, that's then reduced the burden on GP time, nurse time…"*

Despite acknowledging that reduction of non-clinical presentations was a possible outcome, only two primary care representatives that we spoke to reported mPower had had this type of impact. Once occupational therapist explained:

> *"It's made it a lot easier for me because if I refer to mPower… it means that [the Community Navigator] is actually going out to the house and spending time with these people, finding out what their needs are, not with a health hat on but with another hat on. And it means that they are happier so they actually phone me less.... It means I can concentrate on the people that are actually really needing a review of stuff. So it's actually lightened my workload, as in because they are happier they are being seen by other people, it means they are not thinking about [their illness] all the time."*

We were able to interview only one GP about their involvement with mPower which is perhaps not surprising since as we have seen, GPs were difficult to engage with throughout the project. However, a GP based in HSE CHO8 reported the following:

> *"I was finding that patients that had been referred to were doing physio exercises that [the Community Navigator] set them up, she'd given them laptops and they had been engaging in things like mindfulness, things I might advise but it just gets washed away in the fifteen-minute consultation... So she had just met all of these other really important needs I was never going to be able to meet [that] are no less important than the blood pressure tablets. Sometimes I wasn't hearing from the patients that I was worried about and when it comes to prescription time I would phone up, see how they are getting on and she really had saved us an awful lot of work, otherwise they'd be down here, they'd be calling in with spurious things, an ache or pain but she had set up all these different plans for so many people and it's a really invisible web of community work."*

The GP also explained that he had a specific interest in social prescribing but felt he didn't have the capacity to deliver it and also was unsure about what was available in the community:

> *"The Community Navigator actually was great, she did an educational session with our team about what they do and what they can offer our patients, especially in COVID times and I was delighted so I started referring and never stopped."*

For beneficiaries who were referred for social prescribing and completed their follow-up questionnaires before the COVID-19 pandemic, there was no statistically significant difference between the number of primary care appointments attended before mPower and during participation in mPower (n=305). Analysis was based on primary care appointments per month for 12 months prior to and 6 months during mPower involvement. This was probably complicated by the fact that while some people were referred for social prescribing, they may have gone on to complete eHealth.

However, the qualitative evidence is encouraging. It indicates that once primary care staff saw the effect that mPower referrals have on their own work, they were encouraged to refer more. A challenge for the future of social prescribing is to ensure that GPs can observe change and, therefore, promote their engagement with this type of service.

There was an acknowledgement among stakeholders that mPower was part of a larger culture change in primary care, encouraging self-management and a shift in responsibility:

> *"That's the thing we're trying to do through a lot of the different initiatives that we had, is to try and encourage people to take a wee bit more responsibility for their own health and not just rock up at the GP and expect to be medicated, because I think that is a cultural thing, well a cultural, maybe age-related, generational thing as well, I don't know. (Third sector representative)"*

The type of service provided by mPower, therefore, needs to be embedded within both existing structures and connect with other initiatives with similar aims in order to play a part in this culture shift. Inevitably, this will be more difficult in some areas than others due to the way in which health and social care services are structured.

6.7 Economic Evaluation

Some basic, high level financial data was made available to the evaluation team by the NSS Lead Partner. This data is presented in the table below. The costs relate to the cost of employing Community Navigators and Digital Navigators.

This shows that the average cost per interaction with the project (when eHealth beneficiaries and number of completed Wellbeing Plans are added together) is lowest in Ayrshire and Arran. This is the deployment site with the highest number of beneficiaries but also the lower proportion of beneficiaries reporting positive change through the evaluation questionnaire. This site benefited from having existing eHealth interventions within their localities that staff have been able to direct mPower beneficiaries to – this has not been the case in other deployment sites, particularly those in Northern Ireland and Ireland.

The Southern Trust (£132), Dumfries and Galloway (£147) and HSE (£140) have fairly similar costs per individual contact, all of which are higher than in Ayrshire and Arran. The Western Isles (£484) and Western Trust (£595) deployment sites have notably higher costs per individual contact as total numbers of beneficiaries are lower in these two areas. However, the Western Trust has consistently above average proportions of its beneficiaries reporting positive change in the quantitative measures used.

DEPLOYMENT SITE	Individual Contacts (Actual number of eHealth and WB Plans)	Costs (EUR, Actual)	Spend per Contact (EUR, Actual)	Spend per Contact (£, converted)
NHS Ayrshire and Arran	2,484	308,265	124	105
NHS Dumfries and Galloway	1,595	276,478	173	147
NHS Western Isles	484	266,905	551	469
HSE CHO8 and CHO1	1,743	287,807	165	140
Western Health and Social Care Trust	595	247,807	416	353
Southern Health and Social Care Trust	1,366	211,934	155	132

Table 13

It is possible to compare the costs of the intervention with the cost of services that may have been needed in the absence of mPower to generate the same outcomes. This is summarised in Figure 46.

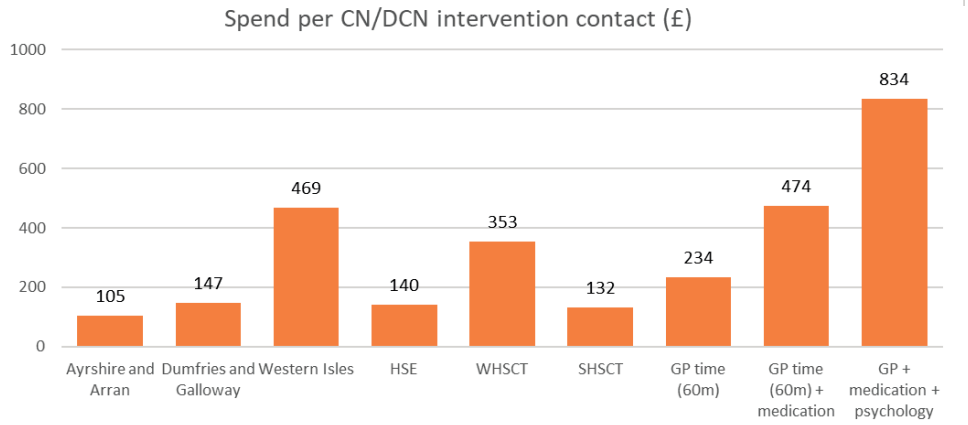


Figure 46 Spend per Intervention

Although we have not been able to evidence reduction in primary care usage for non-clinical need, the primary care staff that we spoke to felt that there was the potential for mPower to generate this outcome. Community Navigators reported spending between 60 and 90 minutes with beneficiaries in their initial consultation. To achieve a similar level of social contact time with a GP would require 4 to 6 appointments. The average cost to the NHS of a GP appointment is £39[9]. Therefore, there is the potential for mPower to save between £156 and £234 of primary care cost per beneficiary. Compared to GP time alone, costs per beneficiary are lower for mPower in all sites except the Western Isles and the Western Trust. However, it should be noted that the kind of outcomes achieved by mPower may not be realised through a GP appointment (especially considering the key components of home and time).

[9] https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2020/

mPower beneficiaries may also be in receipt of anti-anxiety or anti-depression medications such as SSRIs. Our evaluation has shown that beneficiaries experience outcomes of improved mood, wellbeing, self-esteem and confidence through the non-clinical activities offered by mPower. Depression is the long-term condition that shows statistically significant positive improvement through the quantitative analysis. If this mitigates the need for medications related to mood regulation, the mPower intervention has the potential to save the NHS drug costs of around £240 per patient[10]. The cost of GP time and medication is higher than mPower in all sites.

In order to achieve the outcomes of improved mood, well-being, self-esteem and confidence observed for beneficiaries of mPower, it may also be necessary for patients to attend NHS psychology services. The cost of an NHS psychology outpatient appointment is around £60. If mPower diverts patients away from a series of 6 NHS psychology outpatient appointments, it has the potential to save the NHS around £360 per patient[11]. The cost of mPower is substantially lower than the combined cost of GP time, medication and psychological support.

6.8 Organisational Aspects

This section of the report discusses the benefits and challenges of the mPower approach; a central operational service across seven health and social care partnerships, from the perspective of mPower stakeholders. We also report on stakeholders' views on the legacy of the project, as well as issues identified around the name, branding and promotion of the project.

6.8.1 Benefits of the mPower Project-level Approach

Local mPower staff and Project Board members were asked about the benefits of a central operational service spanning all deployment sites. While initially conceptualised as a 'hub and spoke' model, the project evolved in a way that allowed, out of necessity, deployment sites to set up a service that was appropriate for their community, rather than being completely directed by the project management team:

> *"I never particularly liked that model. I think the hub, by definition, suggests it's the centre. And when you've got three jurisdictions, there can't be a single centre. I think it accentuates the whole model of a single service. (mPower stakeholder)"*

The role of the Central Project Management Office (PMO) was therefore seen as supporting the project partners:

> *"[The PMO has] a supportive role… they should be there as the linkage back into the centre. Trying to find some commonality across the partners but also trying to encourage innovation, but on another level, monitoring, reporting, trying to get us the data that we need. Trying to get the information so anything we need to then report out, obviously they are there for, but they should be supportive. (mPower stakeholder)"*

Rather than communication and activities always being filtered through the PMO, many of the local staff cited a key benefit as the ability to 'pick up the phone' and speak to local staff in other sites if they had a problem or concern they wanted to discuss. While participants acknowledged that due to the size of the project, relationships took time to build across deployment sites, being able to turn to colleagues in other areas was seen as valuable:

[10] Drug costs from https://www.ncbi.nlm.nih.gov
[11] Data from NHS Cost Book

> *"I love the idea of three countries coming together, you are grabbing what everybody else is doing…because mPower seems to be well resourced, it seems to have a budget to actually make a difference… Listening to what's gone on as well throughout the country … you are not on your own. It can feel like it in a remote community like this, but to actually hear what's happening with your own organisation in other areas, it's been brilliant. (Local mPower staff)"*

In addition to the potential benefits of shared learning and resources, there was also wide acknowledgement of the difference that the funding of the project has made.

On the Project Board level, it was also felt that the knowledge and experience across the seven sites was key to the mPower model. This however, was dependent on effective communication. Shared learning on this level took place across borders and individual sites, and the central support could enable information to flow more effectively:

> *"That kind of learning is invaluable to the other partners who are coming a couple of steps behind but who now won't need to make the same mistakes... Because that central support… through the project management office, means that that learning is more easily transferrable… It just makes so much sense."*

One Project Board member also remarked that due to the size of the project, *'centralised oversight and project management'* was needed. Project Board members who had been involved in mPower prior to the implementation phase also appreciated the presence of the central team:

> *"I think the exchange across the countries is – it's complex, and each of the areas do things differently so somebody having that oversight of all of that and being able to see that works fine there or 'you aren't going to be able to do that here' … I think is something that would be quite a challenge for us [the project leads] if we were all trying to do it separately in our own areas and reporting to SEUPB (The Special EU Programmes Body)."*

The presence of the PMO therefore took some of the pressure off project leads.

As noted earlier, local teams had agency when it came to shaping the service they were offering. While many found this challenging and not what they expected when taking on their roles, it also provided them with a lot of freedom to design a service most appropriate for their communities:

> *"That freedom to develop is there, if you like, or those reassurances about the ability to develop at a local level, again, were given by the PMO through the Project Board at an early stage but it's always been on the understanding that, if you have any difficultly… the PMO is there."*

6.8.2 Challenges with the mPower Project-level Approach

Overall, participants' opinions on the positives and negatives of the approach differed. Many members of local mPower staff spoke about how their expectations of the project, prior to starting in their posts, had not been met. In particular, many had expected there to be a specific, pre-defined service and eHealth solutions, provided by the central project team, that all local staff would implement across the deployment sites:

> *"I think when I came into the project... I was expecting, 'right, this is here… lift this up and deliver it, the implementation plan, this is what we want you to take and implement.' (Local mPower staff)"*

Instead, local staff were to carve out their approach to service delivery in their area, along with identifying eHealth solutions. The role of Implementation Leads then, was beyond implementation:

> *"I hate that messiness, it's like… just give me a flaming page and tell me how to do it! I feel our roles should be implementing what they have decided upon"*

The lack of guidance put on extra pressure on Implementation Leads in particular:

> *"I've worked on projects before and I just felt there was never a project set up for this…there was no context… I've got my job description, I can work that out but for me, I felt that there was the whole project set-up...it just felt messy."*

This approach was perceived as a barrier for effective service delivery at the start of the project and resulted in a lot of foundational work for local teams which could mean delays in being able to effectively deliver the services they were providing. The lack of guidance on parameters and scope of roles was also reported as a frustration:

> *"You are used to having… standards of practice; this gold standard and you know when you are delivering and you know when you are not! It's that kind of thing; to ensure we're giving a quality service… Even your job description, the job description is very different to what I'm doing (Local mPower staff)"*

These findings are echoed in an evaluation of a social prescribing pilot in south London (Chrysalis Research, 2018). A lack of clarity in its service delivery model was seen by some local teams to impact on the effectiveness of service delivery and the ability to evaluate whether it was meeting project outcomes. A tension between the advantages of the flexibility of mPower and the difficulty in obtaining clarity was indeed a reoccurring theme in the interviews, although as teams became more established as 'business as usual' this became less of an issue. In hindsight, the Programme Manager noted that many of the issues could have been avoided had the job descriptions been more in line with actual role requirements:

> *"The original job descriptions were misleading in the sense the role required flexibility and an exploratory nature; that wasn't clear for some postholders and wasn't suited to their skillset. Perhaps a more traditional Project Manager post would have been a better."*

Concerns around decision-making processes also extended to some local mPower teams. For example, the role of the local steering group in decision-making regarding implementation, vis-a-vis the central mPower team, was not always clear:

> *"I think we have our obvious hierarchy in terms of who to go to but sometimes I feel like one person might say something and then someone else might say something else so it's just – ultimately who do we listen to and go with. I think that would be my frustration from a year down the line. (Local mPower staff)"*

The second key issue raised by local staff was the lack of preparation on a local level for their roles:

> *"I think that maybe mPower or whoever, should have come and done maybe a bit more scoping locally… meeting with the community sector, like what we're doing now I think should probably have been done right at the beginning so people have a baseline start with… And it would be the same with eHealth and the wellbeing. (Local mPower staff)"*

The lack of scoping taking place prior to implementation also resulted in barriers in effectively engaging with the third sector and local health and social care services. This was time consuming and meant that achieving targets may have taken longer than initially envisioned. This, again, is something many felt should have taken place on a project level, prior to local staff being in post:

> *"mPower wasn't designed with the community and voluntary sector considered at all. It was just designed and the idea was we're going to create this new… profession, the Community Navigator, and they are going to signpost people to the services that exist but there was no account taken of those services are at capacity… you have this big pot of money and you haven't put any plan in place for some of that money to follow the signpost. (Local mPower staff)"*

While through the use of a community fund, some of the budget was directed to the community sector, the lack of support for key services relevant to mPower was a barrier for many deployment sites, although this was outside the project's remit and influence.

While the potential for shared learning was widely acknowledged by mPower stakeholders both on the ground and on the strategic level, the cross-border element of the project was also discussed as placing limits on the extent to which this could take place:

> *"Every site is in a different state, I'd say, of readiness… for example, you are talking about the shared learning so the Scotland teams were already embedded there for a year but it's really hard to learn from them in the sense that they have a very different infrastructure. So I think there's this emphasis on shared learning but shared learning can only be applied if it's similar. (Local mPower staff)"*

This is where central operational teams can play a pivotal role, ensuring, through the comprehensive overview they have of the varied contexts of the deployment sites, that the relevant and applicable shared learning can take place, without time being spent focussing on implementation and delivery approaches that cannot be applied across sites.

6.8.3 The Project Board

Project Board members reported a broadly shared understanding of the purpose of the board:

> *"The purpose of the Project Board is to put a project management and governance structure around the mPower project and also to create shared ownership among all of the partners and shared engagement and responsibility and accountability for the delivery of the project and its outcomes.*
>
> *The purpose of the Project Board in terms of the project is really around that overall oversight and has governance responsibility so that we deliver on the key objectives of mPower, it's also got a role around ensuring that we adhere to, I suppose particularly on the finance side, that money is well spent and that also in terms of giving the projects, I suppose that advice and support and steer, so that's what I see ultimately as overall governance and responsibility to ensure that the project delivers on its objectives."*

Many also cited shared learning as an objective. When interviewed in 2018, board members had varied opinions on how well the decision-making processes on board level functioned. Most felt that decision-making was effective and clear, stating that everyone was invited to discuss and debate, and views expressed by other board members were taken onboard. Others however raised concerns over the lack of formal decision-making, as papers put forward were 'assumed' to be approved unless someone raised a particular objection, and papers were sent out a week before but some felt this was too close to meeting dates to allow for members to devote an appropriate amount of time to reading the large amounts of material to be 'approved'.

However, when interviewed in 2022, some expressed that the Project Board had evolved into a useful forum as an understanding of its purpose and function, along with that of the project, developed:

> *"It's transitioned, so in the early days and a lot of head-scratching as always with these projects about what is the role, what are we meant to do, the storming, norming and then the reforming, and I suppose that was the… challenge for the Project Board… So those two big things: to show direction and leadership, to provide good governance and then to make sure there's an opportunity for people to have equality and a partnership approach around the board and that was crucial. And I'd be the first one to say that, in the beginning, we'd always done things with ourselves and Northern Ireland and then across the border, and suddenly you had a Scottish authority coming into the middle of it… But then we learned very quickly… we've got that common objective and we get a lot of learning together and mutual respect', then we were able to work very closely together."*

6.8.4 Meeting aims and objectives

While the project evolved over time, most Project Board members agreed that its core aims had remained consistent throughout:

> *"The original aims were around social and digital connectivity and to support older people to remain independently in their own home. There was a lot of discussion at the very beginning around targeting people over the age of 65 who were living with long-term conditions."*

However, the specifics on how to achieve these aims evolved throughout the project in dynamic ways that also varied by deployment site. The 'how' to achieve the outcomes was not immediately clear:

> *"The objectives… were broad, very broad and probably weren't specific enough and that evolved as we went through. And it took nearly into year 2 before 'what does that actually mean', and how do we operationalise that and what does that translate … into in terms of our services on the ground. So maybe more clarity earlier in the project in terms of what are the deliverables around each of those particular workstreams or components would have helped things"*

Many noted that at the outset, the aim was to target those who were frequent users of primary care in order to support their self-management and in turn, reduce pressure on primary care. However, as a Project Board member acknowledged:

> *"The focus has changed slightly but that was based upon the real life experience of the system and the needs of older people. As the project evolved… I suppose it's been more personalised looking at wellbeing and in its wider sense, that holistic bio-psychosocial model of health and wellbeing, the Community Navigators were undertaking the Wellbeing Plans and looking at, it could be as broad as signposting them into something that was happening in the whole community or during COVID, delivery of pharmacy items or shopping or whatever, so addressing issues like loneliness and isolation, that's where some of the IT or digital aspects come into it as well."*

This again points towards the responsiveness of mPower due to its flexible nature, something that has been reported by stakeholders as being both a negative and a positive.

Overall though, participants expressed that the original aims of mPower had been met, albeit in ways that they did not anticipate from the outset and often not within the time scales they had hoped. One Project Board member reflected on the ambitions of mPower not fully being in line with what was possible from an operational and cultural perspective in all deployment areas:

> *"And I suppose maybe looking back, I think [the project] was really ambitious, innovative, I think the project was probably ahead of its time, if you are asking me about this project now, I think the environment [now] would be different for this project and I think we would have been in a better state of readiness now than we were … So lots of lessons learned."*

6.8.5 Legacy

A question often raised from the beginning by local mPower teams and Project Board members alike was what the legacy of mPower would look like. They raised concerns about the ability to embed Community Navigator type posts within the local systems (in a way that demonstrated added value) and about project planning on a broader, strategic level.

As we have seen, local teams worked towards embedding technology into the community, for example through setting up Digital Community Hubs:

> *"mPower is giving us the ability to test things out, see if they work… About it standing on its own two feet and about it being sustainable. So, for example, with the Community Hub piece there has to be a hand-off so it has to be 'this comes with the support network of a digital champion, we're giving you this equipment to enable you to do this… you need to manage this' and building that sustainability. (Local mPower staff)"*

However, third sector representatives raised concerns about the burden they are potentially expected to bear in terms of carrying on some of the work mPower has begun, at the end of the project:

> *"Yes, I think so [that third sector plays key role in legacy]… I think from a community perspective, what I would like is resources to be able to do that though because I don't think there's any way that a project could be started like that and then expect the community to just pick it up and run with it, without there being something to support that."*

While financial support to community resources was provided in the form of a community fund, the lack of continuity of funding remained a key concern for the third sector. The situation was not unique to mPower and has been widely cited in social prescribing literature. A variety of studies on social prescribing initiatives have highlighted the importance of ensuring that the third sector has the resources to accept referrals, prior to implementing such initiatives (e.g. South et al, 2008). Without an adequately funded and resourced local third sector, implementation of social prescribing and shifting it to 'business as usual' is not possible.

Local teams saw one of the key legacies of mPower as connecting communities to each other and to services. mPower could therefore potentially build pathways that could be sustained longer term, provided the networks built were strong enough. Again, this was dependent on how embedded mPower was in the local health and social care structures, as well as the third sector.

Legacy and sustainability are of course linked to wider transformations in health and social care, and some Project Board members saw an opportunity to embed mPower working models into longer term strategies:

> *"I think we should be talking now around how do those pathways of mPower, is it feeding into your models of care, we need to be talking now around sustainability … I kind of look at it as seed money, to be honest, just initial investment funding."*

There was general acknowledgement among participants that the legacy aspect had not been sufficiently considered from the outset and needed to be a key priority for the project, with the Project Board being the platform for strategic decision-making to ensure an appropriate level of embeddedness across sites. Key to ensuring a legacy for the project, was alignment with national strategy and policy:

> *"One of the responsibilities of the Board is absolutely making sure that mPower is integrated with national strategy and policy. And I really don't see enough of that because some of our partners are struggling, for example, engagements with General Practice… eHealth and digital. Now, the responsibility of us as Project Board and leaders is to make sure that policy advisors, leaders within Scottish Government are making sure that mPower, it comes down through the board, it's supported. (Project Board member)"*

Overall, the legacy of mPower looked different in different deployment sites. Some examples of the shape legacy took include:

- The continued use of technology in various healthcare settings to support patient choice in a variety of clinical pathways.
- Integrating aspects of the Community Navigator role to an existing Link Worker model.
- Community Digital Hubs.
- Increased understanding of social prescribing in health and social care.
- Increased links between health and social care and the third sector.
- Modernising service delivery, services being more open to considering how things can be done differently.
- Rollout of Attend Anywhere in the Republic of Ireland.
- The recognition of the importance of person-centred care where 'what matters to you' is at the centre of healthcare.

For many sites, a cultural shift was taking place, something mPower was a part of:

> *"It can attest to the fact that we've delivered a national platform. We now have a social prescribing framework within the HSE and I know that nationally our services for older people had seen the mPower Community Navigator in play and we now have a community connector post approved for each HSE CHO in the country. I think the whole understanding of those non-clinical supports, that connected piece, the impact of loneliness and isolation... I think the legacy will be that we have this enhanced community care, we're going to have community health networks, we're going to have chronic disease hubs and we're going to have integrated care teams for older people. So I think there's a good infrastructure to embed the legacy of the mPower project within those networks and that infrastructure. (Project Board member)"*

mPower was therefore being implemented at a time when other shifts in the health and care landscape were taking shape and was able to play a part in informing and contributing to these changes.

6.8.6 mPower Name and Logo

An issue frequently raised by local mPower staff and beneficiaries was confusion around the name and branding of mPower. One beneficiary for example, on asking if they would recommend mPower to others, replied:

> *"Yes, without any hesitation at all. But it's an unfortunate choice of name because of the confusion… trying to explain to them that it isn't a power company, the first response you get is 'Oh, I'm with Scottish Power, whatever…'"*

In order to avoid confusion with the energy company, Community Navigators had to develop alternative approaches to introducing themselves in person and on the phone, in order to avoid immediate dismissal. This often entailed introducing themselves as someone working for the local health services or third sector organisation rather than mPower.

Beyond the name, explaining where mPower fits in on the local level was also a challenge for many deployment sites. Participants reported the issue to be two-fold: explaining how mPower is different from existing services, and the complexity of offering both social prescribing and eHealth interventions:

> *"I think there's a confusing thing about mPower… it's trying to do three different things, I would say… social prescribing, the eHealth and then I would see Attend Anywhere as actually a separate thing… But I think it's a difficult combination and I think that's why people don't understand it, it's a – why are you doing all these things all at once, concentrate on one thing and do it well rather than having to juggle these different messages. (Primary care representative)"*

As local teams became more established and relationships within the communities they worked in were established, this was less of an issue. However, to get to that point could take time. The project also developed and took shape differently in different deployment sites as they built up a local identity. This points back to the issue of teams having to create a service rather than implementing one. It is therefore important to consider the aims and outcomes of complex projects like mPower from the outset to be able to effectively secure buy-in. This buy-in cannot be achieved without an understanding of what the project can offer and how this fits in with existing local service delivery and structures.

6.9 Social, Ethical and Legal Aspects

This section considers the local and cross-cutting professional, administrative and technical obstacles encountered during the implementation of mPower.

Most interviewees considered the SEUPB (Special EU Programmes Body)[12] funding and administration requirements to be overwhelming and unusual in comparison to their previous project experience. This was perceived by board members and local staff alike as taking time away from the implementation work and strategic planning. The requirement to travel for project meetings was also cited as a difficulty by many, in particular those with other professional and personal commitments.

While many Project Board members acknowledged the beneficial relationship building that had resulted from mPower, regional differences were an obstacle to effective implementation, particularly on a cross-border level:

> *"Well obviously the challenges are the different jurisdictions, and there's issues in relation to licences… procurement… different primary care systems."*

Procurement was a key obstacle, in particular for Northern Ireland and the Republic of Ireland. One Board member explained:

> *"Procurement… is probably the biggest challenge for us… on the one hand you have Attend Anywhere and you have Florence and things like that in Scotland and you'd love to say 'just transfer them over here and we'll do them here' but that's open to challenge by local providers who would see an unfair advantage there for…a company… We have to be very careful around that procurement piece, to make sure that we do it in accordance with our own procurement rules and laws."*

However, many of these challenges were overcome, with the pandemic being a major catalyst as eHealth was urgently needed, in particular Virtual Clinic technology:

> *"Having to change the way you deliver the services is a very obvious challenge that every element of service delivery across the board has experienced. However, what I think has also been apparent is the huge opportunities that COVID has brought around people's open mindedness, around technology, it's probably shone a light, certainly on our rural areas where we have really poor broadband and we have lots of folk who didn't have technology that enabled them to access the internet, on any reliable way. COVID helped that be completely different. All of those things happened because of COVID in a way that we would have been slogging for a long time, trying to convince folk that this is potentially a way to be doing things differently. So I think it accelerated a lot of those conversations by necessity which I think we've been able to kind of use to our benefit. (Project Board member)"*

This culture shift has been discussed more extensively elsewhere in the report. Furthermore, participants reported that mPower could act as a platform to test new technologies, removing some of the barriers relating to ownership of technologies. However, this could be time consuming as procurement took a long time. Indeed, many expressed frustration over the fact that some technologies could only be rolled out towards the tail end of the project, not giving them enough time to capture impact. However, it was acknowledged that lessons could still be learned from this.

[12] The mPower project was supported by the European Union's INTERREG VA Programme, managed by the Special EU Programmes Body (SEUPB).

ICT issues also resulted in some obstacles. It was decided at the start of the project that no central database would be procured to capture data on beneficiaries as deployment sites worked in different ways and used different systems. Instead, all sites used spreadsheets. This proved to be an ineffective way to capture data, resulting in discrepancies and a lot of time being spent capturing data in a manner that was reported to be onerous. This impacted reporting and monitoring by the central PMO, limited opportunities to analyse data and recommend changes during implementation and significantly impacted the quality and quantity of data secured for evaluation purposes.

Due to difficulties, partly relating to Brexit, it also took a long time to prepare a data sharing agreement to enable data to be shared to the central team as well as the UHI evaluation team:

> *"Who would have thought that we would have Brexit in the middle of all this, and the huge challenge that that has been… with the data-sharing agreements, I learnt more about being a controller than I ever wanted to know as a result of that eighteen months, but again, the work we did now has been a template for how we roll out that technology or these type of agreements across the Western Trust but also across the entire Northern Ireland. (Project Board member)"*

While the impact of delays in data sharing agreements meant that UHI were unable to access and therefore review the data for the majority of the project, the process has had an impact on how future agreements should be handled.

HSE also suffered from a cyber-attack during the project: 'we've had some added challenges in the HSE with a cyber-attack which really closed down all of our IT systems for a number of months'. This led to challenges in communication with project partners, local stakeholders and beneficiaries themselves.

Early issues identified were difficult to overcome. This highlights the importance of a thorough regional scoping exercise being undertaken prior to implementation:

> *"The one year and a half of preparation before the deployment teams took up office should have been more structured – maybe that'll be an important learning for the project. Things should have been identified early on that really need to be in place and covered, before the project on the ground takes off. When some essential items are not available at the beginning to the deployment team it only delays the role out of the project as time then has to be deflected on to practical stuff that should have been agreed and in place before the deployment team took up their positions. (Local mPower staff)"*

On the ground, the main obstacles to implementation were local governance procedures to ensure organisational policies were followed. Recruitment was also a challenge for many deployment sites, with posts sometimes vacant for long periods of time:

> *"I think the biggest challenge we had was really it was about recruitment, I think being able to keep people in the roles long enough for them to start to really make a difference. If we were to do it again, recognise it's a permanent role rather than a temporary role. Some of our partners had gaps in their resources for a long, long time, just – be it just the time it takes to recruit. So we actually need to think about a resourcing model that is flexible enough to allow us to ensure that we've got the capacity deployed on the programme consistently, rather than it being a bit fits and starts. (Project Board member)"*

Challenges in recruitment were therefore often difficult to solve as they hinged on both local level processes as well as EU programme rules. These could be difficult to converge, leading to challenges in project delivery.

6.10 Cross-border Knowledge Exchange

As noted earlier, cross-border knowledge exchange presented both a key opportunity and challenge for the project. When opportunities for shared learning were available, the cross-border aspect of the project meant that learning was not always easy to transfer across areas. One local staff member acknowledged the challenge of having to implement ideas rather than practices due to the different areas and jurisdictions at the start of the project:

> *"I do think sometimes it can be difficult coordinating a project across three different jurisdictions who are all at different phases of development within the project, so what's applicable to us here in the Northern Ireland may not be applicable in Southern Ireland or in Scotland."*

This remained challenging even when teams were well established and no longer in different phases of implementation:

> *"I think shared learning is hard because each of the areas is so different and it's good in one sense because you're seeing something that's totally different but it's hard then to bring that back to your own practice… but shared learning with Ireland, it's good hearing about all the differences and it does sometimes help out your own problems but in a lot of cases, we have totally different setups so we can't bring the learning back to apply it to our own practice but I'm not really sure how to get around that. (Local mPower staff)"*

Before the pandemic, beyond the formal meetings at assemblies and more informal phone calls, local teams found it difficult to connect face-to-face with other deployment sites due to physical distance. This took a lot of advance planning and was not always possible, even when deemed potentially beneficial. However, Community Navigators working in each of the three jurisdictions developed informal support networks to compare experiences: *'we just talk in the same language because we are working within the same system'.* Arrangements to shadow Community Navigators were also in place where distance was not prohibitive. Keeping in touch in more informal ways was particularly important for Community Navigators, who often reported relying on each other for 'general support':

> *"Not necessarily shared learning but just pure support… I would be in contact a lot on the phone with [other Navigators]. And that used to really help reassure me in terms of where we were, where they were and we had similar challenges, frustrations so I don't know if that falls under the model of shared learning or peer support, but that's crucial, I think, absolutely…"*

Despite the difficulties in applying shared learning across borders, the project assemblies became a valued and appreciated avenue to connect to other mPower staff and sharing examples and case studies of beneficiaries they had supported. After the onset of the pandemic, when face to face assemblies were no longer possible, they were very much missed. While virtual assemblies still took place, they didn't offer the same opportunities for more informal conversations that could lead to new ideas and insights.

The mid-term evaluation report recommended the use of the ECHO knowledge sharing network to help overcome some of the barriers to shared learning. Regular ECHO sessions did indeed take place until the end of the project. ECHO - Extension of Community Healthcare Outcomes, provided mPower stakeholders an opportunity to share knowledge, learning and best practice through facilitated virtual sessions. These were generally well received by stakeholders, in particular those who were not in post pre-pandemic:

> *"I think the ECHO network has been a great thing to have. I think if you are going to do something like this kind of cross-border work, it's great to have something like that and learn what other people are doing. (Local mPower staff)*
>
> *And ECHO sessions have been fantastic, the ECHO sessions have been amazing. There's some things that we know we can't do from an HSE perspective and other areas have been able to do that but it's still nice to see that there's different ways of working and passing that knowledge on for future. (Local mPower staff)"*

This demonstrates that despite regional differences, ECHO was a helpful platform to engage with and learn from others, particularly when project partners were not able to meet face to face.

7. Discussion, Implications and Conclusions

The overall objective of this evaluation was to monitor and evaluate the delivery of mPower. The evaluation team aimed to do this in relation to two original aims:

- Assess the effectiveness of new strategies for the delivery of care as a means of facilitating self-management of health and wellbeing.
- Assess the clinical and cost effectiveness, as well as the cross-border suitability, of new services in assisting an ageing population to live well at home for as long as possible.

This report has presented the findings of the evaluation work package of the mPower project. The findings are based on data collected from eHealth Readiness Assessments and the mPower Project Board; alongside interviews with mPower stakeholders, including beneficiaries. Quantitative data from the beneficiary questionnaires that were administered by the mPower Community Navigators have also been included within the analysis and presented within this report.

7.1 Overall Project Targets

The numbers provided to the evaluation team demonstrate that the mPower project has met its target numbers of eHealth interventions and Wellbeing Plans. However, there is some variation between the deployment sites in terms of the numbers achieved: 5,525 digital interventions, 2,742 Wellbeing Plans and 1,353 instances of shared learning.

As discussed in this report, the number of eHealth and Wellbeing Plan beneficiaries are not evenly spread between the deployment sites, nor do they simply follow population distribution. It is, therefore, important to understand the context within each deployment site individually. We have seen that context and approach to service delivery (two themes to emerge from our data analysis) are central to understanding the generation of outcomes within each deployment site and for the mPower project as a whole.

The Scottish sites account for most project interventions: Scotland: 57% of digital interventions; 53% of Wellbeing Plans. HSE 22% of digital interventions, 18% Wellbeing Plans. Western/ Southern Trust 21% digital interventions, 29% Wellbeing Plans.

Several contextual factors have been shown to underlie this. The Scottish sites have benefited from having mPower staff in post quicker and these were generally people who were already familiar with both the third sector and health and social care service landscape of their local areas. Their work has been aided by embeddedness in or around multi-disciplinary teams. In addition, their eHealth readiness assessments generally show environments more conducive to the use of (innovative) health technology. In general, the higher numbers of eHealth beneficiaries are associated with sites that returned a greater level of eHealth readiness in our assessment.

The highest overall numbers of both eHealth beneficiaries (1,722) and Wellbeing Plans (762) are seen within NHS Ayrshire and Arran. However, this is also one of the most populous of the deployment sites and the high overall figures equate to reaching approximately 3% of their population over the age of 65. The beneficiary figures for NHS Dumfries and Galloway are the second highest within the project and they have the greatest reach of any of the deployment sites – equating to reaching approximately 20% of their over 65 population. In the Western Isles deployment site, the numbers of beneficiaries are lower than in either of the other Scottish sites but equate to reaching approximately 7% of the older population in the islands.

Numbers of digital interventions are lower in HSE CHO8 (497) than in HSE CHO1 (754); and the same is true for Wellbeing Plans in HSE CHO8 (167) compared to HSE CHO1 (325). This equates to a reach into the over 65s of 14% in HSE CHO1 and 13% in HSE CHO8.

Digital interventions are lower in the Western Trust (227) that the Southern Trust (929), and the same is true for Wellbeing Plans with the Western Trust (368) in comparison to the Southern Trust (437). In Northern Ireland, the Western Trust reached approximately 3% of the over 65 population and Southern Trust reached approximately 2% of their over 65 population. However, these figures may be underestimates due to a lack of local level population data.

Overall, in terms of reach into the over 65s population, this was highest in Dumfries and Galloway (21%) and HSE CHO1 (20%).

7.2 The Influence of Context and Mechanism of Service Delivery

This report has shown that the three participating areas (Scotland, Northern Ireland and Ireland) share similarly supportive policy contexts for social prescribing and eHealth but different local implementation contexts. The different deployment sites share some common challenges, but each has its own distinctive landscape. Therefore, it has been important for us to look at the trends that shape outcomes in a geographical context.

7.2.1 Local Identity

In Wigtownshire (NHS Dumfries and Galloway), where a high number of Wellbeing Plans have been completed and the reach into the over 65s population is very high, the two social prescribing services operating in the area worked together in order to achieve common goals. Linking in and leveraging other projects and services, helped to meet targets. Crucially, the Wigtownshire mPower team were very clear on what their service offered that was unique – social prescribing tailored to meet the needs of older people. This helped to shape their own identity as a service and helped other healthcare professionals to understand what the Wigtownshire mPower service was about. Having a clear local identity, or USP, helps busy healthcare professionals to easily understand the mPower service and, therefore, to be more likely to refer into it.

A related theme emerged from the qualitative data collected for Irish site HSE CHO8 with regards to eHealth. This site has lower numbers of eHealth beneficiaries compared to HSE CHO1 which was seen, in part, as related to uncertainty, at least initially, as to what mPower can offer in terms of eHealth. Local staff need to understand what is being offered as part of the service in order to be able to confidently and effectively advocate for, and implement, the service and they need to feel supported in this by local and central project management.

7.2.2 Connections to Primary Care and the Third Sector

Community Navigators and Implementation Leads have put a lot of time into making personal connections to ensure referrals into the project were made. This was easier for staff members who had previously worked or lived in the area before taking up their role within mPower. In Ayrshire and Arran (where the highest number of Wellbeing Plans were completed) Community Navigators benefited from pre-existing connections and experience in the local area.

Dumfries and Galloway have the second highest number of Wellbeing Plans completed and a high reach (20%) into their over 65s population. Qualitative findings suggest that this impact may be related to cross-project working and liaison with another local social prescribing service for mutual benefit. Interviewees from Dumfries and Galloway also reported a pro-active attitude to connecting with the local healthcare system such as maintaining a presence at GP practices, speaking to practice staff and shadowing district nurses. They reported being well embedded within the Health and Wellbeing team from which they would receive referrals and they had Community Navigator staff in post fairly consistently throughout the project.

Despite having a high percentage reach into their over 65 population, interviewees from ROI site HSE CHO1 felt that the time needed for staff coming in from outside the local area to build up knowledge of local assets, impacted how quickly they could start engaging with beneficiaries and signposting to activities. This was echoed by interviewees from the Northern Ireland site the Western Trust, who described how the Community Navigator had to spend time physically going to meet with community groups to build relationships. While doing this was ultimately beneficial and necessary, it took away time from completing Wellbeing Plans. The Western Trust evidence also points to time being spent on extensive asset mapping – this again impacts ability to complete Wellbeing Plans as effectively as in other sites where Navigators may have had pre-existing knowledge and connections.

There are different layers of tasks that Community Navigators in particular were asked to do. We have seen evidence from the Western Isles, for example, that effective social prescribing requires good links to both primary care and the local third sector. It is a difficult task for Community Navigators to both build these linkages and to carry out the required number of interactions with beneficiaries. If the task of becoming the fount of knowledge on community assets becomes too time consuming for Community Navigators, the responsibility of asset mapping could be shifted to community champions who have a good knowledge of the area. As there are existing ways in which communities pass on information to each other, these could be tapped into. As the interaction with the Community Navigators often was the most valued part of the service by beneficiaries, other mechanisms of liaison with primary care and the community sector could be explored.

Community Navigators and Implementation Leads being physically based within the same space as multi-disciplinary teams/primary care was seen as a facilitator of success. Ayrshire and Arran, in which the highest numbers of eHealth and Wellbeing Plans have been carried out, cited the value of their mPower team being based within a multi-disciplinary hub at the outset. In the Southern Health and Social Care Trust, where fairly high numbers of digital interventions and Wellbeing Plans have been completed, the value of being based in the same building as primary care was also noted.

Our analysis has shown that in HSE CHO1, a lack of embeddedness of mPower staff may have hindered the number of completed Wellbeing Plans. This was also the feeling in HSE CHO8 in which a particular challenge was that the local team were not embedded into the primary care team at the start – again, this may be reflected in the lower numbers of beneficiaries completing Wellbeing Plans within this area. This was eventually partially mitigated by having a Navigator based within the third sector however.

Evidence from our qualitative work suggests that where Community Navigators sit within their local health and social care services is important. This was not established from the outset in all deployment sites which may have negatively impacted on local mPower teams' ability to recruit beneficiaries.

7.2.3 The Relationship between the Community Navigator and Beneficiary

A common theme across deployment sites was the impact of the relationship between beneficiary and Community Navigator on outcome generation. In all deployment sites, the work done by the Community Navigators was seen to be beneficial and the way they engaged with beneficiaries was conducive to generating positive outcomes. Beneficiaries highlighted, for example, that they were able to engage with the project and achieve health and wellbeing outcomes because Community Navigators visited them in their own home, spent an adequate amount of time with them on each visit and genuinely engaged with them.

Community Navigators were shown to be flexible, adaptable and in possession of a considerable skill set. Evidence shows that the mPower Community Navigators were doing more than signposting, they were adding value through the way in which they engaged with beneficiaries and supported them to take part in activities.

It was apparent to beneficiaries that the mPower Community Navigators genuinely cared about them and that they had the time to spend to get to know them and their needs. This was often contrasted by beneficiaries to interactions with other healthcare professionals that they find to be rushed and unsatisfactory. Beneficiary interviews highlighted, for example, that Community Navigators were seen as professionals who care and search for ways to help, who listen and who remember details about beneficiaries.

Therefore, the key elements to the success of interactions between Community Navigators and beneficiaries are that they take place in beneficiaries' homes, each beneficiary is given enough time (e.g. 1 to 1.5 hours during the initial meeting) and the Navigator addresses the beneficiary in a valued and meaningful way.

The Community Navigators have the power to act on the social determinants of health. The importance of the human contact that they provided for older people who could be experiencing loneliness and isolation is hard to overemphasise. It is the relationship between Community Navigator and beneficiary that is the foundation of much of the generation of positive outcomes within the mPower project.

However, this role carries with it a not inconsiderable burden in emotional terms. Evidence suggests that Community Navigators could have been further supported through more formal debriefing processes and peer support. Within the second half of the mPower project, the use ECHO sessions has gone some way towards meeting this need.

7.2.4 A Broad Definition of eHealth

Numbers of eHealth beneficiaries are highest in two of the Scottish sites (Ayrshire and Arran; Dumfries and Galloway). Both sites were able to connect mPower with existing eHealth infrastructure. Staff from these sites also reported the adoption of a broad conceptualisation of eHealth; for example, the use of video conference technology for social interaction (rather than just interaction with a healthcare professional) supported older people's self-esteem and wellbeing.

Difficulties with transport were reported in all the deployment sites. Older people who are isolated may not be able to get to activities they have been signposted to. Public transport and community transport was not always able to meet needs and did not serve everyone or enable participation at all available events. Therefore, looking at connecting people socially using technology is

one way to achieve impacts such as decreased loneliness and improved self-perceived well-being. mPower has shown that this broader definition of eHealth can be useful in areas where implementation of more formal eHealth services is difficult due to procurement and other barriers.

The Northern Ireland and Republic of Ireland deployment sites generally reported more challenges, less culture of embracing new technology and a lack of eHealth champions and support. This different starting point will have made the implementation of formal eHealth infrastructure through the health services more challenging.

HSE CHO1 has also experienced significant challenges around procurement and broadband connection. Similar challenges have been seen in the other ROI deployment site HSE CHO8.

Larger changes in health and social care require national frameworks but operating beyond these boundaries can make a difference to people's lives and achieve the outcomes anticipated by mPower. If there are structural impediments to 'large-scale' eHealth, a redefinition of our conceptualisation of eHealth, away from home and mobile health monitoring and Virtual Clinics, to technologies that beneficiaries need and want, may be beneficial. In the Southern Trust, for example, the value of enabling cross-border phone calls to keep in touch with relatives was highlighted. This has the potential to have a positive impact on self-management and social connectedness. Although they had a slower start, Southern Trust (NI) and HSE CHO1 (ROI) were able to achieve relatively high numbers of digital interventions at 927 and 733 respectively through a combination of video conferencing and wider digital initiatives, some of which occurred due to necessity relating to the COVID-19 pandemic.

7.3 Beneficiary Outcomes

Our evidencing of outcomes for beneficiaries is drawn from qualitative interviews and analysis and the analysis of questionnaire data from a sample of 1,033 beneficiaries (a sample of approximately 20%).

Through the qualitative research, we could see that local mPower staff felt that mPower met the needs of beneficiaries. It should however be noted that cross-service collaboration was more challenging in some deployment sites than others. The context in which mPower was implemented was key in determining the extent to which beneficiary needs were met. As well as acknowledging the fact that in some cases there were no appropriate services or community groups to refer beneficiaries to, some areas reported struggling with the availability of eHealth, which meant that certain needs they had identified among beneficiaries were not being met. However, the Community Navigator visits themselves were seen to be meeting the needs of beneficiaries to a high degree.

The qualitative research suggests that mPower acted in several ways to support older people to live well at home for as long as possible. Benefits were reported especially in relation to decreases in social isolation, increases in feelings of empowerment and increases in digital literacy. The key positive outcomes reported by all types of stakeholders were social isolation, empowerment and digital literacy. Around 20% to 30% of beneficiaries within the evaluation questionnaire sample experienced some degree of positive change in their health and wellbeing measures. The greatest improvements were seen in life satisfaction and self-perceived level of loneliness. Depression was the one long-term condition that showed statistically significant positive increases in the measurements. In relation to staff interviews, benefits around multi-disciplinary conversations and cross-sector working were evident.

7.3.1 Confidence and Empowerment

There is evidence that engagement with the mPower project increased beneficiaries' confidence and sense of empowerment – this is largely through their interactions with Community Navigators and the completion of Wellbeing Plans.

Evidence has shown that a significant (usually negative) life event was often the catalyst for a beneficiary being referred to the mPower project. Interaction with a Community Navigator at this point could give people the boost or nudge that they needed to get through a tough time and start to (re)engage with activities that they enjoy. We have seen how the process of a guided conversation and goal setting with a Community Navigator was particularly important in generating confidence and empowerment for the beneficiaries.

Many of the beneficiaries who reported increased confidence and empowerment had gone on to do activities that they enjoyed as a result of formulating a Wellbeing Plan with a Community Navigator.

In summary, increases in confidence and empowerment were seen as a result of the variety of tools employed by Community Navigators to support beneficiaries; as well as their creative and person-centred approach to delivering the mPower service in which the broad needs of beneficiaries were identified before any goal setting or sign-posting took place.

7.3.2 Loneliness and Social Isolation

There is evidence from our analysis that interaction with mPower led to reductions in loneliness and social isolation. In fact, a reduction in feelings of loneliness and social isolation was the outcome most frequently discussed by beneficiaries, staff, third sector representatives and interviewees working in primary care. The questionnaire data showed a statistically significant decrease in self-perceived feelings of loneliness for beneficiaries with depression. Reduced loneliness was reported in 20% of beneficiaries. This was not affected by the COVID-19 pandemic as 20% saw improvements after the pandemic had started.

Breaking down the data by deployment site, shows that several sites had higher than the average of 20% of beneficiaries reporting decreases in loneliness: Western Trust (52%); HSE CHO1 (48%), Western Isles (32%) and Dumfries and Galloway (28%). Breaking down the data by long-term condition shows higher than average decreases in loneliness for depression (60%), chronic pain (28%), epilepsy (33%), CKD (31%), asthma (28%), hypertension (27%), diabetes (26%), arthritis (25%) and heart disease (23%). We can see that positive impact for those with depression is at a much higher level than any of the other long-term conditions.

The majority (72%) of beneficiaries reported loneliness levels were unchanged. Of those who reported no change, 36% stayed rarely or never lonely, and 34% stayed lonely some of the time. The largest number of those seeing no change are within Ayrshire and Arran (85% of their sample).

There is evidence to suggest that referrals into group activities contributed to the realisation of this outcome. Beneficiaries reported that attendance at one group activity can spur them on to attend other groups as well. Group activities were also important sources of peer support.

Technology was used by some Community Navigators to improve beneficiaries' connectedness and this, in turn, helped to reduce loneliness and social isolation. The low level and off the shelf citizen technology options discussed above were particularly important for this outcome. mPower staff noted that there was, however, a need to have clear pathways to refer beneficiaries to statutory mental health services when this is most appropriate.

7.3.3 Mental Wellbeing

Evidence from our qualitative analysis suggests that interaction with mPower could contribute to maintaining or enhancing older peoples' mental wellbeing. Social prescribing, and in particular, the nature of the contact with the Community Navigator, was reported as having a positive impact on mental wellbeing. However, there are also examples of eHealth and technology solutions contributing to the enhancement of mental wellbeing. The example of use of Alexa to enhance wellbeing illustrates again that where appropriate, off the shelf technology solutions that are not necessarily clinically focused, could support mPower to achieve its desired outcomes.

Of those beneficiaries who completed the evaluation questionnaires, 18% saw an improvement in the measure of life satisfaction and 77% felt their levels of satisfaction had been maintained over the course of their interaction with mPower. The proportion reporting an improvement was 18% before and after the start of the COVID-19 pandemic. Interestingly, a slightly lower percentage (4%) reported any decrease in life satisfaction after the start of the pandemic than before (6%).

When we break the data down by deployment site, we can see that several of the deployment sites have higher than average proportions of beneficiaries who reported increases in life satisfaction: HSE CHO1 (42%), Western Trust (40%), HSE CHO8 (27%), Dumfries and Galloway (26%), Southern Trust (26%).

When we break the data down by long-term condition, we can see that several conditions also have higher than average proportions reporting a positive change in levels of life satisfaction: depression (43%), chronic pain (39%), CKD (31%), cancer (29%), asthma (29%)

7.3.4 Self-management

There is some evidence from the analysis of our qualitative material that mPower encouraged older people to engage with self-management behaviours. This was most often seen as a result of an interaction with a Community Navigator. We have seen that because Community Navigators took a holistic view of self-management, beneficiaries felt supported to do this in appropriate and meaningful ways.

There is also evidence to suggest that eHealth interventions supported self-management, when the beneficiaries had the appropriate skills, and the motivation, to use the technology provided.

The evaluation questionnaire also asked people their view of their overall ability to manage their long-term conditions after participating in mPower, with 72% saying that their participation had increased their ability to self-manage. The proportion who felt mPower had increased their ability to self-manage rose from 68% pre-pandemic to 74% post-pandemic.

Breaking down the data by type of long-term condition shows a particularly high proportion of people with CKD (91%) and chronic pain (81%) reporting an increase in their perception of their ability to manage their conditions. There are also above average increases for heart disease (76%), diabetes (75%) and epilepsy (75%).

When asked specifically about their perceived ability to manage individual conditions, the highest proportion reporting an increase was those with depression (44%), CKD (40%), chronic pain (33%) and diabetes (29%).

7.3.5 Physical Health

Changes in physical health did not emerge as a strong theme from the qualitative work. The evaluation questionnaire asked beneficiaries whether they had experienced changes in physical health after participating in mPower and 21% reported that their physical health had improved, with 71% saying it had been maintained.

For those who maintained their level of physical health, the majority remained fair, good or very good. The proportions reporting improved physical health were higher pre-pandemic (25%) in comparison to after COVID-19 public health measures were introduced (19%). Interestingly, the proportion of those who maintained increased from pre-pandemic (65%) to after the start of the pandemic (74%) and those worsening decreased from 9% to 7%.

The reported proportions of beneficiaries experiencing improvements in physical health are much higher in some deployment sites compared to others. They are much higher in HSE CHO1 (48%) and Western Trust (48%); and much lower in Ayrshire and Arran (9%) and HSE CHO8 (5%).

When the data is broken down by type of long-term condition, we can see that the proportions reporting improved physical health are higher for CKD (54), chronic pain (38%) and depression (35%).

7.3.6 Travel

While no beneficiaries interviewed had used Virtual Clinics as part of mPower, there was recognition of the potential of the technology, even beyond a health care setting. Local mPower staff, as well as primary care representatives, also highlighted the potential of video conference technology in remote and rural areas. In terms of primary care, participants also highlighted how Virtual Clinic appointments could reduce travel for both beneficiaries and primary care staff, who sometimes had to conduct home visits with beneficiaries who were unable to travel to appointments.

During the pandemic, the use of video conference for health and social care needs became even more imperative. mPower were often able to support this work due to their experience. This in particular was the case in the Republic of Ireland where teams were a key part of rolling out the service across the region.

7.3.7 Digital literacy

45% of those beneficiaries who completed the evaluation questionnaire reported that their level of digital literacy had increased following their interaction with mPower. The proportion was higher in the Northern Ireland deployment sites (65%) in comparison to the Scottish deployment sites (39%). Improved digital confidence was reported by a larger proportion during the pandemic (49%) than pre-pandemic (41%). Digital literacy increased among some beneficiaries as a result of Community Navigators supporting them to use various forms of technology.

7.4 Acceptability of the Service Delivery Approach

7.4.1 Safety of the Approach

Overall, there were few safety concerns raised by participants in our evaluation interviews. Generally, mPower stakeholders felt that social prescribing and eHealth are both acceptable and appropriate ways to facilitate self-management and to improve physical and mental health, and that safety issues do not outweigh the positive outcomes that can be achieved.

Perceptions of safety issues for beneficiaries were not to do with the safety of social prescribing or eHealth per se but more with the fine line between when it is safe for someone to remain living at home and when a move to sheltered accommodation may be necessary.

In terms of eHealth, both home monitoring alarms and medication reminder services such as Florence were perceived to be safe. Personal alarms could bring a sense of reassurance to older people, their family and carers.

Concerns were raised about the suitability of using video conferencing by some interviewees from the primary care sector. Their concerns centred around whether something may be 'missed' if a patient was not physically in front of them during a consultation. These concerns can be alleviated through promotion of appropriate use of video conferencing, e.g. for medication reviews or routine check-ups.

Some concerns were raised about the safety of Community Navigators working alone. These could be addressed through local lone working policies.

It was not generally considered to be unsafe, or risky, to refer older people to third sector organisations or activities. However, it was noted that a good relationship between Community Navigator and primary care physician enhances safety in this regard – as it provides a clear route of dialogue on participant capacity and limits if needed.

7.5 Impacts on Primary Care

Interviews with beneficiaries have not suggested that mPower is having an impact on primary care attendance. This may indicate that 'frequent flyers' were not always targeted for referrals and/or that beneficiaries did not always self-report frequent primary care attendance.

The COVID-19 pandemic made it particularly difficult to assess any impact of mPower on levels of primary care attendance as many beneficiaries reported limiting their attendance due to the pandemic. For beneficiaries who were referred for social prescribing and completed their follow-up questionnaires before the COVID-19 pandemic, there was no statistically significant difference between the number of primary care appointments attended before mPower and during participation in mPower (n=305).

Interviews with GPs indicated that they could see the potential of social prescribing to reduce primary care attendance in the future. Only two primary care representatives that we spoke to reported mPower had had this type of impact. However, the qualitative evidence is encouraging. It indicates that once primary care staff saw the effect that mPower referrals have on their own work, they were encouraged to refer more.

From the basic, high level financial information available, we were able to see that the costs per beneficiary interaction varied from £105 in Ayrshire and Arran to £595 in the Western Trust. Per contact costs were generally lower in the deployment sites where total numbers of beneficiaries were higher. Using average costs per GP contact, SSRI medication and psychological support we were able to see that mPower costs are lower than GP time plus medication and psychological support in all deployment sites.

7.6 Organisational Aspects of the mPower Project

7.6.1 Benefits of the mPower Project Level Approach

Many of the local staff cited a key benefit of the mPower project level approach being that it gave them the ability to 'pick up the phone' and speak to local staff in other sites if they had a problem or concern that they wanted to discuss. The presence of the central operational service spanning the deployment sites took some of the pressure off project leads once this central team had been established.

At the Project Board level, it was also felt that the knowledge and experience across the seven sites was a key benefit of the mPower model. This, however, was dependent on effective communication. Shared learning on this level took place across borders and individual sites, and the central support enabled the information to flow more effectively.

7.6.2 Challenges with the mPower Project Level Approach

The main challenges discussed by interviewees related to the non-realisation of the expectations of mPower that they had prior to starting in their project posts. Commonly, they had the expectation that they would be joining a team to implement a specific service and eHealth solutions, both of which would be centrally provided by mPower. There were feelings of disappointment that this did not happen. Although there are undoubtedly benefits to a tailored, local approach, a lack of guidance on the essence of the mPower service was felt, by Implementation Leads in particular, to increase pressure on them. They felt this approach proved to be a barrier to effective service delivery and ultimately, making it more difficult to reach project targets. The lack of guidance on parameters and scope of roles was also reported to be a frustration for some local staff in later stages of the project.

In terms of targets, Project Board members and local mPower staff expressed frustration over a lack of clarity on what 'counts' as an eHealth intervention. A tension between the advantages of the flexibility of mPower and the difficulty in obtaining clarity was a reoccurring theme in interviews. The second key issue raised by local staff was the lack of preparation on a local level for the commencement of their roles.

7.6.3 Social, Ethical and Legal Aspects

Most interviewees considered the SEUPB funding and administration requirements to be overwhelming and unusual in comparison to their previous project experience. This was perceived by Board members and local staff alike as taking time away from the implementation work and strategic planning. The requirement to travel for project meetings was also cited as a difficulty by many, in particular those with other professional and personal commitments.

Procurement was a key obstacle, in particular for Northern Ireland and the Republic of Ireland. However, many of these challenges were overcome, with the pandemic being major a catalyst as eHealth was urgently needed, in particular virtual conference technology. On the ground, the main obstacles to implementation were local governance and decision-making procedures. This, again, affected the HSE deployment sites in particular as the centralised nature of eHealth delivery at national level sometimes added additional steps. This was overcome when a national ICT Programme Manager became more closely involved in the project and provided the necessary expertise, advice and navigation.

Furthermore, it was decided at the start of the project that no central database would be procured to capture data on beneficiaries. Instead, all sites used spreadsheets. This proved to be an ineffective way to capture data, resulting in discrepancies and a lot of time being spent capturing data in a manner that was reported to be onerous.

Due to difficulties, partly relating to Brexit, it also took a long time to prepare a data sharing agreement to enable data to be shared to the central team as well as the UHI evaluation team.

7.7 mPower Project Legacy

A concern often raised by local mPower teams and Project Board members alike was whether mPower would have a meaningful legacy. In particular, they raised concerns about the ability to embed Community Navigator type posts within their local systems. Third sector representatives also raised concerns about the burden they are potentially expected to bear in terms of carrying on some of the work mPower started, at the end of the project. Without an adequately funded and resourced local third sector, implementation of social prescribing and shifting it to 'business as usual' is not possible. mPower has however potentially built pathways that can be sustained longer term, provided the networks built are strong enough. Again, this is dependent on how embedded mPower is in the local health and social care structures, as well as the third sector.

There was general acknowledgement among participants that the legacy aspect had not been sufficiently considered from the outset. A key to ensuring a legacy for the project, is alignment with national strategy and policy. In the latter stages of the project there has been work done to try and ensure that aspects of the Community Navigator role become embedded across sites. Local teams have worked towards embedding technology through, for example, Community Digital Hubs.

7.8 Cross-Border Knowledge Exchange

Cross-border knowledge exchange presented both a key opportunity and a challenge for the project. Participants struggled to describe ways in which effective shared learning had taken place, although some acknowledged it had. However, even when opportunities for shared learning were available, the cross-border aspect of the project meant that learning was not always easy to transfer across areas. One member of local mPower staff acknowledged the particular challenge of having to implement ideas rather than practices due to the different jurisdictions. However, we saw evidence that Community Navigators working in each of the areas had developed informal support networks to compare experiences.

Despite the difficulties in applying shared learning across borders, the introduction of case studies to project assemblies was broadly welcomed by local staff as it provided a good platform to communicate about challenges and approaches to service delivery. The introduction of ECHO sessions also assisted in cross-border knowledge exchange.

7.9 Conclusions

Evaluation Question1: Does the mPower service meet its target numbers of eHealth and Wellbeing interventions?

This report has demonstrated that the mPower project has achieved its targets in terms of numbers of digital interventions (5,525), Wellbeing Plans (2,742) and instances of shared learning (1,353). There is some variability between deployment sites in terms of the numbers achieved. The highest overall numbers of eHealth interventions are in Ayrshire and Arran (1,722) and Dumfries and Galloway (1,116) with substantial numbers also in the Southern Trust (929) and HSE CHO1 (754). The highest number of Wellbeing Plans are also in Ayrshire and Arran (762) and Dumfries and Galloway (479), followed by the Southern Trust (437). The highest reach into the over 65s population is in Dumfries and Galloway (20%), followed by HSE CHO1 (14%) and HSE CHO8 (13%).

Evaluation Question 2: Does the mPower service support older people to live well at home for as long as possible?

We have shown that the project has achieved impact for beneficiaries, particularly in the areas of decreasing social isolation, increasing empowerment and increasing digital literacy, all of which can support living well at home.

Evaluation Question 3: What are the positive outcomes of the mPower project for patients, staff and service managers?

Qualitative evidence shows social isolation has decreased, empowerment increased and digital literacy increased. Across the questionnaire sample as a whole, approximately 20 to 30% experienced positive changes in the measures used with 18% reporting an increase in life satisfaction, 20% a decrease in loneliness and 21% an improvement in physical health. The questionnaire data shows that 72% of that sample also experienced increased confidence in their overall ability to self-manage their long-term conditions and 65% an increase in the digital technology confidence.

Evaluation Question 4: Does mPower effectively support self-management and/or decrease pressure on primary care?

Almost three quarters (72%) of the beneficiaries who completed the evaluation questionnaire reported that they felt more confident in self-managing their conditions overall following their involvement with the mPower project. In relation to the management of specific conditions, the greatest proportions reporting an increase in their perceived ability to manage the specific condition were depression (40%), chronic kidney disease (40%) and chronic pain (33%).

Whilst we have noted the important positive impact on benefits realisation of connection to primary care and the third sector, we have also descripted the challenges of forging these connections. Engagement with primary care was reported as being particularly taxing and it has not been possible to demonstrate whether mPower has reduced non-clinical appointments in primary care.

Our basic financial analysis suggested that costs of mPower interaction per beneficiary are lower than GP time, medication and psychology support.

Evaluation Question 5: Can any trends be seen in terms of beneficiary characteristics and associated outcomes?

Some long-term conditions and some deployment sites have much higher proportions experiencing positive change than the average. This report has described how the different contexts of the deployment sites have interacted with the generation of impact. The deployment sites of HSE CHO1 and the Western Health and Social Care Trust have the most instances of being substantially above average in terms of the proportion of beneficiaries reporting positive change (in the region of 50%). The deployment sites of Dumfries and Galloway and the Southern Health and Social Care Trust also have above average levels of beneficiaries reporting positive change (although the proportions are closer to 25-30%). Whilst the Western Isles has above average proportions of positive change in loneliness and physical health, it is just below average in life satisfaction. While HSE CHO8 is above average in proportions reporting positive change in loneliness and life satisfaction, it is substantially below average in proportions reporting a positive change in physical health (5%). The deployment site of Ayrshire and Arran is substantially below average in the number of beneficiaries within the evaluation sample reporting positive change across all measures: loneliness (8%), life satisfaction (7%) and physical health (9%).

It has been shown that depression was the one long-term condition which has a statistically significant positive change in quantitative measures. Depression, chronic pain and chronic kidney disease are the long-term conditions that most frequently report above average levels of positive change in the quantitative measures. Frailty and COPD are the two conditions that most frequently report much lower than average proportions of positive change.

We have highlighted the key roles of the mPower Community Navigators and Implementation Leads in the generation of positive outcomes. The Community Navigators took a flexible and adaptable approach to putting together Wellbeing Plans with beneficiaries. The ability to adapt the approach in line with the needs of beneficiaries demonstrated the considerable skillset of the Community Navigators. The qualitative work suggested that having a certain number of Community Navigators with finite capacity meant that not all areas of each of the deployment sites were covered equally.

Evaluation Question 6: What are the benefits of a central operational service across seven HSCPs and across borders?

The key benefits were seen to be the extended peer networks and shared learning opportunities that took place. At the Project Board level, it was also felt that the knowledge and experience across the seven sites was a key benefit of the mPower model. This, however, was dependent on effective communication. Although there are undoubtedly benefits to a tailored, local approach, a lack of guidance on the essence of the mPower service was felt, by Implementation Leads in particular, to increase pressure on them.

Evaluation Learning and Implications

The report has also highlighted some of the key challenges within the project and the implications and learning that can be drawn from these for other social prescribing and eHealth projects.

Whilst work has been done to ensure the legacy of mPower, fully embedding and mainstreaming the type of services started during the project requires consideration of **the lessons learned from mPower for wider technology enabled social prescribing and eHealth interventions.** Lessons learned from the mPower Community Navigators could be useful for policy level discussions on social prescribing as well as to the implementation of other schemes, such as the primary care Link Workers in Scotland:

- Highlight and disseminate the good work of the Community Navigators as without them outcomes would not have been achieved. This can help inform Community Navigator type posts beyond the mPower project. We have seen the importance of the relationship between the Community Navigator and the beneficiary in the realisation of positive outcomes. The Community Navigators were very much seen as meeting the needs of the beneficiaries.
- Three elements have been shown to be key to the realisation of benefits from community navigators' work: the time spent with the beneficiary, the visit to their home space and the manner in which the Navigator engages in a person-centred approach. For many beneficiaries, it was the interaction with the Community Navigator, in and of itself, that was the most consciously valued element of the project. It was often the kick-start that they needed to change behaviours.
- Recognise the benefit of the physical location (base) of Community Navigator or Implementation Lead type posts as we have seen the benefits of sitting within the same space as MDTs and/or primary care staff. In our interviews, staff reported lower numbers of referrals when they were not physically in the office due to the COVID-19 pandemic, meaning referrals from contacts that they were used to speaking to informally on a daily basis were not happening. Staff who were based within a hub with social work, integrated care teams and specialist nurses, for example, reported the benefit of this to getting referrals. Community Navigators based within the third sector also reported similar benefits.
- Where possible, Community Navigators and social prescribing services within a locality should work together, understanding the specialist nature of each one.
- The tasks of local project promotion, asset mapping and relationship brokering were time consuming for Community Navigators within mPower. A lot of Community Navigator and Implementation Lead time was reported as going into making the relevant connections within local communities to ensure that both referrals are made from primary care, and that the mPower teams are aware of which third sector organisations are out there to socially prescribe to. It is perhaps unrealistic for Community Navigators to be the fount of all knowledge on local opportunities. Systems such as open prescribing that asks third sector groups to sign up to being providers may help with this aspect; allowing Community Navigators to move from being individual sources of knowledge on local assets and towards a role as someone who knows where to look for knowledge.
- It is important to consider the staffing resource level of Community Navigators relative to the area and the population to be covered at the planning stage. Some concerns were raised about the safety of lone working and coping with difficult disclosures. The lack of formal debriefing systems with others in similar roles was a key issue.
- Several staff talked about capacity issues within the local third sector. It seems important to gain an understanding of this capacity before the implementation of a social prescribing project.

- Transport was also a much-cited challenge in terms of remote and rural beneficiaries being unable to easily access services. This seems to be a key challenge for the implementation of successful social prescribing in rural areas.
- Another key challenge was liaison with primary care. Project staff reported a disconnect between mPower and primary care clinicians and difficulty in engaging them with the social prescribing element of the project. A challenge for the future of social prescribing is to ensure that primary care staff understand the positive changes that can be achieved by social prescribing and promote their engagement with this type of service. Staff talked about it being difficult for primary care staff to make referrals due to time pressures and working patterns that can be hard to shift. Referral processes therefore need to be as streamlined as possible.
- Basic financial analysis suggests that a project like mPower can cost less than GP time, SSRI mediation and psychology support. This type of project can be particularly cost effective for those experiencing depression.

In relation to eHealth, mPower has shown the potential of 'low level' and 'off the shelf' technological solutions at a project level:

- Evidence suggests that health/care technology is not the only avenue to achieving the mPower outcomes – wellbeing and self-management can be promoted through things as simple as supporting someone to use a smart phone that they already own. We have seen the potential to realise desired outcomes through an increased use of technology for social connection – particularly to connect older people to activities remotely. This may be particularly appropriate in those areas where procurement and other challenges hinder the implementation of eHealth solutions. Connecting people socially may be less challenging in terms of bureaucracy and infrastructure but still realises the outcomes of increased wellbeing that projects like mPower seek to generate.
- Through guided, person-centred conversations, those in Community Navigator roles can also support the identification of appropriate eHealth and technological solutions for individual beneficiaries. There is the potential for a stronger connection between social prescribing and eHealth at a wider scale within the deployment sites.
- Several deployment sites also set up Community Digital Hubs. The hubs continued to run beyond the mPower project, thus contributing to its legacy
- Some sites felt having Community Navigators specifically focussing on digital support to be beneficial. While their role and approach mirrored that of Community Navigators, they were able to offer more specialised technological support.

The ECHO format has been a successful vehicle for sharing learning and peer support/safe debriefing opportunities. This type of support appears to be particularly useful for people in Community Navigator type roles.

In order to focus future activity on areas of greatest benefit to both patients and providers, integrated eHealth and social prescribing systems may profit from identifying and targeting frequent primary care users or those with particular conditions such as depression, which was the one long-term condition within the mPower quantitative sample that showed statistically significant improvements in health and wellbeing measures. Local teams see one of the key legacies of mPower as connecting communities to each other and to services. mPower has therefore potentially built pathways that can be sustained longer term, provided the networks built are strong enough. Again, this is dependent on how embedded mPower is in the local health and social care structures, as well as the third sector.

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9. Appendix

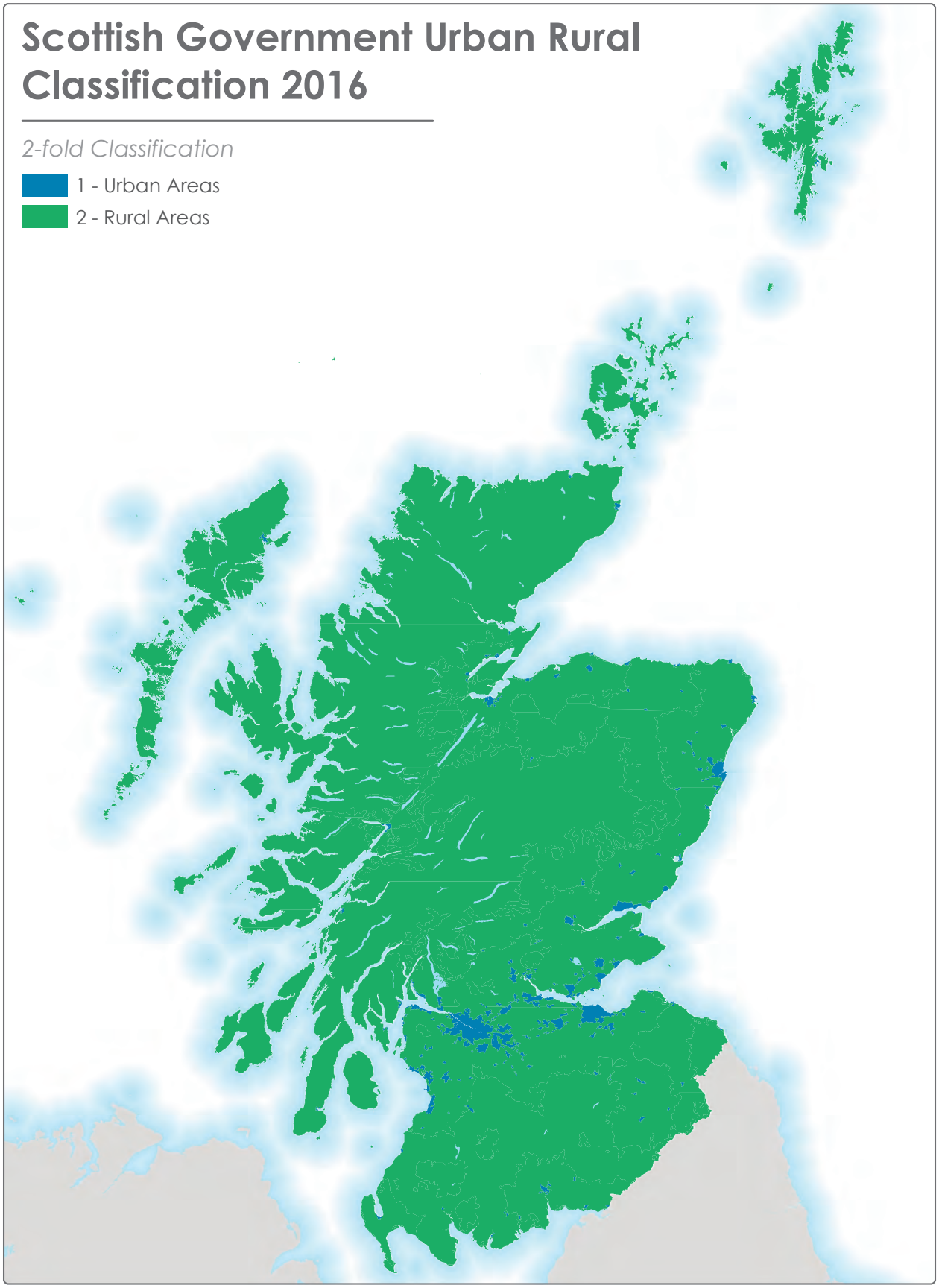
9.1 Scottish Government Urban Rural Classification (SGURC)

The Scottish Government Urban Rural Classification (SGURC) scale provides a standard definition of rural areas in Scotland; it is updated every two-years, and serves to improve the rural evidence base, including issues particularly impacting on rural communities, e.g. transport, education, health (Scottish Government, 2019a). The SGURC provides a consistent way of defining Scotland's urban and rural areas - the SGURC 8-fold Urban Rural Classification is shown in the table and map below:

Table 2.2: Scottish Government Urban Rural Classification, 8-fold

Class	Class Name	Description
1	Large Urban Areas	Settlements of 125,000 people and over.
2	Other Urban Areas	Settlements of 10,000 to 124,999 people.
3	Accessible Small Towns	Settlements of 3,000 to 9,999 people, and within a 30 minute drive time of a Settlement of 10,000 or more.
4	Remote Small Towns	Settlements of 3,000 to 9,999 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more.
5	Very Remote Small Towns	Settlements of 3,000 to 9,999 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more.
6	Accessible Rural Areas	Areas with a population of less than 3,000 people, and within a drive time of 30 minutes to a Settlement of 10,000 or more.
7	Remote Rural Areas	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more.
8	Very Remote Rural Areas	Areas with a population of less than 3,000 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more.

Source: Scottish Government (2018a: 5)



Source: Scottish Government (2018a: 11)

9.2 Single Older Household

The Scottish Household Survey (SHS) uses eight household definitions, of which "a single older household – contains one adult of pensionable age and no children. Pensionable age is 65 for both women and men" (Scottish Government, 2019: 33).

9.3 Scottish Index of Multiple deprivation (SIMD)

The Scottish Index of Multiple deprivation (SIMD) is the Scottish Government's official tool to identify areas of multiple deprivation in Scotland. SIMD is used to identify areas of poverty and inequality, and to help identify areas where investment is most needed. Based on various indicators of deprivation (grouped under seven domains: employment, income, crime, housing, health, education, and access) the SIMD ranks 6,976 Scottish data zones of roughly equal population (760 people per data zone), with data zone number 1 (most deprived) and data zone number 6,976 (least deprived). The type of information gathered under the domains includes benefit claims, crime rates, educational attainment, and distance of core services from peoples' homes. The domains are weighted so that employment and income have the greatest influence (SIMD, 2016).

It is important to note SIMD cannot be used to identify all people who are deprived, as not all those who are deprived live in a deprived area. For example, two out of three people who are income deprived do not live in deprived areas, while just under one in three of those living in a deprived area are income deprived (SIMD, 2016).

9.4 Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS)

The Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS) was developed to enable the assessment of a population's mental wellbeing. WEMWBS features a 14-item scale with 5 response categories, which are summed to provide a single score ranging from 14-70. WEMWBS is suitable for use for adults aged 16+. WEMWBS is not designed to detect mental illness; however, very low scores may indicate the need for clinical support (Warwick Medical School, 2018).

9.5 2016 Pobal HP Deprivation Index

The Pobal HP Deprivation Index enables a targeted approach towards tackling disadvantage in Ireland, through the identification of three dimensions of affluence/disadvantage: Demographic Profile, Social Class Composition, and Labour Market Situation. A score is given to an area based on a national average for zero, ranging between -40 (most disadvantaged) to +40 (most affluent) (Hasse and Pratschke, 2017).

9.6 Dependency Rate

In Ireland, dependents are defined for statistical purposes as persons outside the normal working age of 15-64. Ireland's age dependency rate thus gives a useful indication of the age structure of a population in an area, showing young (0-14) and old (65+) combined as a percentage of the normal working age (15-64) (CSO, 2019).

9.7 Northern Ireland Multiple Deprivation Measures (NIMDM)

The Northern Ireland Multiple Deprivation Measures (NIMDM) 2017 use seven domains of deprivation: income; employment; health deprivation and disability; education, skills and training; access to services; living environment; and crime and disorder. For each of the seven domains, as well as for multiple measures, the 890 Super Output Areas (SOA) in Northern Ireland are ranked from 1 (most deprived) to 890 (least deprived). SOAs are a new geography developed by NISRA to improve the reporting of Northern Ireland's small area statistics (NISRA, 2017).

9.8 Questionnaires

9.8.1 Wellbeing Questionnaire

QUESTIONS FOR WELLBEING PLAN BENEFICIARIES

To be completed by Community Navigator.

Date: _____

Was the questionnaire administered in person or over the phone?

☐ In person
☐ Over the phone

☐ The patient has been informed of the data sharing process.
☐ The patient has been given the fair processing notice.
☐ The patient has agreed to take part in the questionnaire.

How much time was spent with the beneficiary on this occasion? (Please provide answer in minutes.)

_____

Please answer on your first meeting with the beneficiary only:

Does the beneficiary live alone? Yes ☐ No

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Please answer on your final meeting with the beneficiary only:

How many actions did you agree the beneficiary would take as part of their wellbeing plan (e.g. taking part in activities in their community etc.)? Please also include eHealth interventions if agreed on as part of the Wellbeing Plan.

_____

How many actions out of these has the beneficiary taken by the end of their wellbeing plan?

_____

How many primary care appointments has the beneficiary attended since the start of the intervention?

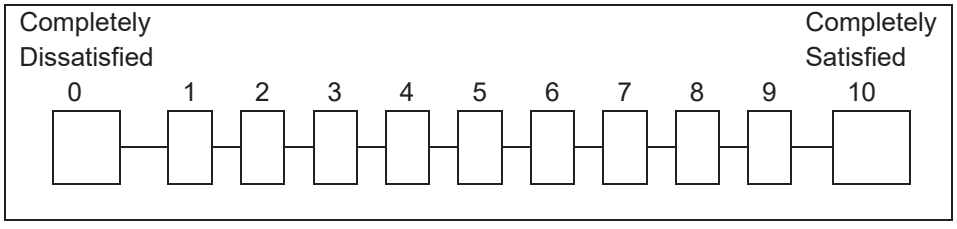
_____

Please read out questions 1-4 to the beneficiary on first, mid-way and final visit.

1. In general, how would you rate your overall level of physical health?

   ☐ Very good
   ☐ Good
   ☐ Fair
   ☐ Bad
   ☐ Very bad

2. Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole?



3. How often have you felt lonely in the past two weeks?

   ☐ All of the time
   ☐ Often
   ☐ Some of the time

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☐ Rarely
☐ Never

4. How confident are you that you can manage your long term condition on a general day-to-day basis?

   (Please ask for each individual LTC if applicable.)

   LTC 1: _____

   ☐ Not at all confident
   ☐ Not too confident
   ☐ Somewhat confident
   ☐ Very confident

   LTC 2: _____

   ☐ Not at all confident
   ☐ Not too confident
   ☐ Somewhat confident
   ☐ Very confident

   LTC 3: _____

   ☐ Not at all confident
   ☐ Not too confident
   ☐ Somewhat confident
   ☐ Very confident

Please read out question 5 on <u>final visit</u> with beneficiary only.

5. How has your participation in mPower contributed to your overall ability to manage your long term condition(s) on a daily basis?

   ☐ It has reduced my overall ability to manage my LTC(s)
   ☐ It has not affected my overall ability to manage my LTC(s)
   ☐ It has increased my overall ability to manage my LTC(s)

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9.8.2 eHealth Questionnaire

QUESTIONS FOR eHEALTH BENEFICIARIES, ONE-OFF VIRTUAL CLINICS

To be completed by Community Navigator.

Date: _____

Was the questionnaire administered in person or over the phone?

☐ In person
☐ Over the phone

☐ The patient has been informed of the data sharing process.
☐ The patient has been given the fair processing notice.
☐ The patient has agreed to take part in the questionnaire.

How much time was spent with the beneficiary on this occasion? (Please provide answer in minutes.)

_____

Does the beneficiary live alone?

Yes ☐ No ☐

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Please read out questions to the beneficiary after they have attended a one-off Virtual Clinic.

1. How much experience do you have in the use of digital technologies, such as Virtual Clinic services?

   ☐ A lot of experience
   ☐ Some experience
   ☐ A little experience
   ☐ No experience

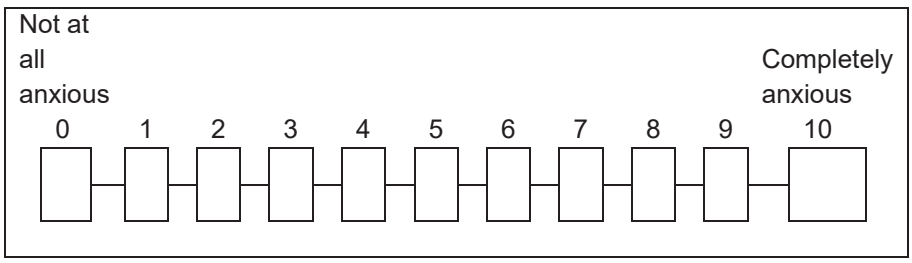
2. How confident do you feel in your ability to use digital technologies, such as Virtual Clinic services?

   ☐ Not at all confident
   ☐ Not too confident
   ☐ Somewhat confident
   ☐ Very confident

3. How do you think attending the Virtual Clinic will contribute to your overall ability to manage your long term condition(s) on a daily basis?

   ☐ It will reduce my overall ability to manage my LTC(s)
   ☐ It will not affect my overall ability to manage my LTC(s)
   ☐ It will increase my overall ability to manage my LTC(s)

4. On a scale where 0 is 'not at all anxious' and 10 is 'completely anxious', overall, how anxious do you feel right now?



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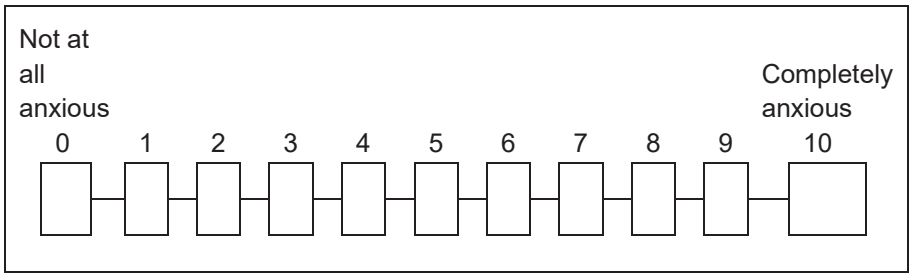
5. On a scale where 0 is ‘not at all anxious’ and 10 is ‘completely anxious’, overall, how anxious do you think you would have felt if you had to travel to get to this appointment?



6. How likely would you be to use a Virtual Clinic again if available?

- ☐ Extremely likely
- ☐ Likely
- ☐ Neither likely or unlikely
- ☐ Unlikely
- ☐ Extremely unlikely

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9.8.3 Virtual Clinic Questionnaire

QUESTIONS FOR eHEALTH BENEFICIARIES, ONE-OFF VIRTUAL CLINICS

To be completed by Community Navigator.

Date: _____

Was the questionnaire administered in person or over the phone?

☐ In person
☐ Over the phone

☐ The patient has been informed of the data sharing process.
☐ The patient has been given the fair processing notice.
☐ The patient has agreed to take part in the questionnaire.

How much time was spent with the beneficiary on this occasion? (Please provide answer in minutes.)

_____

Does the beneficiary live alone?

Yes ☐ No ☐

mPower is supported by the European Union's INTERREG VA Programme and managed by the Special EU Programmes Body (SEUPB).

Please read out questions to the beneficiary after they have attended a one-off Virtual Clinic.

1. How much experience do you have in the use of digital technologies, such as Virtual Clinic services?

   ☐ A lot of experience
   ☐ Some experience
   ☐ A little experience
   ☐ No experience

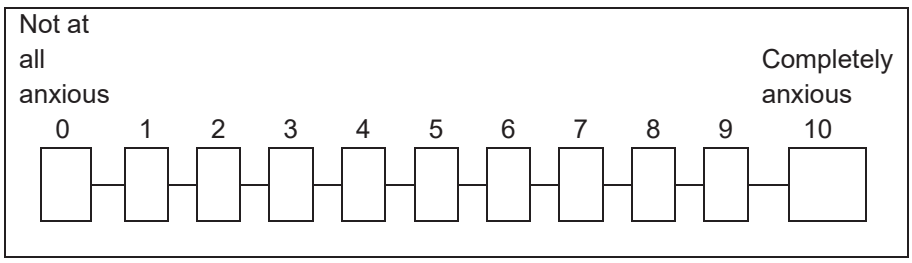
2. How confident do you feel in your ability to use digital technologies, such as Virtual Clinic services?

   ☐ Not at all confident
   ☐ Not too confident
   ☐ Somewhat confident
   ☐ Very confident

3. How do you think attending the Virtual Clinic will contribute to your overall ability to manage your long term condition(s) on a daily basis?

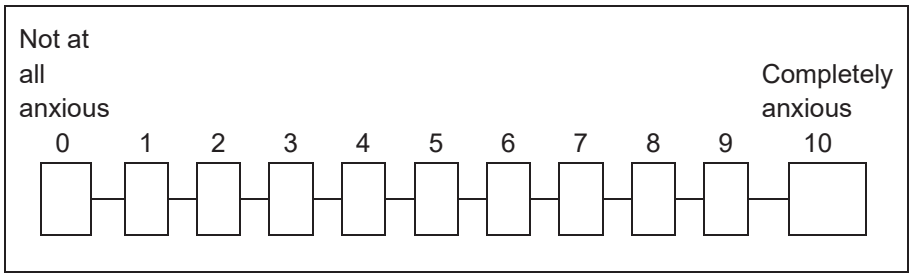
   ☐ It will reduce my overall ability to manage my LTC(s)
   ☐ It will not affect my overall ability to manage my LTC(s)
   ☐ It will increase my overall ability to manage my LTC(s)

4. On a scale where 0 is ‘not at all anxious’ and 10 is ‘completely anxious’, overall, how anxious do you feel right now?



mPower is supported by the European Union’s INTERREG VA Programme and managed by the Special EU Programmes Body (SEUPB).

5. On a scale where 0 is ‘not at all anxious’ and 10 is ‘completely anxious’, overall, how anxious do you think you would have felt if you had to travel to get to this appointment?



6. How likely would you be to use a Virtual Clinic again if available?

- ☐ Extremely likely
- ☐ Likely
- ☐ Neither likely or unlikely
- ☐ Unlikely
- ☐ Extremely unlikely

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9.8.4 eHealth Readiness Assessment Primary Care

eHealth Readiness assessment

PRACTICE/LOCAL PRIMARY CARE

Please indicate to what extent you agree with the following statements in relation to your primary care area by ticking or circling the appropriate box on the following scale:

1 Strongly disagree	2 Disagree	3 Don't Know	4 Agree	5 Strongly Agree

Cultural readiness for eHealth services

In my primary care area healthcare professionals and patients generally have a level of mutual trust that enables the exchange of clinical information between them.

1	2	3	4	5

In my primary care area patients and providers are willing to use ICT (e.g. computers, tablets, mobile phones) within a health service delivery context.

1	2	3	4	5

In my primary care area the underpinning culture embraces the use of technology within health services delivery

1	2	3	4	5

The need for eHealth services

In my primary care area in general, healthcare professionals would agree that there is a need for VC clinics

1	2	3	4	5

In my primary care area in general, patients would agree that there is a need for VC clinics

1	2	3	4	5

In my primary care area in general, healthcare professionals would agree that there is a need for self-management that is facilitated and/or augments by the use of apps by patients.

1	2	3	4	5

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In my primary care area in general, patients would agree that there is a need for them to utilise apps in the self-management of their own LTCs.

1	2	3	4	5

In my primary care area in general, healthcare professionals would agree that there is a need for self-management that is facilitated and/or augments by the use of home and mobile health monitoring by patients.

1	2	3	4	5

In my primary care area in general, patients would agree that there is a need for them to utilise home and mobile health monitoring in the self-management of their own LTCs.

1	2	3	4	5

Ensuring that the eHealth technology is user-friendly

In my primary care area the technology used in VC clinics will be user-friendly for patients.

1	2	3	4	5

In my primary care area the technology used in VC clinics will be user-friendly for healthcare professionals.

1	2	3	4	5

In my primary care area the technology required to use the apps will be user-friendly for patients.

1	2	3	4	5

In my primary care area the technology required to use the apps will be user-friendly for healthcare professionals.

1	2	3	4	5

In my primary care area the technology required to use home and mobile health monitoring will be user-friendly for patients.

1	2	3	4	5

In my primary care area the technology required to use home and mobile health monitoring will be user-friendly for healthcare professionals.

1	2	3	4	5

In my primary care area the introduction of VC clinics would not require an extended training process for patients.

1	2	3	4	5

In my primary care area the introduction of VC clinics would not require an extended training process for healthcare professionals.

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1	2	3	4	5

In my primary care area the introduction of apps would not require an extended training process for patients.

1	2	3	4	5

In my primary care area the introduction of apps would not require an extended training process for healthcare staff.

1	2	3	4	5

In my primary care area the introduction of home and mobile health monitoring would not require an extended training process for patients.

1	2	3	4	5

In my primary care area the introduction of home and mobile health monitoring would not require an extended training process for healthcare staff.

1	2	3	4	5

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9.8.5 eHealth Readiness Assessment Managerial

eHealth Readiness assessment

MANAGERIAL/STRATEGIC

Please indicate to what extent you agree with the following statements in relation to your primary care area by ticking or circling the appropriate box on the following scale:

1 Strongly disagree	2 Disagree	3 Don't Know	4 Agree	5 Strongly Agree

Leadership for eHealth services

In my primary care area there is one or several influential person(s) who will take(s) on a leading role in the deployment of the mPower eHealth solutions

1	2	3	4	5

Putting the patient at the centre of the eHealth service

In my primary care area healthcare professionals have been sufficiently involved in the development of the eHealth services.

1	2	3	4	5

In my primary care area patients have been sufficiently involved in the development of the eHealth services.

1	2	3	4	5

In my primary care area the eHealth solutions are appropriate to meet patients' needs.

1	2	3	4	5

Resources needed for the eHealth service

In my primary care area appropriate financial resources needed for the deployment of the eHealth solutions are available.

1	2	3	4	5

In my primary care area the IT competences needed for the deployment of the eHealth solutions are available.

1	2	3	4	5

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A project supported by the European Union's INTERREG VA Programme, managed by the Special EU Programmes Body (SEUPB)

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Paper | Supporting responsible forestry
FSC® C023105