

Marcello Bertotti *Editor*

Social Prescribing Policy, Research and Practice

Transforming Systems and Communities
for Improved Health and Wellbeing



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Foreword

Social prescribing is an essential set of interventions to reach and maintain well-being for all. It is a way to care for people's emotional and existential well-being through non-clinical activities including physical activity, arts and creativity, gardening and nature-based activities, social and support groups, healthy eating and other forms of social support to tackle employment and housing issues.

Finding meaning and fulfilment in life is possible when we consider the well-being and social determinants of health, specifically by creating and maintaining a dynamic and inspirational social environment, as well as finding balance and appreciation for nature. For instance, mounting evidence shows that art is critical to positive health outcomes alongside medical intervention.

Social prescribing is also a way to revitalise primary healthcare at the local level and encourage the growth of vibrant and healthy communities. This has been proven today through its uptake by many countries worldwide. More and more social prescribing interventions allow for effective returns on investment in healthcare, while systematically reducing the burden of long-term illness.

Social prescribing is also essential for establishing constructive and positive relationships between patients, their caregivers, link workers and a full range of health professionals. It provides a way to scale initiatives in favour of patient and community engagement, as seen in some hospitals where patients become partners and take an active role in long-term self-care, while sharing experiences with others patients and health professionals.

Social prescribing encourages inclusiveness, kindness, and inter-disciplinary approaches and places our capacity to express the best of human being at the centre of efforts to recover individual and collective health simultaneously.

Social prescribing facilitates the design and implementation of effective integrated health services where non-medical and medical needs are considered and equally valued at the same time. It is definitively part of the paradigm shift needed to consider each individual holistically and to develop our cohesive and caring humanity further. This book makes an important contribution towards that paradigm shift.

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Preface

Our health and well-being depend on much more than just doctors and hospitals. Despite greater advances in medicine which make us live longer, our health and well-being rely on social connections and building strong connections with others. Furthermore, while medicine has extended the lives of many, it has not benefitted everyone equally. Life expectancy and quality of life vary along a gradient, with those living in the most deprived areas often dying up to 20 years earlier than those in the least deprived areas. This disparity is primarily due to differences in socio-economic conditions.

Social prescribing aims to address these issues by connecting individuals to non-clinical activities and social support services available in the community. It does so through link workers who provide a flexible number of sessions to individuals experiencing social isolation and loneliness, mental illness, physical health challenges as well as social needs including employment, housing and debt advice.

This book explores social prescribing policies, research and practice in England, Wales, Ireland, Germany, Portugal, Canada and Singapore. It critically engages with these themes, examining the strengths and weaknesses of social prescribing across different countries.

Intended for a diverse audience, this book targets healthcare professionals; policymakers and commissioners; practitioners; link workers; professionals working in the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector; researchers; and university students (including medical students).

London, UK

Marcello Bertotti

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About the Editor

Marcello Bertotti, PhD, is a reader in community health and Deputy Director of the Institute for Connected Communities at the University of East London in England. He has 20 years work experience in the research and evaluation of community health interventions, social enterprise, asset-based approaches to health, and social prescribing. Marcello has led research projects for a range of national (e.g., NHS), regional (Greater London Authority) and local government (Redbridge council) institutions as well as UK research councils (NIHR, ESRC, AHRC) and is now leading the evaluation of a major European Commission-funded project using a social prescribing model to support young people in Italy and Portugal. Marcello has used a range of methodologies and approaches to evaluation including realist evaluation, social network analysis, asset mapping and used approaches to systematic reviews including meta-narrative and systematic mapping to study health interventions and communities. He is a co-founder of the international social prescribing network and of the social prescribing youth network. He also co-designed and co-delivered an accredited level 3 certificate in social prescribing.

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Abbreviations

Co-morbidities	It is defined as the presence of two or more chronic conditions (Fortin et al., 2007)
G-BA	Gemeinsamer Bundesausschuss (Joint Federal Committee)
Integrated Care Board (ICB)	Forty-two Integrated Care Boards exist in England and are placed in Integrated Care Systems (ICS). They came into force in England in July 2022, and they are NHS bodies responsible for delivering a plan for meeting the health needs of the population, managing NHS budget and arranging for the provision of health services in each ICS area which covers on average about 1.5m people. https://www.england.nhs.uk/integratedcare/ics-leadership/
IQWiG	Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (Institute for Quality and Efficiency in Health Care)
Link worker	This is an individual who can receive referrals from a wide variety of sources including GP practices, hospitals, local public sector agencies and other organisations and, following a flexible number of sessions with a client, refers them primarily to non-clinical activities delivered by the Voluntary, Community,

	<p>Faith and Social Enterprise (VCFSE) sector. Link workers have a range of skills and educational background and may work in General Practice, voluntary sector, secondary care or local public sector agencies. They are all generally equipped with empathetic and motivational skills that they use to support clients and may be termed as well-being coordinators, navigators, community connectors, referral facilitators and well-being buddies to name a few.</p>
Long-Term Conditions (LTCs)	<p>These include diabetes, hypertension, depression and anxiety amongst others. The management of LTCs requires a combination of medical, lifestyle modification and self-care.</p>
NVF	<p>New form of care (Neue Versorgungsform)</p>
OECD (Organisation for Economic Co-operation and Development)	<p>It is an international organisation that promotes policies to improve the economic and social well-being of people around the world. It has 38 member countries: Australia, Austria, Belgium, Canada, Chile, Colombia, Costa Rica, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, South Korea, Latvia, Lithuania, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Portugal, Poland, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, the United Kingdom, the United States.</p>
PCN	<p>Primary Care Networks, groups led by GP practices delivering primary care to a population between 30,000 and 50,000 people in England and Ireland.</p>
Primary care	<p>Primary care is a term used to describe the first point of contact or entry into the healthcare system for individuals seeking</p>

medical care, health promotion, disease prevention and basic medical services. It is typically delivered by healthcare professionals including general practitioners, family physicians or primary care doctors. It is a WHO recognised term.

SGB V

Sozialgesetzbuch Fünftes Buch (Social Code – Book V – Statutory Health Insurance)

Voluntary, Community, Faith and Social Enterprise (VCFSE) Sector

This is also referred to VCSE sector. This sector includes small informal voluntary sector organisations, medium and large voluntary sector organisations including charities, Community Interest Companies and social enterprises. Examples include cooperatives, credit unions, non-governmental organisations amongst others. It is also referred to as the third sector in many countries. In some chapters in this book the VCSE is also referred to the VCFSE which includes the Faith organisations (e.g., Church, Mosques).

Chapter 1

An International Perspective on Social Prescribing: Introduction



Marcello Bertotti

1.1 Setting the Scene

Consider Kevin and Shanti (fictitious names). Kevin, English, 54 years old, lives in one of the poorest urban areas of England. He suffers from back pain so decides to visit his local GP, John. Upon Kevin's visit, John realises that Kevin does not just suffer from back pain but he has lost his job 6 months before, lost many of his social contacts and started presenting symptoms of depression. However, John does not have time to talk to Kevin in much depth (only 9 min on average) and does not really know how to help Kevin apart from giving him medications for his back pain and refer him to a consultant for his mental health problems with the likely consequence of prescription of anti-depressants which can become addictive.

In a slightly different situation is Shanti, 70 years old, British and from Indian background. Shanti has lost her husband and her children have moved far from where she lives. She meets them twice a year. Shanti does not have social connections in the community and feels lonely and socially isolated. Because of this, she tends to visit her GP, Paula, more than she really needs as her health is generally under control. Paula does not know how to help Shanti with her loneliness as she does not know what social activities may be available in the community, how far these may be from Shanti's house and what is really required for Shanti to consider attending these. Paula, like her colleague John, does not have time to spend with Shanti and decides to send her to a lunch club which, unfortunately, is too far from Shanti and does not suit her taste. So, Shanti enters the 'revolving door' of visiting the GP practice once a week in an effort to connect with somebody and find a solution to her loneliness.

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These two fictional stories are not just confined to Kevin and Shanti but represent real situations for many people across different countries as it will be clearer in specific case studies available in some chapters of this book.

Social prescribing has grown out of the need to support Kevin and Shanti and others in similar situations. So, what is social prescribing? While the details of the history and policy development of social prescribing are discussed in detail in the chapter by Kerry Husk and James Sanderson (Chap. 2), in this introductory chapter we will set the broad boundaries of what social prescribing is in the recognition that it has been and continues to be a debated term. Although the practice of social prescribing may have a long tradition dating back some decades and available in many countries, the 'term' social prescribing was first developed in England. There are now many different models across several countries with multiple referral sources, but social prescribing has traditionally involved the presence of three main agents: A GP practice referring individuals with a range of needs (e.g. loneliness, social isolation, physical ill-health, mild to moderate mental health problems, but also social problems including housing, employment, debt) to a non-clinical link worker who makes contact with individuals, supports them, flexibly, on an equal footing to identify and access non-clinical activities and services primarily delivered by the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, but also the statutory sector, as required. For example, if Shanti and Kevin attend social prescribing, they can benefit from a referral to a link worker who can support them with finding activities and social networks in the community where they live and ones that are culturally appropriate for them.

Debates around the concept and definition of social prescribing have ensued over the years. The boundaries of the definition are posed as two opposite sides with many variations within them. For some, the term social prescribing may 'just' refer to the action of accessing non-clinical activities in the VCFSE sector. This means that if an individual attends an activity (e.g. art classes, walking groups, lunch clubs, music, dance, yoga, mindfulness) delivered by the VCFSE sector – that is labelled as social prescribing. On the other side of the spectrum, the term social prescribing describes a structured pathway that involves the referral of individuals between the three agents mentioned above, i.e., GPs or other referral sources, link worker and VCFSE sector. In the most structured models, individuals are accompanied by link workers to VCFSE activities.

Kimberlee (2015) firstly attempted to describe and systematise different types of social prescribing: from signposting, light, medium to holistic progressively emphasising the involvement of a link worker (albeit with a different name) to support individuals with health-related issues, but also drawing attention on models that support individuals holistically with their health and social issues (e.g. employment, housing, debt). Since then, social prescribing has experienced significant development in terminology. There are few relevant examples of this including the chapter by Carolyn Wallace and colleagues in this book on Wales (Chap. 5) who have developed a social prescribing glossary of terms, using group 'concept mapping' methodology, which is an integrated consensus method and involved a co-production between a range of stakeholders, including the VCFSE sector.

Very recently, Muhl et al. (2023) conducted a Delphi study to identify the conceptual and operational definition of social prescribing with the support of 48 experts from 26 different countries. According to this definition¹ and somewhat in line with the work of Kimberlee (2015), the link worker (i.e. connector) may or may not be present in social prescribing.

These definitional issues have almost always been discussed in relation to the notion that social prescribing is an intervention, scheme or a pathway. However, for many stakeholders involved in policy, research and implementation, social prescribing is also – or instead of – considered an ‘approach’ as it aims to widen the spectrum of opportunities available to the healthcare sector for the benefit of individuals’ health and wellbeing. For such stakeholders, social prescribing is much more than an intervention but the ‘Trojan horse’ (Dixon, 2016) to trigger changes in the health and care system in ways that will be explained below and in the rest of the book. The fundamental element of social prescribing as an ‘approach’ is the incessant search for social connections across services, people and their communities, networks as assets that can be organised and re-organised and shared to improve health and wellbeing. These cannot operate without the presence of a dynamic, well-resourced VCFSE sector which ultimately support individuals in their journey to recovery. As a result, many chapters of this book will mix the discussion of social prescribing as an ‘intervention’, with its discussion as an ‘approach’.

We recognise these different views, and in this book we have taken a pragmatic position that one of the fundamental elements of social prescribing is the presence of a link worker (sometimes called health facilitator, community navigator, wellbeing coordinator, connector, referral facilitator, health champion to name only a few different variations).

1.2 The Rationales for Social Prescribing

Shanti’s and Kevin’s stories discussed above are by no mean isolated cases. They can be contextualised by looking at different global trends which have underpinned the development of social prescribing. These include an ageing population, pressure

¹Social prescribing is “a holistic, person-centred, and community-based approach to health and wellbeing that satisfies Condition 1 and either Condition 2 or Conditions 3 and 4:

- Condition 1: Identifier identifies that person has non-medical, health-related social needs (e.g., issues with housing, food, employment, income, social support)
- Condition 2: Identifier connects person to non-clinical supports and services within the community by co-producing a non-medical prescription
- Condition 3: Identifier refers person to connector
- Condition 4: Connector connects person to non-clinical supports and services within the community by co-producing a non-medical prescription”.

on primary care,² an increased emphasis on prevention and integration of health and social care, stubbornly marked social and health inequalities and the need to build stronger communities. These are examined in more detail below and provide a backdrop to the rest of the book.

1.2.1 Ageing Population

Between 2015 and 2050, the proportion of the world's population over 60 years old will nearly double from 12% to 22% and the population over 80 years will treble (WHO, 2022). This change is more marked in high-income countries, but middle-income countries will also follow a similar trend (WHO, 2022). One of the most significant issues associated with ageing is the growing number of co-morbidities (e.g. diabetes and depression) and a more complex set of needs including multiple long term conditions. Long term conditions such as diabetes, for instance, have an important impact on annual deaths in the world. It has been estimated that in 2012, 620,000 people died of human violence (war and crime), 1,500,000 died of diabetes (WHO, 2012), leading the historian Harari to conclude that “Sugar is more dangerous than gunpowder” (Harari, 2016: 17). The prevalent view in the healthcare system is that most long-term conditions are untreatable so a different approach is required which focuses on ‘management’ rather than ‘treatment’ of long-term conditions which, in turn, requires a more coordinated set of professionals across sectors. Management of long-term conditions and coordination across sectors has been achieved by social prescribing through the linking of primary care with the VCFSE organisations operating in the community, which are ideally positioned for supporting people with managing their conditions over a period of time.

1.2.2 Increasing Pressure on Primary Care

One of the reasons for the interest toward social prescribing by those in health systems has been the need to alleviate pressure on primary care. Although data on the number of GP appointments across countries is difficult to measure and compare as the role of GP varies across countries (Clay & Stern, 2015), on average in 2021, GPs filled 23% of all doctor positions in the OECD. Portugal and Canada fared substantially better than average (47% and 48% of all doctors respectively), whilst other countries fared just above or below average (the UK and the Netherlands, 26% and 24% respectively, and Germany, 16%). Many countries have recognised that they

²Primary care is a term used to describe the first point of contact or entry into the healthcare system for individuals seeking medical care, health promotion, disease prevention and basic medical services. It is typically delivered by healthcare professionals including general practitioners, family physicians or primary care doctors. It is a WHO recognized term.

need to recruit more GPs as they are facing considerable shortages and are not able to attend to the ever-increasing number of appointments. Shortages are due to many reasons: In England, for instance, there are recruitment challenges due to poor pay when entering the profession, excessive workload, and early retirement is also a factor.

One of the reasons for the high number of GP appointments, for instance in England, is that a high number of visits to GP practices are for social rather than clinical reasons (Torjesen, 2016). This means that doctors find themselves supporting patients with a wider range of social needs that influence health and could (potentially) be handled outside GP practice appointments. In deprived areas where many social prescribing schemes operate, the number of GPs per patient is also lower which makes it more difficult to provide appropriate healthcare. At the same time, the average appointment with GP in England lasts 9 min and costs £39.23 (Curtis & Burns, 2022), which does not leave much time for GPs and the patients to discuss the details of health and social needs. If we consider that in 2017, the number of GP appointments in England was 340 million, and that a study by Clay and Stern (2015) estimated that social prescribing could contribute to avoid about 4% of GP appointments, the total avoidable cost for the NHS could be about £533 m. In addition to this, Hopkins et al. (2023) pointed out that increasing pressure on primary care is very likely to lead GPs to recommend and overprescribe drug-based interventions, such as anti-depressants which create dependency and have other unpleasant side effects.

The pandemic has only exacerbated these problems, particularly in relation to mental health issues with a rapid estimated increase in the prevalence of mental health disorders globally by 27.6% for depression and 25.6% for anxiety in 2020 (Santomauro et al., 2021). In this context, some evidence has shown that social prescribing, particularly through the work of link workers, is able to relieve pressure on primary care and work alongside healthcare staff in primary care to provide more effective support for people. Later chapters in the book will examine the role of primary care in relation to social prescribing in more detail.

1.2.3 Prevention and Integration Between Health and Social Support

Alongside an ageing population and pressure on primary care, it is important to recognise that our health – as measured in terms of life expectancy and quality of life – depends upon a wide range of factors including our own behaviour (e.g. smoking, drinking habits), the quality and access to clinical care (e.g. GP practices, hospitals), our socio-economic condition/status and the quality of our physical environment (e.g. housing, air quality). A range of studies have consistently shown that clinical care (i.e. treatment in primary, secondary and tertiary care) is one of the least important factors affecting our health and, instead, socio-economic factors

(e.g. education, employment, income, community safety, family links) followed by health behaviours are amongst the most important (McGinnis et al., 2002; Hood et al., 2016). In essence, our health is determined primarily by our socio-economic conditions, also known as social determinants of health, and our behaviour. Despite the greater importance of these factors, most resources are spent treating ill people in clinical and acute care rather than behaviour change and helping to address socio-economic needs. In 2014, the total budget of the NHS in England was £185b of which only 5.2% was spent on prevention (Buck, 2019). Martin et al. (2019) also calculated that expenditure on 'prevention' through public health grants would be up to four times more effective than expenditure on clinical care. With its emphasis on supporting individuals holistically (health and social support) and referring people to the VCFSE sector organisations operating primarily in delivering activities to local residents, social prescribing provides an important mechanism to prevent ill health, although it has primarily been deployed to manage care rather than preventing ill-health.

In addition to 'prevention', another important implication of the social determinants of health is that service provision needs to be integrated to better respond to individuals' multitude needs. In policy terms, this led to 'personalised care' and 'integration' between health and social care services. However, the term 'integration' has several connotations that can be relevant for social prescribing and are examined in more detail in this book. The term 'integration' can refer to a range of policy and practical ideas: from delivering integrated care to the individual to the integration of services at different spatial scales. For example, in England social prescribing link workers can participate in Multi-Disciplinary Teams (MDTs) to identify and provide solutions for individual needs. MDTs are made up of health-care staff (e.g. physio, nurses, psychologists, social workers and social prescribing link workers) that provide integrated solutions to an individual. The term integration, however, can also refer to integration of health and social services at the borough or sub-regional scale where representatives from different public sector organisations come together to identify synergies in the delivery of care. In England, these may include local authorities and primary care networks at borough/county level or at the sub-regional level such as Integrated Care Boards that pull strategies and resources together to identify synergies and common priorities over a number of local authorities or county councils. The chief aim of this level of service integration is to overcome 'silos' between services, improve communication and coordination between these to better respond to individual needs and maximise the result from the use of combined resources. Social prescribing can be seen as an example of practical implementation of integration where local public sector organisations come together to fund and implement social prescribing and where link workers enact integration by supporting their users' health and social needs through connecting/linking with existing provision/systems. This book will examine these themes in more detail in various chapters as integration is happening in various countries.

1.2.4 *Social and Health Inequalities*

A number of authors have analysed how the distribution of income across and within countries affect health and wellbeing over a considerable long period and across a range of countries (Margaret, 1992; Wilkinson & Pickett, 2010, 2018; Marmot, 2010, 2020). Wilkinson and Pickett, in particular, have shown across OECD³ countries and within States of the U.S., how differences in income inequality relate to a wide range of outcomes and symptoms. In essence, countries with wider income inequalities had worse performing mental health outcomes, higher drug use, poor physical health, lower life expectancy and higher obesity to name but a few. Reducing inequalities has become an important policy theme worldwide as the WHO has included it as Goal 10 amongst the Sustainable Development Goals (SDGs).

In England, the ‘Marmot review 10 years on’ (Marmot, 2020) showed that differences in life expectancy at birth between the least and most deprived areas in England have been remarkably consistent between 2001 and 2017, with health varying by location and socio-economic circumstance. In most deprived areas of England, life expectancy is 8 years lower than least deprived areas and considerably worse if we consider years lived in ‘good health’, with about 20 years difference.

With its emphasis on supporting individuals with both their health and social concerns (e.g. employment, housing, debt), social prescribing has traditionally been seen as contributing to address health inequalities. In practice, social prescribing is designed to meet whatever needs individuals present with which include issues deriving from the social determinants of health. In tackling these needs, social prescribing would also contribute to tackling health and social inequalities. However, as highlighted in the chapter from Koser Khan and Stephanie Tierney in this book (Chap. 3), some people experiencing disadvantage do not access social prescribing, an issue recognised recently by the NHS which introduced ‘proactive’ social prescribing, a targeted programme to improve access to social prescribing to a cohort with unmet needs (NHS England, 2022). Despite this, their chapter considers some of the key challenges and discusses some still unanswered questions in relation to the argument that social prescribing addresses health inequalities in England and beyond.

³OECD (Organisation for Economic Co-operation and Development): It is an international organisation that promotes policies to improve the economic and social well-being of people around the world. It has 38 member countries (see glossary for more info) which work together to address global challenges, share knowledge and develop and implement effective policies to foster economic prosperity, social progress and environmental sustainability

1.2.5 *Building Stronger Communities*

Social prescribing can also be seen as an approach that contributes to building and strengthening communities. It does this by connecting individuals with their communities, primarily through the work of the link worker in connecting individuals with activities in their community. By attending activities delivered by the VCFSE sector, individuals meet other individuals who live in their local area and build new social relations. More conceptually, it offers a complementary pathway focused on salutogenesis (Antonovsky, 1979) rather than pathogenesis and on the bio-psychosocial rather than the bio-medical model of health. The starting point for salutogenesis is that humans are inherently flawed and as such health and wellbeing need to be continuously and proactively sought. As such this model is different from pathogenesis which implies that an individual is well until they fall ill. The emphasis is on salutary factors which translate into actions that contribute to maintain and expand our wellbeing. As such the emphasis is on creating, maintaining and expanding the ‘assets’ that support our health and wellbeing. Assets are defined as “*any factor (or resource) which enhances the ability of individuals, groups, communities, populations, or social systems to maintain and sustain health and wellbeing and help to reduce health inequalities*” (Morgan & Ziglio, 2007: 18). Such factors may include skills, knowledge and commitment of community members, resources and facilities within the public, private and/or third sector and relations between stakeholders involved in the community (e.g., friendships, local groups, voluntary and community associations) (Foot, 2012). With its emphasis on ‘asset’ rather than ‘deficit’, the asset-based approach represents a counterbalance to the much more established deficit-based approach which assumes that individuals and communities do not have the necessary resources or expertise to address health problems themselves.

A recognition of the importance of communities and networks of social relations is the primacy of social prescribing in the UK Government Loneliness strategy as an approach to reduce the incidence of growing loneliness and social isolation in the country. Social isolation and loneliness are a particularly important issue. A large meta-analytic review showed that early mortality for social isolation is as high as established risk factors such as smoking and obesity (Holt-Lunstad et al., 2015).

In summary, social prescribing is an approach that can help to manage care through non-clinical activities delivered by the VCFSE sector, focused on aspects of salutogenesis, bio-psychosocial model of health, holistic, taking forward health service integration at different levels, particularly suitable to prevention and potentially contributing to build stronger communities. Table 1.1 offers a summary of the role of social prescribing in supporting the transformation of healthcare systems. We need to emphasise here the point that transformation does not mean excluding or moving away from conventional healthcare but the inclusion and integration of social prescribing with current primary, secondary and tertiary care. For instance, the greater focus on care close to patients, taking place in their community is additional to primary, secondary and tertiary care.

Table 1.1 The role of social prescribing in transforming health systems

	Traditional health system	Integrated healthcare system	Social prescribing role
Purpose	Diagnose and treat	Prevent, manage long term conditions ^a	Tackling health inequalities
Place	Primary, secondary, tertiary care	Primary, secondary, tertiary care but with greater focus on communities/home	Providing greater connection to community level via VCFSE sector and statutory support
Process	Health and social care are separate	Integrated, collaborative involves multiple stakeholders including VCFSE	Holistic (health and social, non-clinical); wide range of skills needed; link worker as key actor to operationalise integration
People	People recipient of care but have little say in the care they receive	People are partners, self-care if right support is in place	People are partners, flexible to the needs of users (light touch/ in-depth support); empowerment of individuals; based on a 'what matters' conversation
Conceptual approach	Bio-medical/ pathogenesis	Bio-medical and psychosocial	Psychosocial (social cognitive theory; attachment theory); social capital; salutogenesis; asset-based community development

Source: Chapter author

^aLong Term Conditions (LTCs): these include diabetes, hypertension, depression and anxiety amongst others. The management of LTCs requires a combination of medical, lifestyle modification and self-care

1.3 The Structure of This Book

Social prescribing is undergoing rapid spread and scale across the globe (Morse et al., 2022). As for 2023, at least 25 countries have introduced social prescribing at different levels (Khan & Chiva Giurca, 2023). It has become national policy in England, Wales and Ireland and other countries are working with their health system to consider the introduction of social prescribing. As discussed in more detail in the chapter by Kerry Husk and James Sanderson (Chap. 2), the NHS in England has recruited over 3000 link workers, as for mid-2023, and rolled out social prescribing nationally through Primary Care Networks (PCN) led by GP practices and providing services to an average of 30,000–50,000 people in each PCN (Sanderson & Watts, 2019). This number is even higher as social prescribing in England is not just provided by primary care but delivered by some local authorities, hospitals and other local and regional organisations beyond the health service. In Wales, the Welsh Government has also taken a keen interest on social prescribing, albeit with a different emphasis on the role of VCFSE sector, as it will appear clear from the chapter in this book from Carolyn Wallace and colleagues (Chap. 5). In Ireland, The Health Safety Executive has introduced social prescribing nationally in 2020, as David Robinson and colleagues explore in more detail in their chapter (Chap. 8).

Despite growing investment and policy interest, critical engagement with the concept of social prescribing, its evidence base, policy approach and practice are lacking in different ways. As a result, researchers from England, Wales, Republic of Ireland, Germany, Portugal, Canada and Singapore have come together to start drawing together the experience of social prescribing in these different contexts to critically engage with the key issues. For example, several government documents claim that social prescribing can address health inequalities. Yet, this claim has not been systematically tested. The chapter from Koser Khan and Stephanie Tierney will contribute to deepen the debate and highlight some ways forward (Chap. 3).

In order to provide some clarity and examine different dimensions of social prescribing, we have structured the book in three main parts: policy, research and practice. Each country developed their discussion around these three themes in order to provide a comprehensive picture of the development of social prescribing in their country. As England developed social prescribing earlier than other countries and has been evaluated more than other countries, the literature available enabled the drafting of a chapter for each of the three themes. Thus, social prescribing in England has a chapter concerning policy (Chap. 2), research (Chap. 3) and practice (Chap. 4).

The policy theme discusses the context in which social prescribing has developed in each country. For instance, the legislative framework in which social prescribing can develop often varies from country to country and between levels of government from local to national. As such, it becomes important to examine what adaptations social prescribing has had to make or should consider in order to adjust to different legislative and policy frameworks. In this respect, the chapter from Wolfram Herrmann and colleagues considers the challenges of development of social prescribing in Germany (Chap. 7). Similarly, Kheng Hock Lee and colleagues examine the policy context in which secondary care social prescribing has grown in Singapore pointing out the differences in secondary care infrastructure between acute and community hospitals (Chap. 10).

The research theme examines the type of research and evaluations that have been conducted in each country focused on different methodologies, specific themes (e.g. health inequalities) as well as the experience using technologies to monitor the journey of users through social prescribing. For instance, the chapter from Carolyn Wallace and colleagues (Chap. 5) discuss the development of a local monitoring framework in collaboration with Welsh service providers, whilst Marie Polley considers the range of outcomes that social prescribing has collected and should collect in the future (Chap. 4). Wolfram Herrmann and colleagues discuss different methodologies to evaluate social prescribing particularly the adoption of specific types of design to undertake Randomised Controlled Trials (RCTs) (Chap. 7). Kate Mulligan discusses the development of the evidence based in Canada including the contribution of the recently created Canadian Institute for Social Prescribing (Chap. 9). The chapter by Sonia Dias and colleagues reports on their experience of adopting mixed methods to evaluate social prescribing in Portugal (Chap. 6).

The ‘practice’ theme focuses on the ingredients that would make the implementation of social prescribing successful, including the discussion of implementation challenges. The practical development of social prescribing has also followed a historical trajectory in some countries where the first developers saw social prescribing as a way to develop new models. For instance, chapters from Singapore (Chap. 10) and the Republic of Ireland (Chap. 8) have focused on discussing policy and practical models of social prescribing in secondary care working with hospitals as referral sources for social prescribing and helping people who have been discharged from acute hospitals to access activities and services in the community. The chapter by Marie Polley discusses in detail the enablers and barriers of implementation of social prescribing (Chap. 4).

In order to create a link between discussions in the book and the actual lived experience of those people using social prescribing, we have also included some case studies of lived experience in each country to suit the specific target group of social prescribing there, similarly to Shanti’s and Kevin’s stories in this chapter.

1.4 Conclusion

Returning to the stories of Kevin and Shanti described in the introduction, social prescribing provides a complementary pathway to Kevin who instead of taking antidepressants (or at least alongside it) can be referred to a link worker who has a flexible number of hours (about 40 mins per session) to listen to Kevin’s needs and aspirations and, in collaboration with Kevin, can find solutions available through community organisations (re-establish social networks) and/or through local services to help Kevin to return to employment. In relation to Shanti’s situation, the GP does not have a solution to her loneliness. Referral to a link worker enables Shanti’s GP to find alternative solutions and access activities and support Shanti to establish new social networks. The link worker can meet Shanti in-person, in her home, and discuss at some length what activities Shanti may be willing to attend. Interestingly, an Indian-based community organisation organises walking groups near Shanti’s home. The link worker accompanies Shanti to the first walking group meeting as Shanti is a bit nervous about joining the group. It is important to note here that in both stories the link worker has in-depth knowledge of activities and services available locally, a skill that many GPs do not have as it is not part of their training.

We hope that this book will be useful to a range of audiences including health-care professionals, policy makers, practitioners (e.g. link workers involved in the delivery of social prescribing), professionals working in the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, researchers and university students (including medical students) in many countries around the world.

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Chapter 2

Social Prescribing in England



Kerryn Husk and James Sanderson

2.1 Introduction

Social prescribing is not new. It has existed for as long as family doctoring has existed; communities have always been at the heart of primary care and working alongside local communities to understand and develop health and wellbeing, a fundamental part of general practice. Social prescribing is also not a single, coherent entity but rather an idea. An idea that has been interpreted and implemented in diverse, diffuse, and myriad ways.

In this chapter, we chart the health and policy history that led to the ‘modern’ idea of social prescribing, the roll out of the link worker role through the NHS, and how practice has matched the intention. We will draw on practical examples to explore the benefits, tensions, and occasional drawbacks of social prescribing in the English context. We will also look at the key organisations, actors, and processes for delivering social prescribing, as they are understood in the English situation.

2.2 ‘Pre-modern’ Social Prescribing and Family Doctoring

Communities have always been at the heart of primary care and, whilst the geographies of delivery change relatively frequently in England, the local surgery has always been something of a community focus or hub. As such, general practitioners

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have always worked closely with those in the local area to understand, develop relationships with, and engage in activities that foster good health and wellbeing.

Individual practitioners often work closely with multiple generations of the same family, in the same place, and their support networks and so bringing the notion of local community assets and activities into consultations is a logical extension of those interactions. Below we describe formalised examples such as time-banking or exercise referral schemes, but actually a great deal of the interlinked working is much more nuanced and less structured and more relationship driven.

2.2.1 Community-Based Approaches to Health

If family doctoring has always reached into the community then it is also important – when considering the foundations of social prescribing – to consider the reach of communities into health services. Detailed knowledge about how to generate health and wellbeing in specific populations is often held within those communities themselves. A detailed description and examination of community-centred approaches is beyond the scope of this chapter and has been well documented elsewhere, but it is important to recognise the importance of empowering those in local areas to work alongside statutory services.

Community-centred approaches to health see communities as more than simply a setting for health services (South & Stansfield, 2023) and recognise that there must be an active and equal relationship that seeks to build empowered and connected communities. Indeed, in 2015, the then Public Health England published a report (South, 2015) in which they state that:

- Community-centred approaches seek to mobilise the assets within communities, promote equity, and increase people's control over their health and lives.
- There is a diverse range of practical, evidence-based approaches that can be used by local leaders, commissioners, and service providers to work with communities. These are grouped into: strengthening communities; volunteer and peer roles; collaborations and partnerships; access to community resources.

This diversity of approaches is important, and many will be familiar with approaches such as Asset-Based Community Development (Garven et al., 2016) or C2 Connecting Communities (Durie & Wyatt, 2013). Generally, these models take a strength-based (i.e. not deficit focused) approach and work alongside those in communities to facilitate, mobilise, and empower them to flourish. The phrasing moves from health being 'done to' communities, through being 'done for' or 'done with' and moves towards health being 'done by' communities themselves (Russell, 2020).

2.2.2 *Links to Formal Health Services*

This shift in focus and the placing of health services within and as an equal partner in communities to empower provides a critical backdrop to how social prescribing develops in England over subsequent years. The coming together of these two sides of the coin – the reach of primary care into and the co-working with community development activities – has not always gone smoothly. However, there has been significant development since around 1990 in formalising and solidifying these links into structured systems and pathways.

These links are not without their detractors; with some arguing (not unreasonably) that joining up these services medicalises social needs and harms those individuals, their communities, and the services that are subsequently overloaded. Linked, it is also possible that interjections from formal health services into community settings are somewhat paternalistic, again medicalising issues that are best approached by local residents themselves (Russell, 2017). Lastly, there are anecdotal reports from social prescribing projects that some would assert these pathways individualise and make communities responsible for health problems that are (at least in part) systemically driven.

What is presented above are actually over-simplified polar ends of an argument and hide much of the necessary and important complexity and nuance. The relationship between communities, the health services, and other system actors is much more intertwined and the power dynamics much less clear (Westlake et al., 2022). It is more useful to think of ‘pure’ community development and completely formalised ‘prescription’ of community activities as the ends on a continuum, where a vast majority of activities and programmes exist between these two points (Westlake et al., 2021). Indeed, positioning on this continuum often changes over time with the maturity of systems, the actors involved, and the funding structures all impacting significantly.

2.2.3 *Some Examples*

There are myriad examples of intersectoral working across health service and community-centred approaches and below we link to three, which give a good sense of how these two ways of thinking might work successfully and how there is often tension. These examples ‘pre-date’ more formal social prescribing being embedded in the NHS in England, so again they provide a useful backdrop to later sections.

EXAMPLE 1: Time-banking, see <https://www.community360.org.uk/get-involved/time-bank/>

EXAMPLE 2: Exercise referral schemes, see for example <https://www.nice.org.uk/guidance/ph54>

EXAMPLE 3: C2 Connecting Communities, <https://www.c2connectingcommunities.co.uk/>

2.3 Personalised Care in England

2.3.1 *The Move Towards Personalised Care*

In the preceding sections we outlined the foundations or principles from which social prescribing can be said to emerge; the links between community development, community-centred approaches to health, and the links with formal health services and systems. However, it is important to also trace the shift towards more personalised approaches to care in England. There are two main threads here: the more informal shift towards a patient-centred and personalised experience of health-care, and the formalisation of this shift into health policy.

The former represents a subtle, relatively slow shift away from clinical interactions resulting in an instruction or prescription to a more equal, balanced conversation reflecting an individual's needs, preferences and then co-developing a plan of action. This plan can include pharmaceutical, non-pharmaceutical, and other interventions as well as more general planning around lifestyle. The important mantra of this shift was to move away from asking 'what's the matter with you' and ask more 'what matters to you' in health interactions (NHS England, 2019).

The rationale for this shift was both political, with a drive towards giving people increased choice and control over their healthcare, and also rooted in evidence-based medicine and changes in approaches to primary care delivery that demonstrate the opportunity to change outcomes through shared decision making and improved skills knowledge and confidence in the patient (NHS England, 2019).

2.3.2 *Formalisation into Policy and Practice*

Social Prescribing was first formalised within the NHS as part of the NHS Long Term Plan published in 2019 (NHS England, 2018). However, prior to this there were two important policy documents mentioning social prescribing; the first being the Five Year Forward View (NHS England, 2014) which mentioned Rotherham as an emerging model, and which also evidenced reductions in emergency attendances, outpatient and hospital admissions. The other precursor was the General Practice Forward View (NHS England, 2016) which highlighted social prescribing as 1 of 10 high-impact actions to release system capacity as well as a key driver to personalisation and integration across health and social care systems.

Subsequently, as part of five major shifts towards a future NHS model, the Long Term Plan called for the expansion of Personalised Care to give people increased control over their health. The Comprehensive Model for Personalised Care set out a new approach to patient care that challenged clinicians to engage more effectively with patients through Shared Decision Making and by developing holistic Personalised Care and Support Plans which took account of the whole person. The Model also introduced new targets for Personal Health Budgets which shifted the

control of NHS resources to people living with certain health needs and further expanded approaches to self-care.

Social Prescribing was included as a major part of this shift, formalised as one of the six components of the comprehensive model, making England the first health-care system in the world to commit to the introduction of psychosocial interventions alongside biomedical approaches.

The Comprehensive Model was developed through extensive engagement and coproduction with people and communities across the country, through an approach which sought to harness best practice in the delivery of personalised healthcare. Whilst there were strong examples of innovative approaches being taken, these were somewhat isolated and fragmented. The pulling together of these various approaches into a single model enabled the collective commitment to support 2.5 m people through the model by 2024. Within this commitment, the introduction of the role of the Link Worker and the target for 900,000 people to benefit from Social Prescribing by 2024 put social prescribing right at the heart of a future NHS model.

2.3.3 Integration with Community Approaches

There are clear links with the principles underpinning personalised care outlined here and those detailed in earlier sections around community-centred approaches to health. Putting those who will be central to and those with the most direct experience of their circumstances and needs at the forefront of health decision making is at the core of both. There are repercussions from the coming together of these ways of thinking, including increased discussions around practical delivery using tools such as asset mapping (Kramer et al., 2012) and the ties to other statutory services and local authorities (Pescheny et al., 2018). Again, it is beyond the scope of this chapter to consider future developments in joint working between primary care and public health teams, but the utility and use of processes like joint needs assessments in developing programmes becomes clear.

2.3.4 Some Examples

Below we present two examples of personalised care from both policy and practice which go some way to illustrating the issues raised in these sections:

EXAMPLE 1: Realistic Medicine in Scotland, see <https://www.realisticmedicine.scot/>

EXAMPLE 2: Rethinking Medicine in England, see <https://rethinkingmedicine.org.uk/>

2.4 Social Prescribing and the Social ‘Movement’

So far, this chapter has described the threads that come together into a modern understanding of social prescribing. A shift in primary care towards community-centred approaches alongside a policy, a practice shift towards more personalised care means that the political and health service landscape was primed for something that looks like social prescribing. In describing what comes next, we make a distinction between social prescribing as a social ‘movement’ and social prescribing as a formal policy being implemented and rolled out. The movement was (and is) a distinct group of early adopters, champions, and policy lobbyists who made the successful case for developing social prescribing as a coherent entity in England. Concurrently, and often involving the same people, there was a solidifying in health policy around what social prescribing might look like and how it could be scaled up.

Before examining these two phenomena in detail, it is important to consider what we really mean when we talk of social prescribing. There are multiple, overlapping but not coterminous definitions and we would point readers to that developed by the Social Prescribing Network (The Social Prescribing Network, 2016), very recent work developing consensus amongst worldwide experts on definitions (Muhl et al., 2023), and that developed by the Wales School for Social Enterprise Research (for more details see chapter by Wallace et al., in this book). As we stated above, we would argue that social prescribing is not a coherent thing, but rather an idea and an idea that has been interpreted and implemented in diverse ways. However, and as we have argued elsewhere (Hazeldine et al., 2021; Husk et al., 2020), any conceptualisation of social prescribing should reflect that it is constructed of a series of relationships between services and individuals that make up a pathway that people then experience.

At its core is the notion that individuals move from a place of need, through services, and via personalised conversations to activities and assets in local communities that seek to address the specific needs of that individual. There are, we would assert, four core components that must be present in order for us to think of a programme as (a modern version of) social prescribing:

- An individual with a ‘need’, often involving mental ill health symptoms, or social needs.
- A referral function, often primary care based but could also be, for example, a school.
- A linking function, often a link worker funded through the NHS rollout, but could also be based in the VCFSE or elsewhere.
- Community activity, which can be myriad – firstly grouped by the National Academy for Social Prescribing into four distinct zones: ‘nature-based’, ‘physical-activity based’, ‘arts and culture based’, or ‘knowledge, learning, and advice based’ (National Academy for Social Prescribing, 2023d). But also, importantly, including access to employment, housing services, or debt advice all often offered by statutory sector organisations.

2.4.1 *The Rise of a Social Movement*

As alluded to above, the move towards a more concrete and formal social prescribing in England was, arguably, driven in large part by a coherent and powerful social ‘movement’ that grew up around the approach. Given that the ideas underpinning this modern form of social prescribing are not new, there have always been those that have championed such approaches. These individuals have sought to lead a social movement and ultimately have social prescribing adopted into statutory health services both in England and more widely (The Social Prescribing Network, 2016).

The number of individuals involved in this movement are great, however it is worth noting and citing the work of Marie Polley and Michael Dixon; who created and developed the Social Prescribing Network with support from NHS England (led by Bev Taylor). This is an influential collective of people who have been successful in obtaining grants, holding events, coalescing ideas, and communicating and ultimately influencing national policy. The Network has been fundamental in defining, communicating, and championing social prescribing in England.

2.5 Investments in Social Prescribing

The various threads – political, policy, social movement, and lobbying – began to solidify in England around 2016/2017 and what we now see as the modern incarnation of social prescribing emerged. At this point what existed was informal, with link workers funded through myriad routes and often cited in the VCSE. Whilst social prescribing was happening, it was not in any way joined up or centrally funded (though of course we are not asserting this is necessarily a negative).

In 2018, this changed. The Department for Health and Social Care launched, through their Health and Wellbeing Fund (part of the voluntary, community, and social enterprise (VCSE) Health and Wellbeing Programme) and invested close to £4.5 m into 23 projects across the country (Department of Health and Social Care, 2018). These projects aimed specifically to “reduce health inequalities by building the evidence base around good practice in social prescribing, sharing lessons and widening adoption of practices that are proven to work”.

This was a significant investment by central government into social prescribing. Importantly, these projects were to be fully funded through the scheme in their first year but with joint funding from local commissioners through the subsequent 2 years. Given social prescribing necessarily crosses organisation and often sectoral boundaries, this sets the scene for a complex funding landscape.

2.5.1 The Long-Term Plan and Universal Personalised Care

Building on this initial investment, social prescribing began to be seen as more central to delivering health services and specifically personalised care. The NHS Long Term Plan (NHS England, 2018), published in 2019, marked the first real embedding of these programmes into central health policy. However, unlike the funding described above the commitment from the NHS was to fund and roll-out the link worker role in primary care, stating that by 2024, every GP practice in England would have access to one of these workers.

In England, primary care is now organised into Primary Care Networks (PCNs), groups of GP practices that serve, on average, a population of 30,000–50,000. Each of these PCNs has the ability to draw down funds for a set of roles through the Additional Roles Reimbursement Scheme (ARRS)(NHS England, 2023). Social prescribing link workers are one of these additional roles, therefore in principle each of the PCNs in England will have a link worker as part of that workforce. This places both social prescribing and the dedicated link worker role at the heart of primary care and represents a step-change in the level and robustness of investment across the country.

As of mid-2023, over 5 m people have benefited from a range of approaches to Personalised Care with at least 1 m people accessing Social Prescribing through a network of over 3000 Link Workers (internal NHSE/I communication).

2.6 The Link Worker Roll-Out in England

The link worker roll-out through the Long Term Plan and PCNs is only one piece of a rapidly shifting and developing landscape. The ‘new’ link workers were additional, in most respects, and had to fit into a complex, nuanced, and often opaque system of social prescribing delivery at a time when there were increasing pressures on services and significant changes in population needs (Hazeldine et al., 2021; Tierney et al., 2020). It is also worth highlighting that even across PCNs, there is significant variability in the commitment to, treatment of, and implementation of the link worker approach to social prescribing, with little systematic data to capture this complexity.

There is a growing literature around implementing the link worker role in England, with a divergence between the intended scope and scale of the role and the reality. It is beyond the scope of this chapter to consider these issues in depth, however the following points are frequently raised (see, as above, both Tierney and Hazeldine (Hazeldine et al., 2021; Tierney et al., 2020)):

- Integration with existing programmes and roles: ARRS/PCN funded link workers find themselves immediately navigating a system involving the VCFSE and statutory services, including link workers that are funded through different routes and often have subtly different remits.

- **Intended scale and scope of the role:** Whilst the intention was for link workers to engage in symptoms related to mild to moderate mental ill-health and link to relevant community assets to alleviate those symptoms, the reality is that link workers are often engaging with those with more severe symptoms and sometime in crisis. Additionally, link workers often report needing to engage with more pressing concerns, such as housing or food, before other areas (these issues can be explored in more depth using the Social Prescribing Observatory Data (Jani et al., 2020)).
- **Location and integration with primary care:** Being co-located in primary care with dedicated space is often preferable for link workers and go some way to validating and integrating the role. However, in practice this is not always possible and is driven by pragmatics such as availability and proximity of space.
- **Access to and use of training/development:** Given the complexities above around role location and funding route, it is often the case that link workers in different places have variable access to training and career development. There is progress in developing a coherent training package for all link workers and this is welcome but lagged behind implementation of the role.

2.7 Emerging National Bodies

Given this rapid scaling of social prescribing through projects, programmes, and the dedicated roles, there was (unsurprisingly) at times a lack of coherence at anything other than local geographies. The networks of relationships that function to make social prescribing work (Husk et al., 2020) were communicated locally and often regionally through self-emergent networks (for example link worker meetings, provider networks, and similar); however, at a national level it took longer to coalesce. At the time of writing (2023), this is an area that is developing rapidly but below we detail the main strands of national level join-up as they stand and the key organisations that are involved. These are in addition to the pre-existing and well-developed Social Prescribing Network that we detail in preceding sections.

2.7.1 *The National Academy for Social Prescribing (NASP)*

In late 2019, the National Academy for Social Prescribing was set up using an investment of £5 m of government funding (Department of Health and Social Care, 2019). NASP is a national charity and brings together stakeholders such as NHS England, NHS Improvement, Sport England, Arts Council England, and a range of voluntary sector partners. The stated goals for the organisation are to (National Academy for Social Prescribing, 2023c):

- Support the grassroots groups and national charities who offer socially prescribed activities.
- Connect the health system to the incredible work that's happening in communities.
- Help medical professionals, including Social Prescribing Link Workers and students.
- Work with leading researchers to build more evidence for social prescribing.
- Develop effective new approaches to common problems.
- Champion social prescribing across the world.

In the 4 years since inception, NASP has worked to raise the noise levels for social prescribing by amplifying the activities of local community groups in supporting people to live healthier lives. Through their Thriving Communities Programme, NASP worked with National bodies including The Arts Council, Sport England, Natural England, and NHS England to commission a major community initiative connecting separate organisations across the 'zones' of social prescribing. NASP also supported the development of Global Social Prescribing Alliance which has encouraged collaboration across boundaries to share knowledge regarding the establishment of Social Prescribing Practices within healthcare settings. Alongside this, the development of an academic partners collaborative has served to increase the evidence base for many aspects of social prescribing practice. The success of NASP as an independent body supporting the roll out of social prescribing has seen the development of similar approaches being taken in other countries including the development of the Canadian Institute for Social Prescribing.

2.7.2 National Association of Link Workers (NALW)

Much of social prescribing, in policy and practice, is centred on the link worker. As we described above, this is not a new role but has become more formalised and better entrenched in statutory services since around 2018 in England. With the Long Term Plan (NHS England, 2018) came the rapid expansion of the role into each Primary Care Network and the roll-out continues at the time of writing. Formed in 2019, the National Association of Link Workers (NALW) was the first, and currently only, professional body for social prescribing link workers. A social enterprise, the organisation aims to: "promote the role and value of Social Prescribing Link Workers, support and develop them to improve quality of life for themselves, their clients/patients, and communities"(National Association of Link Workers, 2023).

2.7.3 All Party Parliamentary Groups (APPGs)

Policy relating to social prescribing largely relates to two distinct areas: (i) the social prescribing ‘pathway’ that we described above and including the referral, link worker role, and health systems involved; (ii) the activities that are offered as part of a social prescription, often grouped into the four zones described previously (nature based, physical activity, arts based, and advice).

As of 2023, there are two relevant All Party Parliamentary Groups that directly relate to social prescribing. Firstly, convened by NASP, is the All-Party Parliamentary Group (APPG) on Health and the Natural Environment (National Academy for Social Prescribing, 2023a) which investigates the connections between the natural environment and human health. This group has heard evidence presented from academia, policy and voluntary sector organisations, as well as practice examples from a wide range of sectors. Secondly, convened by The National Centre for Creative Health (NCCCH), is the All-Party Parliamentary Group on Arts, Health, and Wellbeing (Culture, 2023); which has explored a similar range of issues and also produced the 2017 enquiry report on creative health (All-Party Parliamentary Group on Arts, 2017).

2.7.4 The Green Social Prescribing Pilot

With the social prescribing roll-out described across covering the pathway elements, there has been renewed interest in developing, learning, and scaling the ‘zone’ activities outlined above. Probably the most prominent of these has been green social prescribing, or any social prescription that includes an activity based in the natural environment. There is already a well-developed evidence base for the impact of nature-based activities on health and wellbeing (Garside et al., 2020; Husk et al., 2016), however less well developed around introducing these sorts of activities into formal social prescribing pathways.

At the end of 2020 and into 2021, the government invested £5.77 m into seven test and learn sites across England which are to “explore and bring together opportunities for communities to get involved in their natural environment”(Department for Environment, 2020). Learning from these sites and the concurrent evaluation programme will feed into the green social prescribing roll-out nationally.

2.7.5 NASP Evidence Summaries

Unlike a great deal of other initiatives, social prescribing was scaled and implemented without a highly developed evidence base but rather based on prior linked work and political traction. In the early stages of the roll-out, and given the diversity

of approaches, implementation, outcomes, and cohorts for which social prescribing is relevant – as well as myriad methodological complexities – high-quality evidence was slow to emerge (Husk et al., 2019).

There has been a steady increase in the number of studies published relating to social prescribing in England from 2015 onwards, rising sharply from 2018. This meant there was a large body of studies for policy makers and practitioners to sift in order to keep abreast of the latest research.

As such, in 2019–2020 the National Academy for Social Prescribing formed the International Evidence Collaborative (National Academy for Social Prescribing, 2023b) made up of core academic partners, whose first task was to undertake prioritisation of topics related to social prescribing and generate rapid evidence summaries and policy briefings on these topics. Throughout 2021–2023, 15 evidence summaries were produced relating to areas such as funding models, appropriate outcomes, demographics, and accessibility (all found here: <https://socialprescribingacademy.org.uk/read-the-evidence/>).

2.7.6 Other Research and Pipeline Studies

The evidence summaries provide a snapshot of the evidence base as it stands. However, the number of studies is increasing still and there are numerous large studies still underway and due to report in 2024–2025. For example, the National Institute of Health Research commissioned an evaluation of the link worker role (National Institute for Health and Care Research, 2022), which will “map current provision and service configuration and to assess whether access, engagement and outcomes vary by delivery model, geography and population characteristics over time”. There are also myriad studies assessing the effectiveness and implementation of the four zones of activities, including the green social prescribing evaluation mentioned above and funded randomised controlled trials of green activities.

The development of this evidence base is critical to understanding how social prescribing might best be placed to be of most use to those most in need, at the right time and place to be appropriate. As we detailed at the outset of this chapter, social prescribing is not a coherent thing but rather an idea that has been interpreted and implemented in different ways. As such, evidence relating to social prescribing relates to specific points in the pathway, or specific cohorts or activities as part of that pathway. Putting this jigsaw of studies together is challenging but essential.

2.8 The Future: Some Thoughts

We have outlined the various threads that came together in England to provide a platform from which a modern version of social prescribing was launched; from the shift towards community-centred approaches to health and to the developments in

personalised care. We charted the social movement associated with social prescribing and the integration into core health service policy, as well as the significant investments made by the government in England from 2017 onwards. We described the roll-out of the link worker role in primary care, the national bodies that have emerged seeking to coalesce thinking on the topic, as well as the growing evidence base.

All this is well-documented, and we are now in a position where social prescribing as an approach is here to stay in English health policy and practice. But where might there be developments? Where are there opportunities for refining services and delivery? Below, we set out some thoughts – and they are just thoughts – about where we think the practice of social prescribing might develop next:

- **Funding:** Funding has been the most controversial, most uncertain element of the roll-out in England. Funding elements of the pathway, the activities, and how and in what ways these funds travel with individuals as they navigate various organisations and services has been problematic to say the least. There are reasons to be optimistic, however. There are new funding routes coming online that apply more broadly than the link worker role, travel, and equipment (for example, NASP's Thriving Communities Fund). It is important to recognise though that the scale should match the policy and practice demand, whilst things such as the Thriving Communities Fund are steps in the right direction, they are an order of magnitude too small to sustainably invest in the groups needed to deliver SP at scale.
- **Health inequalities:** Much has been written about the potential for social prescribing to reduce or work towards reducing health inequalities, which makes sense given the work that link workers engage in. However, it is currently not certain how much this is the case (Cartwright et al., 2022) or in what ways pathways might be developed to reach those most in need. Work in this area is developing rapidly and is potentially one of the most important areas on which evidence should be generated (also see the fantastic work done by the Social Prescribing Observatory (Jani et al., 2020). These arguments are set out in much more detail in the chapter in this volume by Koser Khan and Stephanie Tierney.
- **Targeting and specific cohorts:** There is significant work being done to assess how social prescribing might function for specific groups and respond to specific needs. We know, for example, that social prescriptions have to be implemented in subtly different ways to be most appropriate for children and young people (Bertotti et al., 2022), those with autism or learning disabilities (Featherstone et al., 2022), older people (Tierney et al., 2022), and in areas experiencing significant social isolation and loneliness (Bertotti et al., 2020).
- **Relatedly,** there is a need for comprehensive and robust mapping of provision at a national scale. Whilst this would be a significant undertaking, understanding how many link workers, across which models, where, and using what funding would allow for more coherent and nuanced planning into the future.
- **Global developments:** Social prescribing is not unique to England – far from it – and so there is a growing movement seeking to understand the ways in which

social prescribing has been interpreted and implemented in different contexts, and the ways in which this community can learn from one another, share best practice, and communicate what works, see for example (Morse et al., 2022). Indeed, this book is another step along that path.

- Lastly, and more philosophically, those in policy and practice need to work through and articulate where the community sees the role of social prescribing to be in the future. There are good arguments that moving away from health service scaffolding and placing pathways more in communities themselves may be appropriate, or whether to blend these more community-based pathways with those dovetailing with primary, secondary, and specialist health services is more useful.

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Chapter 3

The Role of Social Prescribing in Addressing Health Inequalities



Koser Khan and Stephanie Tierney

3.1 Introduction: The Role of Social Prescribing in Addressing Health Inequalities

We start this chapter by describing what is meant by ‘health inequalities’ before outlining and reflecting on assumptions around social prescribing’s role in tackling these challenges. We also present an overview of the evidence on this topic. We conclude by raising points for consideration when discussing social prescribing’s contribution to addressing social determinants of health – contextual factors such as work situation, income, housing, community surroundings, and social support that underpin health inequalities. We draw on practice, policy, and research in the UK, as this is the location of our work. However, the messages in this chapter will have resonance for other countries.

3.1.1 *What Do We Mean by Health Inequalities?*

The term ‘health inequalities’ is used to describe unjust and avoidable differences in levels of illness, mortality, and well-being between groups of people or communities; it can include differences in access to and experiences of care, and opportunities to engage in positive health behaviours (Williams et al., 2022). These inequalities may be due to life stressors people encounter and their impact on health. Issues such

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as unemployment, domestic violence, poor housing, and lack of social support may affect health directly due to problems such as anxiety or respiratory difficulties. It can also mean that people do not undertake preventative health measures (e.g. through diet and exercise) or do not engage in medical treatments if they have an established condition, as their priority is on surviving (Fiscella & Shin, 2005). Furthermore, health inequalities can encompass struggles that people face navigating service provision and knowing what path to take to receive support with their specific needs (e.g. where to go if they have housing issues or queries about securing welfare benefits) (Popay et al., 2007).

3.1.2 An International Priority

Health inequalities can be present between countries (WHO, 2014), but also within; for example, data from England showed that people living in the country's most deprived areas were diagnosed with serious illness earlier, were more likely to have multiple health conditions, and died sooner than those in more affluent parts (Watt et al., 2022). In 2005, the World Health Organization convened a Commission on the Social Determinants of Health. Its report (CSDH, 2008) highlighted an aim to tackle, on an international level, social and economic inequalities present within and between countries. It proposed the need to (a) improve daily living conditions (from children's early life through to enabling people to flourish in older age), (b) address factors contributing to the unequal distribution of resources (including power and money), and (c) further understand the problem and raise public awareness of it, through assessment and measurement.

3.1.3 The Marmot Review

The role of socioeconomic circumstances in determining health and well-being is not a new idea. The Black report, published in 1980, highlighted how inequalities in health in the UK could be attributed to social factors such as people's income and education level, housing, and employment conditions. It recommended greater spending on community health and primary care and the need for increased child benefits, better housing, and improved working conditions. Health inequalities came to prominence again in the UK following a review, led by Michael Marmot, published in 2010. It highlighted how decisions made on issues such as tax and benefits and austerity contributed to inequities within and across populations. The review stated that where individuals are born, grow, live, and age shapes their health and well-being. The COVID-19 pandemic underscored the serious impact of these social determinants of health, with higher mortality rates from the virus in certain groups based on ethnicity, deprivation, and occupation (Marmot et al., 2020a).

3.1.4 NHS Policies

The Marmot Review (Marmot et al., 2010) and follow up reports (Marmot et al., 2020a, b) have underpinned policy in the UK. For example, NHS England's (2019) Long Term Plan centred on the need for more action on preventing and tackling health inequalities to enable people to live well for longer and to reduce demand on health services. An emphasis on personalised care formed a key component of this plan, with social prescribing depicted as central to its realisation. This move towards personalised care has seen the development of Core20PLUS5 (NHS England, 2021), a strategy within the NHS in England to support the reduction of health inequalities at a national and system level. It places a focus on healthcare provision for (a) the most deprived 20% of the national population, (b) populations identified at a local level as requiring additional support/attention (the PLUS), (c) five clinical areas (maternity, severe mental illness, chronic respiratory disease, cancer diagnosis, cardiovascular disease). Link workers and social prescribing are noted as a core component of meeting the ambitions set out in the Core20PLUS5 framework (NHS Providers, 2022).

3.2 What Are the Assumptions Around How Social Prescribing Can Address Health Inequalities?

Social prescribing has been depicted as an avenue for tackling health inequalities (Melam, 2021) because it is asset-based (working with communities and individuals to identify solutions) and place-based (connecting people to outlets in the community that can assist with their non-medical needs). It is also defined as holistic and person-centred (Office for Health Improvement and Disparities, 2022), concentrating on what matters to people and repositioning the lens through which health is viewed from the biomedical to the biopsychosocial. It has been suggested that placing social prescribing within primary care encourages health professionals to consider health inequalities when working with patients (Pescheny, 2017) and provides them with a direct referral route to a link worker.

Social prescribing link workers can support individual lifestyle issues such as smoking, diet, and physical activity. When such support is delivered in areas of deprivation, this may be considered as addressing health inequalities. They also assist people with problems that relate to social determinants of health through direct and practical support or referrals to relevant services or organisations (Moffatt et al., 2017). The link worker role involves developing relationships with 'community assets' (e.g. groups, charities, activities), often in the voluntary-community sector; this should enable them to make timely referrals to relevant assistance in a personalised and culturally sensitive manner (John, 2022). More recently, link workers funded through the NHS have been tasked to undertake 'proactive' social prescribing (NHS England, 2022). This involves identifying local populations who

might benefit from accessing a link worker that do not tend to engage with primary care. As those who do not attend primary care are often some of the most ‘vulnerable’ and excluded groups in the population, it is proposed that proactive social prescribing will contribute to addressing health inequalities.

3.3 What Are the Challenges for Social Prescribing in Terms of Addressing Health Inequalities?

3.3.1 Access to Social Prescribing and Referral Routes

One of the main referral routes to social prescribing in the UK is through primary care general practice. However, not everyone has access to primary care in the same way; this may be a particular issue for groups such as people who are homeless, migrants/asylum seekers, and refugees (Aspinal, 2014). Evidence also suggests young adults access primary care services less frequently than other ages, and that men have lower consultation rates compared to women (Davey et al., 2013; Wang et al., 2013). This could mean that social prescribing only reaches certain individuals.

A referral to social prescribing relies on open conversations between patients and practitioners that enable non-clinical needs to surface. Not all patients may feel comfortable discussing their non-medical issues or think it is appropriate to raise such matters with a GP, particularly when consultations have limited time allocations. Capacity and time pressures are likely to impact the extent to which practitioners consider the holistic well-being and wider needs of patients (Bertotti et al., 2018; Brandling, 2009). Demand for consultations with a GP are greater in areas of high economic deprivation, giving GPs less focussed time with patients (McCallum & MacDonald, 2021). Hence, there may be less opportunity to discuss social prescribing or explore social needs of patients in more deprived areas. Some GPs may even question if addressing social needs is part of their role (Solberg, 2016).

It is important to understand referral behaviours to help address any biases at play and to consider more equitable routes to access (e.g. supporting self-referral and outreach to underserved populations). GPs may have their own assumptions about who might benefit and be receptive to social prescribing and, thereby, unintentionally exclude some groups. This may be mitigated by having a shared understanding of what social prescribing can offer, how and who can benefit to help encourage referrals, embedding link workers in GP practices, and developing systems that support feedback on outcomes between healthcare professionals and link workers. It might be useful for those involved in social prescribing to consider the work of researchers in Canada; they have established an international conceptual and operational definition of social prescribing after garnering the thoughts of representatives from 26 different countries (Muhl et al., 2022). Their definition could help to create a shared understanding of social prescribing by delineating the components and processes involved.

3.3.2 Link Worker Role and Engagement in Social Prescribing

Once someone has been referred to social prescribing, success relies, in part, on the strengths and personality of the link worker. Brandling and House (2007) stated that these roles require a good understanding of health inequalities and groups defined as ‘hard to reach’ so they can work sensitively with a range of individuals. Patients need to be able to develop a trusting relationship with their link worker to support continued engagement (Wildman et al., 2019). The perceived relatability of the link worker to a patient’s worldview and how culturally relevant the support appears to be for the individual is likely to impact participation. There is a risk that link workers could alienate people if they reinforce previous negative experiences of health-care access, particularly for minority groups.

3.3.3 An Individualised Focus/Availability of Personal Resources

Social prescribing often calls for people to access personal resources and a degree of motivation that we argue are not equally distributed in society. Evidence suggests that interventions focused on individual level changes in knowledge and behaviour can increase health inequalities (Blaxter, 2007; Laverack, 2017; White et al., 2009). Such interventions have been described as ‘agentic’, requiring mobilisation of personal, social, and economic resources (Capewell & Graham, 2010). People who could benefit from social prescribing may lack such resources (Brown et al., 2021). Hence, social prescribing could favour those who have more personal resources, thereby having a detrimental impact on reducing health inequalities (Brown et al., 2021; Capewell & Graham, 2010). Gibson et al. (2021: 6) wrote that social prescribing needs to take account of factors that influence accessibility and engagement otherwise it “masks the effects of class by discursively positioning those without access to the legitimated capital required for engagement as individually and morally failing to invest in their health and wellbeing”.

3.3.4 Availability of Local Resources

A key component of social prescribing includes referral to community assets and activities, generally delivered by the voluntary, community, faith, and social enterprise sectors (VCFSE). Successful social prescribing calls for a thriving VCFSE (Islam, 2020; Kimberlee et al., 2022; Pescheny et al., 2018). Absence of such provision risks widening inequalities associated with social prescribing, particularly for areas with limited community organisations. Undoubtedly, local resources impact the type of support people can be referred to through social prescribing but more

crucially when we consider the disparity in funding cuts in the UK; areas of higher socio-economic deprivation experienced the greatest cuts (Alexiou et al., 2021; Bambra & Garthwaite, 2015). People living in areas where more resources are allocated are more likely to have access to a wider range of support (Bambra & Garthwaite, 2015; Drinkwater et al., 2019; Wildman et al., 2019).

Social prescribing referrals are likely to cause an increased demand on VCFSE organisations (Brown et al., 2021). VCFSE organisations have their own frameworks for service delivery, which may not always align with the needs of people being referred through social prescribing (Islam, 2020). This raises questions about the sustainability of social prescribing schemes as VCFSE organisations, by their nature, have a degree of instability due to their dependency on grant funding. Activities and services are often provided free-of-cost, but this can be made difficult due to short-term funding. There has been too little focus on funding for these services; the priority for funding social prescribing has been on the link worker role, particularly within primary care in the UK (White, 2018). Yet the sustainability of social prescribing depends on an equitable allocation of resources along the social prescribing pathway, which includes to VCFSE organisations (Bertotti et al., 2018; Wildman et al., 2019).

What individuals are connected to as part of social prescribing, how and where activities or support are delivered and what is available can exacerbate inequalities in access. For example, there may be insufficient cost-effective and accessible interventions for adults with learning disabilities, for people on low incomes, or those requiring more flexible provision after working hours (Wildman et al., 2019). There may also be insufficient or inadequate provision in an area for people from different ethnic backgrounds. Cultural acceptability is important when considering activities (The Oasis Partnership, 2023; Wigfield, 2019).

3.3.5 *Tackling Structural Inequalities*

There has been debate about the extent to which link workers can resolve structural factors contributing to health inequalities. Hence, whilst social prescribing may improve the lives of individuals, it is widely recognised that health inequalities are influenced by structural issues that need to be addressed through ‘macro-economic’ policies (Chng et al., 2021; Phelan et al., 2010). Mackenzie et al. (2020) refer to the *fantasy paradigm* that is being perpetuated through social prescribing; the idea that health inequalities created by global and national structures can be addressed via local or individual actions. A study conducted by Griffith et al. (2023: 290), exploring the role of link workers, concluded that they “had limited capacity to reverse the impact of austerity and local funding cuts, putting the lived reality of link working at odds with discourses that promote the capacity of social prescribing to address the social determinants of health”. This critique around the scope of social prescribing to tackle health inequalities highlights a need for link workers to be supported by system level interventions that reduce economic disadvantage and address

structural causes (Calderon-Larranaga et al., 2022), including upstream policies (Fixsen et al., 2022) that focus on living conditions and social inequities due to, for example, class or ethnicity.

3.4 What Does the Evidence Say About Social Prescribing and Health Inequalities?

There are many anecdotal reports and data in qualitative studies of social prescribing assisting individuals with circumstances in life that can cause stress and that can be a burden – like unemployment, lack of educational skills, housing issues, income worries. Yet there is little robust evidence of social prescribing directly ameliorating these factors on a population level (Chng et al., 2021; Mercer et al., 2019). Hence, discourse appears to be more claim rather than evidence based, with statements such as:

Social prescribing... is also effective at targeting the causes of health inequalities and is an important facet of community centred practice. (Office for Health Improvement and Disparities, 2022)

That said, we start this section with some specific approaches reported in the literature whereby social prescribing has been used to try and address particular health inequalities.

3.4.1 Approaches to Address Specific Health Inequalities

In the literature, there are descriptions of social prescribing schemes that target specific situations or conditions. For example, Lawler et al. (2023) reported on a project run in Scotland led by housing and energy organisations. The project focused on making material changes to people's living situation, so they were warmer and happier. It involved advice and assistance with energy use and tariffs, heating systems and insulation. Alongside this, there was provision of a community navigator, who could refer people to community-based support. There were indications that the project benefitted users, but the study's design meant it was not possible to make strong conclusions about its ability to address health inequalities.

Hassan et al. (2020) described a specific social prescribing approach to address social determinants of mental health. It was run in the north west of England and focused on learning (e.g. psychoeducation) and social connections. It also included an ability to access support for things like housing, debt, employment. Participants suggested it offered a safe, welcoming, non-clinical space, where they could express their needs. It was a place they could go to for support with a range of issues without feeling overburdened by barriers to access (e.g. paperwork). They described having choice and control over what they engaged with and for how long; this allowed them

to develop new interests and to create their own journey towards self-development and ways to manage their mental health. Engaging with the service was said to improve family relationships and helped with finding employment (due to learning new skills and gaining confidence). However, evidence came from people opting to participate in a focus group, who may have had a more positive experience.

3.4.2 Evidence on Who Accesses Social Prescribing

Emerging data suggest there are inequities in access to social prescribing. The Royal College of General Practitioners Research and Surveillance Centre (RCGP RSC) gathers and collates data from over 1700 GP practices across England and Wales. A report by this organisation highlighted how collecting evidence around patterns on who is and is not accessing social prescribing has been hampered by a lack of standardisation and variable quality of how this information is recorded (Jani et al., 2020). Findings from this report did suggest that women were more likely to be referred to social prescribing, as were people defined as being of White ethnicity. It also showed higher levels of referral to social prescribing among people aged 45–64 years (Jani et al., 2020). However, later data from 2020 to 2021 found that people aged 65+ were more likely to be referred (Jani et al., 2021); this later report also suggested that children and young people tended to not be referred for social prescribing. More referrals alongside more declined referrals for social prescribing from people living in deprived areas were also reported (Jani et al., 2021).

Referral patterns described by the RCGP RSC in terms of age, gender, and ethnicity were reinforced in a review of the literature by the National Academy for Social Prescribing's Academic Partners (Cartwright et al., 2022). The review found that referrals were reported most among adults, with limited evidence involving children. Likewise, women seemed more likely to access social prescribing and individuals defined as White/White British (when information on ethnicity was presented). These findings have been mirrored in other work in the UK (Khan et al., 2023).

As set out above, we have some data on potential inequalities in use of/referral to social prescribing, yet uncertainties around understanding these differences remain. We know efforts are afoot to make social prescribing available across the lifespan, with attention given more recently to services for children and young people (Bertotti et al., 2022; MacConnachie, 2022). This is covered in chapter five and is an area that warrants consideration to ensure that social prescribing is universal.

The lower representation of ethnic minority groups in service user data indicates that this is another area requiring further consideration. This variable is often presented as a barrier to accessing healthcare in general, although it has been noted that “it is not ethnicity per se but a lack of prioritizing of the cultural and social needs of minority groups in decision-making that renders it a problem” (Fixsen et al., 2022: 678).

3.5 What Needs to Happen to Evidence the Impact of Social Prescribing on Health Inequalities?

We propose that more research is warranted to explore the question of if and how social prescribing can address health inequalities and to ascertain if social prescribing may, in some circumstances, increase health inequalities. We recognise that this is not an easy task due to the complexity of social prescribing, measuring impacts on health inequalities, and data collection challenges (Bickerdike et al., 2017; Husk et al., 2019; Vidovic et al., 2021). However, when looking at the evidence base, there appears to be little focus on how social prescribing might be positively or negatively impacting health inequalities. Where there has been some attempt to explore this, it has been difficult to demonstrate due to the lack of or poor-quality data.

Feasibility studies conducted by the Applied Research Collaboration North West Coast (ARC-NWC) in the UK found that data on the social determinants of health were not routinely collected by organisations delivering social prescribing or within primary care recording systems (Khan et al., 2021, 2023). It was not possible to break down data beyond basic demographics of age, gender, ethnicity, and deprivation in terms of who was accessing social prescribing and who was being referred. Equally, there were gaps in data recording on what happens when individuals are in the service (i.e. what support they receive, where they are signposted onto), and outcomes measured. To understand the impact on health inequalities and social determinants of health we need to ensure we collect data that enable us to explore this.

The Cochrane 2008 PROGRESS-Plus factors, as described in Table 3.1, provide a useful framework to consider health inequalities (Cochrane Methods Equity, n.d.). These factors are characteristics that are related to health outcomes and opportunities (Kavanagh et al., 2008; O'Neill et al., 2014). Moscrop et al. (2019) state that collecting such information has the potential to improve health equity by helping service providers to understand different population groups and to direct service provision to those most in need.

However, it is not sufficient to simply think of equity in terms of uptake and referral; we need to consider equity in terms of who is and *is not* accessing social prescribing, how people access social prescribing, what happens when they are in the service, and what outcomes are being reported. We need to then use this information to explore variations across these considerations – do some groups report better outcomes than others, do some groups get referred to additional support services, or stay longer in the service? Key to achieving this is to ensure that socio-economic and demographic profiles of those who do and do not access social prescribing are recorded; an analysis of the profile of the local population in the social prescribing catchment area also needs to be conducted to provide a comparison point. We need to understand what disparities exist and why, and what equity issues influence these outcomes, not only to assess impact on health inequalities, but also to explore what could be done to address any barriers to access or differential treatment experiences of social prescribing encountered by service users from different population groups.

Table 3.1 Progress Plus factors

P	Place of residence
R	Race/ethnicity/culture/language
O	Occupation
G	Gender/sex
R	Religion
E	Education
S	Socioeconomic status
S	Social capital

Source: Adapted from Cochrane Methods Equity (n.d.): <https://methods.cochrane.org/equity/projects/evidence-equity/progress-plus>

+ **Plus** refers to:

- (1) Personal characteristics associated with discrimination (e.g. age, disability)
- (2) Features of relationships (e.g. smoking parents, excluded from school)
- (3) Time-dependent relationships (e.g. leaving hospital, respite care, other instances where a person may be temporarily at a disadvantage)

In particular, more research is required around the reasons why people from deprived areas seem to decline referrals to a link worker. Authors of the report that made this observation proposed that inequalities in access to primary care, and lack of trust in statutory services, may be factors influencing take up (Jani et al., 2021). There is evidence to suggest that personal history and current context create the conditions for people to benefit (or not) from social prescribing (Gibson et al., 2021). As noted above, some people may start their engagement in social prescribing from a position of being less able to benefit because of their preceding life circumstances and associated lack of health and social capital; those bringing little inherited capital to their experience in this respect enter the process at a disadvantage (Gibson et al., 2021).

It is important to reflect on the types of outcomes and measures being used to assess impact on health inequalities. Existing measurement tools may not capture outcomes that reflect the needs and priorities of those who access social prescribing or their views on what constitutes health and well-being (Carnes et al., 2017; Pescheny et al., 2020). Polley et al. (2019) found that over two thirds of identified outcomes associated with the social determinants of health were not routinely measured by social prescribing interventions. Meaningful measures are required that not only reflect the perspectives of service providers and users but also help to demonstrate impacts on health inequalities.

3.6 Concluding Thoughts

We recognise that social prescribing can provide value and benefits. It can improve health and well-being, quality of life, and help reduce social isolation (Pescheny et al., 2020) by supporting social relationships and networks (Costa et al., 2021;

Woodall et al., 2018), reducing anxiety, and improving self-efficacy (Morton et al., 2015). It can also empower people to make individual choices (Vidovic et al., 2021). However, it is important to have clearer distinctions about what social prescribing can and cannot do.

Social prescribing can support individuals to become more engaged with their health. It can provide support to those with social needs to address some of the consequences of inequities across the social determinants of health by facilitating access to relevant support (welfare rights, housing, and employment support). Social prescribing can in turn help reduce negative impacts on the health and well-being of people who access it.

That said, tensions have been described between acknowledging structural forces as shaping social determinants of health but then presenting social prescribing as a solution, which centres on individualised strategies as solutions (Calderon-Larranaga et al., 2022). Critical discourses argue there is a danger of social prescribing exacerbating health inequalities by assuming that everyone has the capacity and opportunity to engage with it; failing to acknowledge that those who could benefit most from social prescribing may not come to the attention of link workers (e.g. because they are reticent to engage with services or healthcare) (Gibson et al., 2021; Mackenzie et al., 2020).

It is important to collect data that can highlight inequities in access, service experience, and outcomes to ensure that social prescribing is not inadvertently increasing inequalities. We also need an improved understanding of explanations for the figures on referral and uptake referred to above, which came from large datasets; for example, a better grasp of why people may not take up referrals to a link worker or to community support. We need to explore where obstacles lie in the social prescribing pathway that relate to health inequalities – at the stage of referral, in interactions with link workers, or at the point of connecting people to community assets? We are aware that there are other health inequalities that could affect access to social prescribing (e.g. disability, location – rural, urban, or coastal, education, sexual orientation/identity, homelessness). These factors form part of the social determinants of health that underpin health inequalities and, therefore, also warrant investigation in relation to social prescribing referral, uptake, and experience.

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Chapter 4

Implementing Social Prescribing Schemes: Learning from Practice



Marie Polley

4.1 Introduction

When the National Social Prescribing Network was set up in January 2016, the first conference was used to identify and co-design key components of social prescribing. These components or key principles were identified by the people ‘on the ground’ who were actively innovating in this area (Polley et al., 2016).

Social prescribing has been rolled out in many different ways, from proof-of-concept approaches in small geographical areas, to areas rolling out at scale without any previous testing. There has been an exponential increase in the research and evaluation into social prescribing, from different stakeholder perspectives, from system perspectives and from international perspectives. This research and evaluation continues to inform what we know to be good practice when implementing a social prescribing scheme where you want it to be as effective and sustainable as possible.

This chapter aims to bring together the research and evaluation that relates to implementation of social prescribing, so you can see what has already been tried and what other people have already learnt from. It also draws on the author’s experience of supporting the implementation and evaluation of social prescribing at local, region and system level. It is hoped that this will support those of you who may be interested in implementing a new social prescribing scheme or enhancing an existing one.

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4.2 The Key Ingredients for Implementing Social Prescribing

Social prescribing in England was implemented in a diverse range of ways before it became National Health Service (NHS) policy (NHS England, 2019) and a target for roll out in the other devolved nations (Department of Health NI, 2017; Public Health Wales, 2018; Scottish Parliament Health and Sport Committee, 2019). The initial innovators (Brandling & House, 2009; Friedli et al., 2008; South et al., 2008; Woodall & South, 2005) were keen to find non-traditional and innovative approaches to commissioning support for people. From their work, the role of a link worker was identified.

When I set up the Social Prescribing Network with my colleagues and collaborators, we found that there were many people in England, Ireland and Scotland who were innovating ways of prescribing non-medical support to improve people's well-being, often via supporting their social determinants of health. The initial research carried out when setting up the Social Prescribing Network sought to understand what the innovators ($n = 182$) at the time thought the key ingredients to social prescribing were. From that data we developed what could be seen as the first theory of change, or a road map for implementing social prescribing (Fig. 4.1) (Polley et al., 2016).

The data we analysed in 2015–2016 agreed with the points derived from an earlier review of seven social interventions which linked participants from healthcare services to a range of community-based resources (Mossabir et al., 2015). Interestingly over the past 8 years, very few of these key points from Fig. 4.1 have changed. There is the need to widen some of the language – for instance the

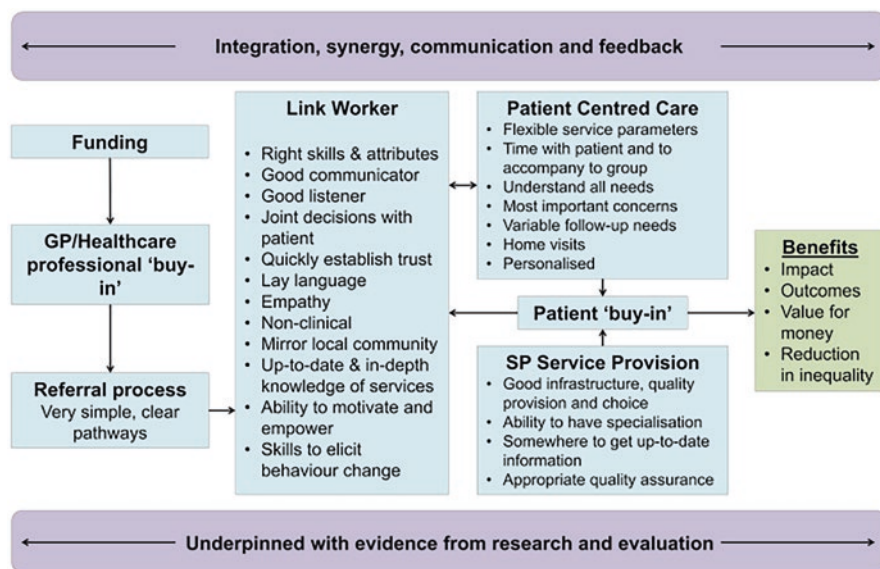


Fig. 4.1 The key ingredients of social prescribing from Polley et al. (2016)

professionals referring a person into social prescribing are much broader than just GPs and the description of service users, as solely patients, is too narrow to represent current practice. But overall, all the components have remained important. It is important to note that patient or service user buy-in does not happen automatically, but there are three components that need to be in place: (i) an appropriate link worker with the skills listed in Fig. 4.1; (ii) a person centred approach to care which values a person's voice and provides some flexibility on how support is provided and (iii) enough provision to refer a person onto further groups and support often in the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. Subsequent research that has been carried out has added more details into some of the aspects of this roadmap and this will be discussed as we journey through the chapter together.

4.3 “Just Tell Me What I Need to Do!”

If I had £1 for the number of times that I was asked this question by people who wanted to set up a social prescribing scheme, I would be rich. The work pressures that are ever constant for commissioners and health practitioners have meant that there is often little time in their day to get immersed into implementing a new scheme. Instead, there is a plea along the lines of ‘I don’t have the time or capacity to get into this so just tell me what I need to do’. For successful implementation of social prescribing, however, you need to talk with all the stakeholders that will be involved in the social prescribing scheme and co-design the focus of the scheme with them.

Social prescribing is not something you can do to someone else, and good implementation that will lead to a sustainable set up for the scheme, is not about parachuting a link worker into a local environment. Good implementation is about collaboration and understanding that all stakeholders need to have an equal voice, despite the power dynamics that may exist. I have often been heard saying that you all have to ‘shuffle along together’. This may feel slow at times, but it is important that all stakeholders are included.

4.4 What Is Already Happening and What the Local Population Needs

A good place to start in considering the process of developing and implementing social prescribing is to take time to find out what schemes are already available in the locality. For instance, in England it was not uncommon for a local authority or VCFSE organisation to have a social prescribing scheme already underway and for a primary care network to set up their own social prescribing scheme, often when there was funding available to implement link workers in primary care networks.

But even before then, I had conversations with people who had very successful schemes running in a locality, good outcomes demonstrated and then funding was cut because another very similar scheme was commissioned elsewhere in the locality. Once it was realised that both schemes were so similar, funding was cut to the established scheme as to avoid duplication. This is frustrating for all involved, but crucially this is damaging to the vulnerable people who are already being supported by schemes. The relationship a person builds up with a link worker is vital in enabling a person to feel safe, supported and able to talk about what they need support with. This relationship was identified as a key facilitator by all schemes reviewed by Mossabir et al. (2015). Cutting funding as in the example above or having a high turnover of link workers in a scheme is extremely distressing for the service users when they are most vulnerable and in need of compassion and support.

Social prescribing is a very flexible approach to supporting local population needs. The NHSE policy has described the NHS version of social prescribing as a holistic approach (NHS England, 2020).

There are many social prescribing schemes, perhaps the majority have specified what the local adult population's needs are and how social prescribing will be focussed on some of those.

In Tandridge, Surrey, the wellbeing on prescription service was for all adults, with their approach being adapted for the much older service users (Polley et al., 2021b). In Shropshire, the social prescribing service was implemented based on the local population health strategy and targeted a preventative approach, supporting people who had more than 20% risk of cardiovascular disease or were experiencing loneliness (Polley et al., 2021a). Other services really focus on social determinants for example financial wellbeing (Financial Shield, n.d.).

Ultimately, it is important for all stakeholders to determine what group(s) will most benefit from social prescribing in their local area, based on local population health statistics, needs and gaps in existing services and type of support available locally to support different groups of people.

The best way to ensure that you are informed on what assets already exist in the local community that can support the issues experienced by the target social prescribing population, is to carry out asset mapping. Asset mapping is an exercise used in asset-based approaches to community development and allows you to start this social prescribing design and implementation process by building on the existing strengths of the local VCFSE organisations (Haines, 2014). This can also help you identify stakeholders to be part of the co-design process early on in your journey.

4.5 Who Are Your Stakeholders and Are They Bought-In?

Once you have researched what is available locally, in terms of other social prescribing schemes, voluntary organisations and key people who are passionate about social prescribing aim to bring everyone together for a discussion. In my experience

this could mean 20 people sat around a table, and hopefully they represent general practice, local authority, local hospital if relevant, VCFSE organisations and broker organisations, social care, housing services, allied health professionals, and any existing link workers, care coordinators or health coaches. It can also help to have the police, fire and ambulance services represented. If your scheme aims to support children or young people, then you also need to have youth workers, education professionals, public health present. By now you may think this is a lot of people. I have even been asked before *'but why do we need housing representation?'*. Many people who will use the social prescribing schemes will have ill health because there are issues with the social determinants of their health which include housing. A good social prescribing scheme, therefore, is set up from the beginning to work with as many relevant stakeholders as possible. Similarly, if there is an intention to evaluate the social prescribing scheme, then evaluation or research representation should ideally be included at this first meeting.

Setting up the first stakeholder meeting can be challenging. One needs to plan well in advance and then coordinate many diaries. Whilst this can feel frustrating for whoever is tasked with getting a date sorted, it is worth the effort. In my experience, the first meeting raises lots of questions, identifies a huge amount of good practice that is already happening that other sector stakeholders were unaware of (therefore preventing reinventing many wheels) and enables the social prescribing scheme to be genuinely co-produced. It can also throw up some interesting challenges and identify overlaps in professionals' roles and existing services and forces decisions about the boundaries of the social prescribing scheme to be collectively agreed upon. I would recommend that the meeting is scheduled for at least 2–3 h to enable the discussions to deviate away from a linear agenda and encompass everything that needs discussing. In my experience, the agenda items usually get covered by the end of the meeting, but allowing a more flexible discussion to take place can be very beneficial.

Inevitably some people will be unable to make some of the early stakeholder meetings, so it is worth encouraging them to send a different representative in their place and keep asking the group *'who is not at the table?'*. Identifying stakeholders who were not initially invited is crucial to establish the full group of people who need to actively participate in implementing social prescribing. The investment of time at the beginning of an implementation project may feel a lot, but it will bear fruit later on.

There are several resources and toolkits available on the implementation of social prescribing and these are worth reading before any multidisciplinary stakeholder meeting, particularly to identify topics that you may not have already considered (Fullam et al., [n.d.](#); NHS England, [2020](#); Polley et al., [n.d.](#); WHO Western Pacific Region, [n.d.](#)) A particular useful guidance document was published by the Social Prescribing Youth Network (Bertotti et al., [2020a, b](#)). These guiding principles were co-produced with input from children, young people, families, practitioners, commissioners, academics and policy makers and a survey to a community of practice

of 647 people and are part of a suite of resources.¹ The seven key principles (Governance and accountability, Ethos, Design and planning, The referral process, Link worker role, In-scheme monitoring, Outcomes and Impact) are broken down into clear statements which can be used at the very beginning of setting up an all-age social prescribing scheme and throughout to monitor progress. Whilst developed to include the perspective of children, young people and families, the resources can easily be adapted to adult only schemes.

4.6 Why Is It So Important for Stakeholders to Be Actively Engaged with Social Prescribing Implementation?

To further understand why it is important to actively make time and effort to bring so many stakeholders together in the success of implementing social prescribing, we can draw on Normalisation Process Theory (NPT). NPT argues that there are four core constructs that are required when implementing a new practice – coherence, cognitive participation, collective action and reflexive monitoring (May et al., 2009). This theory of NPT was applied to the evaluation of Deep End community Links Worker Programme evaluation which followed seven GP practices serving some of the most deprived patients in Glasgow (Chng et al., 2021). The evaluation identified that three of the seven practices fully integrated social prescribing according to NPT principles and the remaining four only partially. The researchers identified clear differences in how good implementation practice was used and whether it continued. The downside was that where only partial integration had occurred, there was discontent between admin and GP staff, and community link practitioners were less able to proactively visit areas or organisations to network and see what was going on. In the fully integrated practices, there was a better shared understanding of the social prescribing scheme (coherence), staff were more likely to participate as required (cognitive participation) to implement the social prescribing scheme (collective action). The authors were unable to attribute specific reasons as to why some practices had not fully integrated social prescribing but point out that implementing social prescribing is not a quick fix approach to supporting the wellbeing needs of the local population, even when fully funded. However, it is acknowledged in other reviews that the lack of training for GPs to work in a biopsychosocial way is a barrier for social prescribing implementation in general (Aughterson et al., 2020).

The implementation of social prescribing in Shropshire is another example where NPT can be applied. The evaluation reported that the key stakeholders used an agile management approach coupled with action, learning to document all aspects of the implementation process (Polley et al., 2019). The initial work bringing stakeholders together and treating all stakeholders with equal status developed

¹The other resources can be found at <https://www.streetgames.org/what-we-do/areas-of-work/health-and-wellbeing/youth-social-prescribing/>

coherence and cognitive participation as the project developed. A reflexive ethos was developed from the start enabling regular appraisal to understand and keep the successful elements, whilst discarding the less effective elements as the scheme expanded to additional GP practices. Stakeholders were interviewed and all staff in the project felt that this was a collaborative venture. Despite the barriers they faced, they were able to take collective action, due to developing their community of practice around the implementation of the social prescribing scheme.

4.7 Equity of Voice

From an implementation perspective, it is important that all stakeholders have an equal opportunity to voice their opinions on how a social prescribing scheme should be devised and that equal weight is given to each stakeholder. In the past, the voice of the VCFSE² sector has not always been included in the design phase, yet arguably, this sector has the most knowledge of providing person-centred support and understanding what service users want or need. In the guiding principles, all age social prescribing implementation, hearing the opinions of children and young people and how that related to the design of the service is mentioned many times (Bertotti et al., 2020a, b). It is also important to consider if the voices of those who are marginalised due to age, geographical isolation, socio-economic deprivation have been heard. A review of eight studies on co-production and co-design concluded that these are effective approaches to engage stakeholders in the development and implementation of social prescribing in a community setting (Thomas et al., 2021). Further examples of the importance of harnessing local assets is discussed in the case studies of a project designed to prevent social isolation in older people, using a range of food activities (Wildman et al., 2019), and in a qualitative study engaging residents in a rural community in North West Wales to understand their view of co-design and co-produced social prescribing interventions to meet the wellbeing needs of the community (Spencer et al., 2021). As we move into the new territory of Integrated Care Boards in England and an increased push for collaborative and local commissioning, there is more opportunity to have co-designed, co-located services and designated people to oversee the implementation of social prescribing.

²VCFSE = voluntary, community, faith and social enterprise sector.

4.8 Exploring the Relational Dimension and Emotional Buy-In

Throughout my time working with a broad range of social prescribing schemes, innovators and researchers, a common theme around relationships emerged. Many social prescribing schemes have been set up because a person has been particularly passionate about driving it forwards – often this is an emotional sense of buy-in to the work. This person often becomes the one with oversight over the complex and dynamic interplay between stakeholders, local politics and other confounding issues. As such, we sought to understand where the concept of emotional buy-in was located within the existing Critical Systems Thinking (CST) models. CST enables us to explore how relational issues impact on people in organisations and how their responses influence current and future practice (Flood & Finnestrand, 2019; Jackson, 2019). From our experience of implementing social prescribing in Shropshire (Polley et al., 2021a), we used this as a case study to develop our thinking on social prescribing and the emotional buy-in from CST perspective (Fixsen et al., 2020).

Amongst other things, CST argues that emergence, interrelatedness and sustainability should all be considered together along with the aspect of complexity. CST also recognises that decisions made will exclude certain ideas or groups and include others and that these should be based on equitability and sustainability (Cordoba & Midgley, 2006; Flood & Finnestrand, 2019). A sociology of emotion would argue that feelings are at the heart of human life and therefore a key influence on rational decision making (Collins, 2004; Turner, 2009) and impact the sustainability of any project. As social prescribing schemes are an ecosystem of complex and interchanging dynamics between many different actors, thinking about it at a system level seemed very appropriate. Relationality is a key concept for both CST (Cordoba & Midgley, 2006; Flood & Finnestrand, 2019; WHO, n.d.) and social prescribing (Dayson, 2017a, b; Fixsen et al., 2020; Polley et al., 2019) and our exploration led us to conclude that it is at the heart of the operational and relational components of social prescribing implementation as seen in Fig. 4.2. The diagram in Fig. 4.2 illustrates a positive relational cycle which would contribute to the success and sustainability of local social prescribing programmes and similar schemes. The elements identified are: ‘shared vision’, ‘confidence and commitment’, ‘motivation and encouragement’, ‘support and wellbeing focus’, ‘collaborative relationships’, ‘communication and feedback’, ‘access to information and resources’, ‘learning in and from action’. Boxes on the left represent the more operational components, those on the right are more relational, while emotional buy-in is located at the ‘heart’ of both.

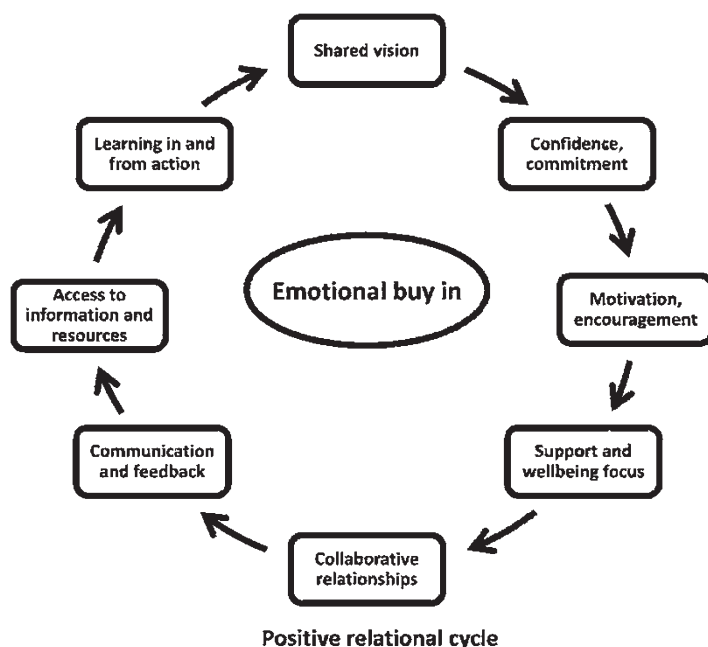


Fig. 4.2 The positive relational cycle from Fixsen et al. (2020). (Reprinted from Fixsen et al. (2020), Figure 3. <https://doi.org/10.1186/s12913-020-05443-8>, licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>))

4.9 Monitoring and Evaluation of Social Prescribing

Core monitoring and wider evaluation of how a social prescribing service is working in relation to what was anticipated is a key aspect of developing a service that meets the needs of its users.

There are many research papers and reports published that dealt with the types of outcomes that have been measured which you can dip into as a reader (Bertotti et al. 2020a, b; Bertotti & Temirov, 2020; Case et al., 2021; Dayson et al., 2020; Dayson & Damm, 2020; Griffith et al., 2023; Howarth et al., 2020; Husk et al., 2020; Liebmann et al., 2022; Polley et al., 2020; Thomson et al., 2018; Pescheny et al., 2018). This section will put forward practical points related to monitoring and evaluation for you to consider.

4.9.1 *What to Monitor*

As all social prescribing schemes are set up to meet local needs, for local populations, it is important to choose data items to monitor based on your intended scheme and not what someone else has published. To help determine how your social prescribing scheme will work, it is recommended that a logic model otherwise known as a theory of change is developed from the outset. This can be a live model, which revised as a scheme is implemented. This will enable you to identify what the key pieces to be monitored are. It is tempting to want to measure lots of things but please be mindful of the issue of data burden, both for a service-user also for a practitioner collecting the data. The Information Commissioners Office (ICO)³ succinctly describes that personal data you process should be sufficient to properly fulfil your stated purpose; relevant with a rational link to that purpose; limited to what is necessary so you do not hold more data than you need to for that purpose.

4.9.2 *What Will You Do with the Data You Collect?*

It is considered good practice to report, before data collection, how that data will be analysed and used to determine if the service is indeed performing as expected. This links to the ICO principle of having a rationale for why you are collecting the data initially. Without going through this process two things can happen – (i) you can unnecessarily burden service users to complete forms when the data is never going to be used – this is unethical; (ii) you can fail to collect a key piece of data and only recognise this when it is too late.

4.9.3 *What Outcomes Will You Measure?*

As well as collecting process data, many services want to further ‘evidence’ their schemes by measuring specific outcomes of people who go through a social prescribing scheme. Choosing outcomes to measure usually raises several questions as social prescribing has many potential outcomes (Dayson & Damm, 2020; Howarth et al., 2020; Husk et al., 2020; Polley et al., 2020; Thomson et al., 2018). An example of the range of outcomes is highlighted in this meta synthesis of qualitative data (Liebmann et al., 2022). Some of them appear almost immediate, e.g. increased hope, improved wellbeing, decreased isolation, while other outcomes may take months (e.g. improved housing conditions) or even years (e.g. return to paid

³Information Commissioners Office data minimisation principles <https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/principles/data-minimisation/dayson>

employment, taking up volunteering) to manifest. Moreover, multiple outcomes may improve at the same time, but a timeframe may be different for different service users. Choices for monitoring outcomes may also be influenced by the target issues or target population you wish to support with social prescribing. This can leave a lot of people scratching their head on what to measure. If you have completed a logic model/theory of change, then it will be much easier to collectively agree on which specific outcomes to measure. You may also opt to collect other outcomes through case studies and qualitative data capture, to build up a broader more representative picture of the social prescribing service.

It is worth noting that there is a bias for collecting health-based outcomes in many cases, yet when mapping the outcomes associated with social prescribing, we discovered that 62% of identifiable outcomes are ones that will cause ill health by increasing the allostatic load and stress on a person but are not themselves health outcomes. We describe these as social determinants of health and the reasons for this bias towards health outcomes are discussed further in Polley et al. (2020). Increased social determinants of health are associated with people in the lower socioeconomic groups and those who experience higher levels of inequalities (Marmot et al., 2010). To determine how well-suited social prescribing is to addressing inequalities, these outcomes, therefore, have to be captured otherwise we risk silencing the people whose voice is already marginalised. A crucial question to ask is if the outcomes chosen are relevant to the service users as well as the policy makers and commissioners? Revisiting the idea of co-design, this can be applied to evaluation and monitoring, including the service users' voices to support which outcomes to measure and at which level.

Outcomes in social prescribing often identified in qualitative research fall into three categories – those for service users, those of the system and those of the community. Much of the discussion in this section is related to service users and their outcomes. Very little research really captures how social prescribing is impacting at the community level. Sir Michael Marmot has built on his early work (Marmot et al., 2010) to develop a set of Marmot indicators of the social determinants of health, health outcomes and social inequality,⁴ and it would be interesting to see these applied to social prescribing schemes in the future. There are multiple attempts to capture how social prescribing affects system usage, particularly the health system (Bertotti & Temirov, 2020; Case et al., 2021; Dayson, 2017a, b; Dayson & Damm, 2020; Polley et al., 2017, 2021a; Rössler et al., 2022; Wildman & Wildman, 2023). Whilst there is no agreed method to analysing this data, it is worth deciding, before the implementation stage, if an economic-based assessment of system used is required, and how the relevant data will be accessed to facilitate this.

⁴The Marmot Indicators can be found here – <https://fingertips.phe.org.uk/profile-group/marmot>

4.9.4 What Training Do People Need to Collect Data?

It is very important to determine who will collect the data monitoring or evaluation data before data collection starts. Challenges to collecting consistent data, particularly at follow-up, is the lack of training for practitioners on how to do this, lack of time planned into a consultation with a service user to enable data, additional to the consultation process to be captured and poor choice of outcome measures – for example, choosing measures which service users feel uncomfortable completing. The best approach is to, first of all, train practitioners collaboratively on how to collect data and then trial the outcome measures chosen with service users and the practitioners collecting the data, to get feedback. A data collection strategy may benefit from training workshops between practitioners and researchers, as practitioners can provide useful ideas about how to collect data which minimises disruption to the participant and maximises response rate.

4.9.5 Barriers and Enablers of Social Prescribing

There has been a range of barriers and facilitators to implementing social prescribing identified, as we have journeyed through this chapter. Tables 4.1 and 4.2 summarise what has been identified in the social prescribing literature (Brandling & House, 2009; Chng et al., 2021; Kitmitto et al., 2022; Mossabir et al., 2015; Mughal et al., 2022; Pescheny et al., 2018; Polley et al., 2019; Polley & Sabey, 2021). Whilst these are not exhaustive, they provide a good start in understanding how you can maximise the enablers and minimise the barriers when implementing social prescribing.

4.10 Conclusion

Designing and implementing social prescribing schemes is neither a quick process nor a simple one. It requires collaboration, good relationships, patience, flexibility, reflexivity, a designated implementation lead and the willingness to work with and alongside colleagues in many other sectors. The investment of time and energy is, however, worth it when a fully implemented social prescribing scheme is able to help the most vulnerable people with complex needs in our society.

Table 4.1 Enablers of social prescribing

Enabler	Referral into SP	Linking professional	Service users and support activities
Multi stakeholder meetings and training	Regular steering group meetings to discuss operational procedures, develop and provide training and networking events, increases cross sector relationships and provides opportunity to discuss flexibility of social prescribing scheme parameters. Creates a shared understanding and readiness to start the social prescribing scheme		
Trusting relationships	Supports likelihood that people will take up referral	Enables a client to honestly describe their support needs	Increases the likelihood that a client will attend the support prescribed
Co-design and co-production	Increases likelihood of local residents using the social prescribing service	Enables link workers to reach underserved populations	Ensures that knowledge, expertise and connections from VCFSE are valued and utilised to design social prescribing scheme fit for service users' needs
Phase roll out approach with realistic timings	Supports development of new and effective partnerships between GP surgeries, linking professionals and the VCFSE sector		
Having a practice culture supportive of social prescribing	Generating appropriate referrals within criteria and include link workers in multidisciplinary team meetings	Link workers provided with enough consultation time Providing appropriate 1-to-1 supervision and peer support	Improved value of the VCFSE sector and organisations who provide the social prescribing activities, by referrers
Training	Improves practice staff capability, confidence and knowledge about social prescribing and the role of link workers	Provides adequate time for link workers to access training and CPD	Provides people collecting evaluation data the confidence to do it well
Quality assurance	Improves GPs confidence in quality of local activities	Ensures link workers are appropriately trained and supported	Safeguards vulnerable people referred to local organisations and groups
Feedback loops	Enables referrers to understand how social prescribing can make a difference		

Table 4.2 Barriers to social prescribing

Barrier	Referral into SP	Linking professionals	Service users and support activities
Funding		Short-term contracts increase likelihood of staff turnover. Linking professionals under more pressure to support individuals in consultations without local activities and services to refer on to. Increases emotional burden of their role	Lack of available services and activities in the local community when services experience funding cuts and can no longer provide capacity to support referrals from linking professionals
Accessibility		Inappropriate referrals put vulnerable people and link workers at increased risk	Activities may not cater for specific needs such as disabilities or the need to include a support worker
Lack of transportation or money to pay for it	Prevents a person going to a face-to face meeting at any stage in the social prescribing pathways. This is a particular barrier for accessing support activities		
Lack of childcare or money to pay for it	Prevents a person going to a face-to face meeting at any stage in the social prescribing pathways. This is a particular barrier for accessing support activities		
Lack of 'buy-in' from stakeholders	Reduces likelihood that referring professionals will generate referrals to link workers	Link workers feel less valued and have reduced time to do the networking and proactive part of their role	Lack of value placed on the VCFSE sector and increases short-term nature of funding
Lack of consultation time	Difficult to understand patient preferences, knowledge and beliefs regarding different types of support	Reduces time to work with people who have complex needs including physical, mental, social welfare, legal and financial problems	Increases potential that services users' needs are not fully established and support needed isn't fully prescribed by link worker
Lack of knowledge and respect of link workers	Creates poor working relationships and increased chance of inappropriate referrals to link workers. Increases staff turnover		
High staff turnover	Reduces the capacity of referrals to be made to link workers until new staff have been recruited and trained. Delays social prescribing delivery	Loss of linking professionals breaks relationships with services users. Personal contacts with local services and organisations lost, social prescribing delivery delayed	

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Chapter 5

Social Prescribing in Wales



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5.1 Introduction

This chapter is divided into three parts, developing the evidence base, the glossary of terms, and the evaluation and monitoring framework. Part 1, developing the evidence base in Wales using a translational model, describes how Welsh Government

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and its public services, with support from the Wales School for Social Prescribing Research (WSSPR), have worked together using a translational model of research and development to build the evidence base in Wales for social prescribing. This approach has helped to provide some underpinning evidence for the Welsh Government National Framework for Social Prescribing which is expected to be published in October 2023. Part 2 discusses the glossary of terms in Wales, its development, and application. This was developed because terminology associated with social prescribing and definitions associated with terms used differ between countries, regions, and even services within regions (Newstead et al., 2023a). Finally, Part 3 provides us with an understanding of social prescribing evaluation and monitoring (including SROI) in Wales and how these fit together.

5.2 The Social Prescribing Policy Landscape in Wales

Wales is a small country of about 3.1 million people (Office for National Statistics, 2021). It has an ageing population with 21.3% aged 65 years and over, and 1% aged 90 years and over. Since the COVID-19 pandemic, the existing inequalities experienced across the lifespan in Wales have widened. The most recent cost of living crisis is thought to exacerbate this, resulting in organisations such as the NHS Confederation in Wales recommending that ‘Welsh Government should produce a cross-government plan for reducing inequalities in adults and children’ (NHS Confederation, 2022).

Since 1998, Welsh Government has had responsibility for a number of devolved policy areas such as health, social care, housing, environment, and education. Its health and care organisations include NHS Wales, which has seven integrated acute and community health boards which plan, commission, and deliver services. In addition, there are three NHS trusts; Public Health Wales, Velindre NHS Trust (tertiary cancer services), and WAST (Welsh Ambulance Services NHS Trust) and two special health authorities, Digital Health and Care Wales and Health Education and Improvement Wales. The country is served by 22 local authorities who deliver public services including housing, leisure, and social services. The Wales Council for Voluntary Action (WCVA) is the national umbrella body for third sector and voluntary organisations. It works closely with the 19 County Voluntary Councils (CVCs) as part of Third Sector Support Wales (TSSW) to meet the needs of local populations. WCVA also work together with national voluntary sector networks through the Third Sector Partnership Council (TSPC) where it also enters into conversations with Welsh Government. There are 5465 charities registered in Wales that also operate in areas of Wales, including 1210 charities which operate across Wales (WCVA, 2023).

To ensure that health boards, local authorities, third sector, and environmental agencies work together across regions, there are seven Regional Partnership Boards (RPBs). These were established in April 2016, as part of the Social Services and Wellbeing (Wales) Act 2014 (Welsh Government, 2014). There they engage with

citizens, co-produce, plan, and commission health and care services for those with complex needs (e.g., safeguarding) and improve the well-being of the population (Welsh Government, 2020). The Wellbeing and Future Generations (Wales) Act 2015 (Welsh Government, 2015) also requires services to work together to identify areas where they can work more sustainably to protect future generations. It requires us to consider working more efficiently for the long-term good, for example through integrating services and carrying out well-being assessments and an annual local well-being plan through its public service boards (Davidson, 2020).

It is under these two legislative documents that we have developed our cross sector working practice in social prescribing in Wales. Generally, access to social prescribing comes through third sector, local authorities, community resources, universities, or self-referral (Wallace et al., 2021). Services have moved away from the medical model of care and focus on holistic and person-centred methods to improve wellbeing (Pringle & Jesurasa, 2022). Social prescribing in Wales reflects this trend by predominantly offering a holistic approach which is integrated with existing community and statutory services and has no limit to the number of times the person is seen (Wallace et al., 2021). The goals of social prescribing align closely with policies set out by Welsh Government in initiatives such as A Healthier Wales (Welsh Government, 2019) and the Connected Communities strategy (Welsh Government, 2020), particularly in values focussing on prevention and proactively supporting people.

Social prescribing in Wales is defined as ‘connecting people whatever their age or background with their community to better manage their health and well-being’ (Welsh Government, 2023; Rees et al., 2019). The definition was originally developed during a consensus workshop using a Nominal Group Technique (Van de Ven & Delbecq, 1972; Kenkre et al., 2013), which brought together an invited group of 45 participants reflecting cross-sector working practices, including practitioners, commissioners, social prescribers, academics, and members of the public. They represented statutory and non-statutory health and care organisations, as well as third sector, voluntary, and community groups. The original definition and its person-centred model (Fig. 5.1) informed the Welsh Government consultation document for the new National Framework for Social Prescribing in Wales (Welsh Government, 2022a, 2023). The consultation document described five possible referral pathways, the self-referral pathway, the healthcare referral pathway (additional support or alternative support), the statutory sector referral pathway (e.g., police, housing, social services), the third sector pathway, and the targeted referral pathway (a proactive offer for individuals or populations who have specific identified needs). It is a strength-based approach with five key parts, relationship building which includes a ‘what matters conversation’, signposting, reconnecting people with their own community, community development, and providing feedback to the original referrer. Signposting or connecting individuals to community-based support could be provided face-to-face or online. In 2021, we found that there was a variety of community assets including mental health support, befriending, healthy lifestyle, and financial support (Wallace et al., 2021). The new Welsh Government National Framework for Social Prescribing was published in December 2023.

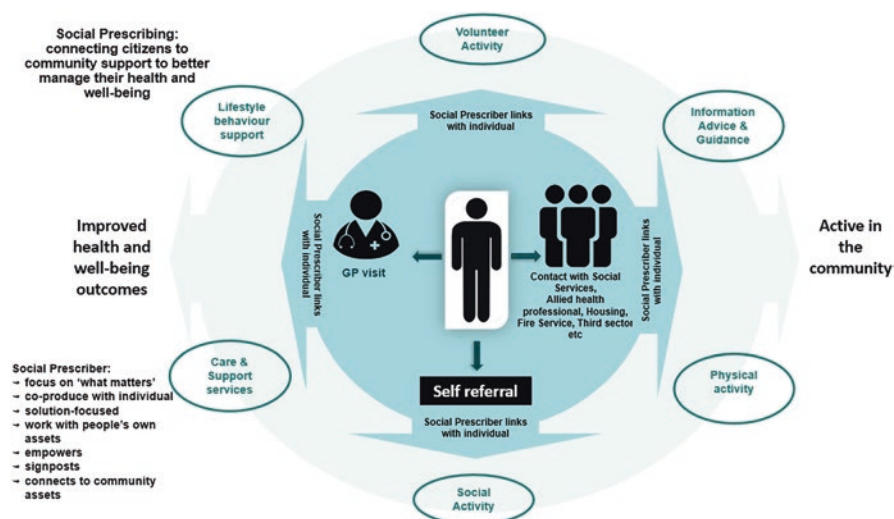


Fig. 5.1 Social prescribing model – person-centred. (Rees et al., 2019, Appendix 6, Proposed Option B)

5.3 Developing the Evidence Base in Wales Using a Translational Model

The Wales School for Social Prescribing Research (WSSPR) has supported the development of the social prescribing evidence base. It uses a translational model of research (Cooksey, 2006; Weeks et al., 2013) collaborating with colleagues from health, social care organisations, and members of the public. This approach develops and critiques knowledge to/for practice-based contexts to mutually enrich practice and theory. It promotes a symbiotic equal relationship between theory-building, knowledge acquisition, and practice without privileging any one activity over the other. Translational research is described as a ‘multi-phase and systematic programme of applied research, development and evaluation’. This is achieved through four phases (Fig. 5.2), which we are illustrating through the context of the glossary of terms as follows:

1. *New knowledge production* through network engagement, grant collaboration and study engagement. It is concerned with ‘framing’ the research or evaluation problem. For example, in June 2018, whilst consulting with members of the public in the PRIME Centre Wales SUPER Group (Evans et al., 2020), the need for a glossary of terms was identified to ensure that terms were used in a consistent way.
2. *Knowledge transfer and translation for use in real-world environments.* For example, in 2021, funding was secured and the process of developing the glossary of terms commenced with a scoping review and a Group Concept Mapping (GCM) consensus study.

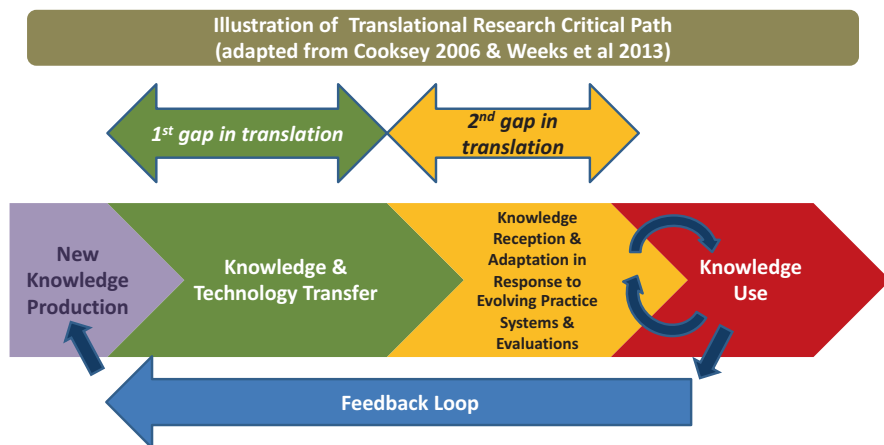


Fig. 5.2 The translational research critical path. (Adapted from Weeks et al., 2013. Copyright 2013, with permission from Elsevier)

3. *Knowledge reception, assessment, and evaluation by stakeholders.* Knowledge gained in phase 2 went through two consultation processes, following the scoping review and GCM study, but prior to producing the initial draft version of the Glossary and then multiple rounds of consultation with various stakeholders to further refine the glossary. Stakeholders included members of the Public Health Wales Social Prescribing Coordinating Group, WSSPR Steering Group and Patient and Public Involvement (PPI) members, social prescribing professionals from networks associated with WSSPR and PHW. The consultation process helped to define the scope of terms to be included in the glossary, identify potentially missing terms, classify terms as either a ‘core’ or ‘non-core’ social prescribing term, refine the various draft versions of the glossary, and developed a visual representation of the social prescribing pathway that encompasses all the suggested terms in the glossary.
4. *Knowledge use* post evaluation introduction and application of knowledge in practice. This phase will begin in 2024.

There are two ‘gaps in translation’ that must be bridged for knowledge to move from ‘lab’ (place of origin) to ‘bedside’ (place of use). We have adapted the Cooksey/Weeks et al. (2013) model to incorporate insights from the workings of complex adaptive systems and paradigmatic change (Braithwaite et al., 2018). Once the Knowledge Use phase is reached, an iterative process develops, where evaluation from practice leads to adjustment in knowledge use, until such time as it is no longer fit for purpose and new knowledge is needed. In this way, iterative cycles of knowledge production, transfer, evaluation, and use are generated on variable time scales in response to societal changes. Once the glossary of terms in its Welsh and English formats are used in practice and we receive feedback on use (new knowledge production), the four phases begin again.

5.3.1 *Developing a Glossary of Terms for Social Prescribing in Wales (and Beyond)*

5.3.1.1 Development of Terms

Social prescribing has seen a period of proliferation and development over the last decade, across the UK nations and beyond (Bertotti et al., 2018; Morse et al., 2022; Rempel et al., 2017). The speed at which social prescribing has developed has led to a lack of standardisation of the language which accompanies it (Newstead et al., 2023a; Rempel et al., 2017; Wallace et al., 2021). This lack of consistency in the social prescribing-related language creates confusion for professionals and the public alike, impairing communication between sectors, professionals, and the public. Through consultation, the Wales School for Social Prescribing Research (WSSPR) identified a need for a reference tool to unify the language associated with social prescribing (Wallace et al., 2018, 2021) and committed to the development of a glossary of terms for social prescribing in Wales (Wallace et al., 2018). This work was undertaken in conjunction with Public Health Wales (PHW) and informs the Welsh Government National Framework for Social Prescribing and commissioning guidance.

The identification of social prescribing terminology and subsequent development of the glossary of terms drew on data from a scoping review, group concept mapping (GCM) consensus study, and feedback following consultation within Wales (Fig. 5.3).

Research into the terminology associated with social prescribing began with a comprehensive scoping review that examined peer-reviewed journal articles from within the UK and grey literature documents produced within Wales, which identified 373 terms associated with social prescribing (Newstead et al., 2023a).

While there was some overlap between terminology used in the peer-reviewed literature of the UK nations, and that used within the grey literature of Wales, there

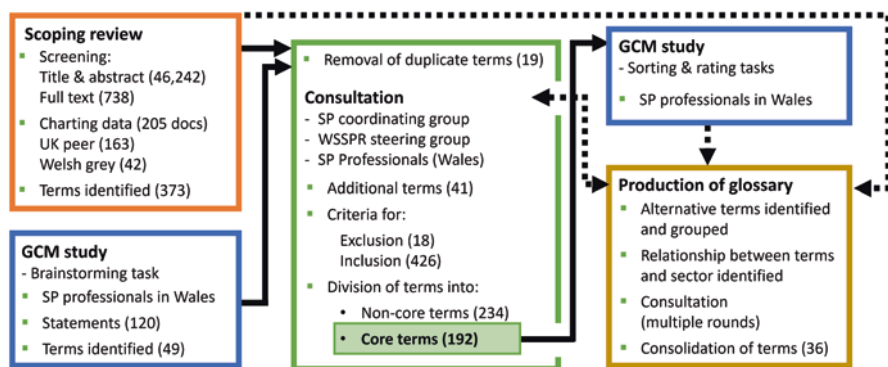


Fig. 5.3 The process of identification of social prescribing terminology and the development of the glossary of terms. (Newstead et al., 2023b)

were also substantial distinctions. Eighty percent of the terms identified occurred within the peer-reviewed literature, 30% occurred within the Welsh grey literature, and there was a 10% co-occurrence of terms across both sources.

The influence of the English, healthcare-based model of social prescribing on terminology was apparent. Most of the terminology used within peer-reviewed articles occurred in articles that described research or interventions based within England, with 49% of these terms solely occurring in such articles. For both peer-reviewed and grey literature, the largest contributions of terms were found in articles that were authored from the perspectives of health or health and social care. However, the contribution of terms that solely occurred or co-occurred in articles authored from the perspective of third-sector community and voluntary sector organisations was much higher in the grey literature of Wales than in the peer-reviewed literature. This may reflect differences in the social prescribing models in England and Wales, and/or the barriers that third-sector organisations face to publishing in peer-reviewed journals.

A Group Concept Mapping (GCM) study (Newstead et al., 2023c), using GroupWisdom™ software, captured an additional 49 terms from social prescribing professionals in Wales via a brainstorming task. The study provided contextual insight into how core social prescribing terms (described below) identified throughout the course of the research related to each other (Fig. 5.4), and how these might differ between the healthcare and social care sectors and third sector community and voluntary sector organisations via sorting and rating tasks.

The iterative translational phases of research used to develop the glossary of terms included multiple rounds of consultation and refinement. This consultation process helped define the scope of terms to be included, identify any potentially missing terms, and classify included terms into two groups: (1) 'core' social prescribing terms i.e., those that specifically relate to and/or describe an essential part of the social prescribing process; and (2) 'non-core' social prescribing terms i.e., terms that are associated with social prescribing but which do not specifically relate to and/or describe an essential part of the social prescribing process. In total, 426 terms were identified; 192 core terms and 234 non-core terms. The development of the glossary of terms focused on the core terms. Most glossaries are simply comprised of a list of 25–50 specialist terms, without any accompanying descriptions or definitions. A list of 192 terms is simply too cumbersome for everyday use and the complexities of social prescribing language necessitated a different approach to help inform the user, provide additional contextual information, and standardise terminology.

A consolidation process of the core terms resulted in a final list of 36 glossary terms. Prior to this research, it was known that a variety of terms existed to describe specific aspects of social prescribing, although the extent of this diversity of terminology was not fully appreciated. Data from the scoping review and GCM study indicated that many of the terms identified related to a few specific aspects associated with social prescribing and/or were alternative and often less commonly used terms used to describe the same principles or process (Newstead et al., 2023a, b, c). For example, the research produced a list of 28 terms describing the process of

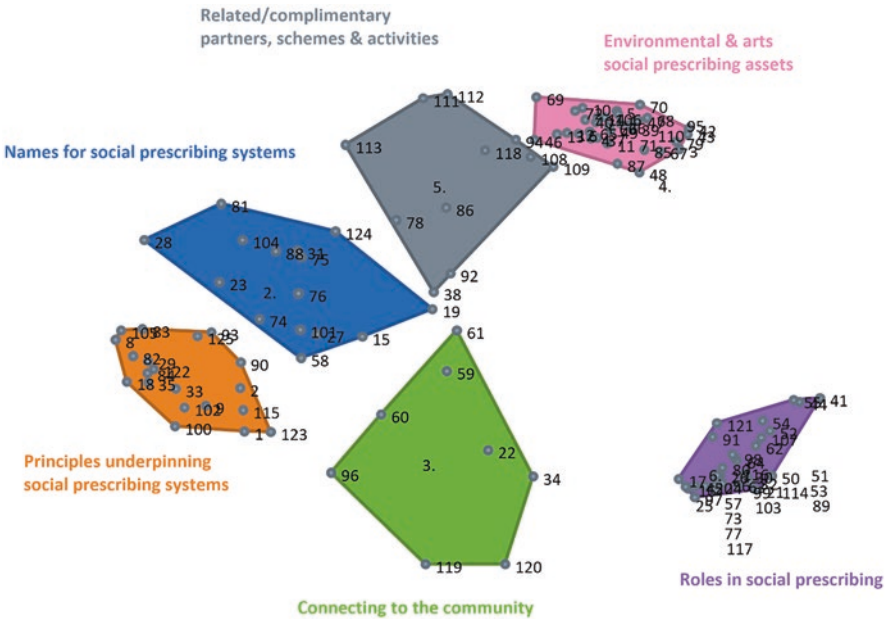


Fig. 5.4 Cluster and point map of core social prescribing terms. (Newstead et al., 2023c)

social prescribing and 27 terms describing the role of the social prescribing practitioner. Similarly, in the sorting task of the GCM study, 22 terms were included in the cluster ‘Principles underpinning social prescribing systems’, several of which were alternative terms for the same process or principle.

Where multiple terms for a particular aspect associated with social prescribing were identified, the most commonly used and/or the most appropriate term for use across sectors was identified and included in the glossary entry. Each of the 36 terms was accompanied by a description, a list of alternative terms (including sector-specific preferences for terms, where appropriate), and a list of connected glossary terms to help the user understand how the terms related to each other (Fig. 5.5). The descriptions were initially obtained from the scoping review literature and refined to reflect social prescribing practice in Wales and align with Welsh Government policy. Further refinements were made following consultation feedback. By displaying information in the manner described, all 192 of the core terms are represented within the entries for the 36 glossary terms, either as a glossary term, an alternative term, or in the accompanying description.

Throughout the development of the glossary of terms, editorial considerations were made to ensure that the terminology reflected the current status quo of social prescribing within Wales. The UK academic literature on social prescribing is largely produced by England and is predominantly based within healthcare. However, within Wales social prescribing is largely concentrated within the third sector (Wallace et al., 2021). The production of a glossary of terms for social

Social Prescribing Practitioner^{C, GCM, SR}

Description: Social prescribing practitioner is an umbrella term that is used to describe someone who assists individuals with identifying their non-medical needs through a [what matters conversation](#), and helps them [co-produce](#) an [action plan](#) and access local [community assets](#), such as **groups, interventions or services**. If they identify a potential medical need they may also [refer](#) the individual to a GP or pharmacist. The **social prescribing practitioner** will work with individuals to find activities tailored to their preferences and needs, explore barriers and challenges to attending, and encourage ongoing participation. While there are preferred terms for the **social prescribing practitioner** role within sectors, they may also be known by a variety of terms that can be specific to the organisation in which they work. **Social prescribing practitioners** can be employed by a range of different organisations, such as local authorities, health boards or [Community & Voluntary Sector Organisations](#).

Alternative Terms: **Community connector**^{CVSO}, **community co-ordinator**^{SC}, community health champion, community link officer, community links practitioner, **community navigator**^{CVSO}, facilitator, health adviser, health broker, health connectors, link co-ordinator, **link worker**^{HC}, **local area coordinator**^{SC}, **local asset coordinator**^{SC}, non-medical link worker, referral agent, referral worker, referrer, social prescriber, social prescribing coordinator, social prescription officer, wellbeing advisor, wellbeing community co-ordinator, wellbeing co-ordinator, wellbeing links advisor, wellbeing worker.

Connected Terms: [Action planning](#), [asset-based approach](#), [asset mapping](#), [care navigator](#), [community assets](#), [co-production](#), [health facilitator](#), [holistic](#), [person-centred approach](#), [referral](#), [signposting & active signposting](#), [social prescribing](#), [social prescribing models](#), [social prescribing pathway](#), [wellbeing](#), [what matters conversation](#).

Fig. 5.5 Example of one of the 36 suggested terms in the glossary of terms. (Newstead et al., 2023b)

prescribing provides an opportunity to move away from this healthcare bias and embrace terminology that reflects the cross-sectoral Welsh model of social prescribing.

For example, the term ‘link worker’ was the most commonly used within the literature to describe a social prescribing practitioner and was the only term used within the literature across all nations of the UK. Within Wales, however, the terms ‘community connector’ and ‘community navigator’ were the preferred terms used by social prescribing professionals working within the third sector. It was felt that promoting ‘link worker’ as the glossary term would ignore the prevalence and importance of terms favoured by the Welsh social prescribing community. The glossary, therefore, suggests the use of the term ‘social prescribing practitioner’, while highlighting sector-specific preferences for the use of those alternative terms within the glossary entry.

Consultation feedback on the Welsh Government National Framework for Social Prescribing (WG, 2022a, b), which occurred in tandem with the development of the glossary, indicated that the ‘prescribing’ element of the term ‘social prescribing’ was itself divisive. ‘Prescribing’ was perceived as a process that told individuals what they should do and did not accurately reflect the nature or key elements of social prescribing, which include a ‘what matters’ conversation and the co-production of goals between the social prescribing practitioner and individual (Thomas et al., 2021). Due to its ubiquity and international recognition, it was decided that the glossary of terms should promote ‘social prescribing’ as an umbrella term, but

that sector-specific preferences for the use of alternative terms, such as ‘community connection’ and ‘community navigation’ within the third sector, should also be highlighted.

The bias of healthcare-derived terminology was again evident in the labelling of various community assets. For example, art ‘on prescription’, which does not easily sit within the cross-sectoral model of social prescribing within Wales. Consequently, it was felt that ‘on referral’/‘referral’ was a more appropriate suggested term of use and one that more accurately reflects the terminology used by Welsh-speaking communities. In some cases, such as ‘exercise on referral’, the term already existed in the literature, while others were modified for the glossary of terms to help unite the social prescribing language within Wales. For example, ‘green prescribing’ became ‘green referral’ and the umbrella term ‘creative referral’ is used to describe a variety of assets such as ‘art on referral’ and ‘dance on referral’. Consultation on the glossary also highlighted that research had not identified a term in use that described aspects of social prescribing such as debt support and legal and financial advice. To describe these aspects of support, the term ‘welfare support referral’ was coined.

5.3.1.2 Using the Glossary of Terms

The glossary of terms (Newstead et al., 2023b) is a professional-facing and interactive document aimed at those working in/with social prescribing. The language and narrative used, while hopefully accessible to the general public, is therefore reflective of the target audience. The glossary of terms includes an interactive flowchart (Fig. 5.6) that depicts how each of the 36 glossary terms sits within the social prescribing pathway.

It is anticipated that the glossary of terms will be used by academics, social prescribing professionals, health and social care professionals, and those working within community and voluntary services. It provides a frame of reference for aspects such as commissioning social prescribing services, policy documents, training, job descriptions, research, and public information. Indeed, it has already been used in the development of the Welsh Government National Framework on Social Prescribing (WG, 2022a, b, 2023), their public-facing national model of social prescribing in Wales, and commissioning guidance. While the glossary of terms is available to the public, it was acknowledged that different language may be needed to make the document more accessible. To this end, an easy-read version was developed in conjunction with Learning Disabilities Wales (Newstead et al., 2023d), which contains the 22 terms those accessing or delivering social prescribing are most likely to encounter. A website (www.splossary.wales) that houses both versions was also developed. The website allows users to easily switch between versions and between Welsh and English. As social prescribing language and terminology evolve, the glossary will be refined and updated. The website will aid in the collection of data to support these changes (feedback loops; Fig. 5.2) and facilitate dissemination of the updates. Referring back to our translational model of research (Fig. 5.2), once the Knowledge Use phase in our translational model is

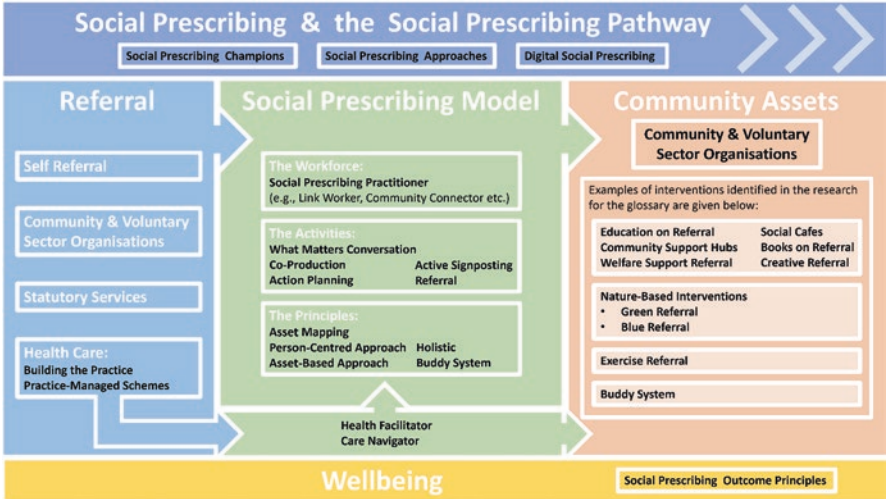


Fig. 5.6 Social prescribing glossary terms depicted within the social prescribing pathway. (Newstead et al., 2023b)

reached, an iterative process again develops where evaluation from practice is needed to develop new knowledge and so the translational phases continue.

5.4 Understanding Evaluation and Monitoring in Wales

5.4.1 Rationale for ‘Standardising’ Evaluation and Monitoring: What Is It and How Does It Fit?

The World Health Organization (2022, p. 32), defines monitoring and evaluation as:

Monitoring: Routine assessment of the intervention, which helps to assess if the targets are achieved on time and within the budget. Timely monitoring may help to identify barriers to successful implementation of social prescribing.

Evaluation: Episodic assessment of the intervention to determine if the objectives have been achieved efficiently and effectively. Evaluation generates the evidence to show whether social prescribing is effective and cost-effective in the given context.

Monitoring and evaluating social prescribing is crucial to determining intervention success, in terms of aims, objectives, and intended outcomes for the target population. Efficient monitoring and delivery of robust evaluations provide evidence of the effectiveness of the intervention, including what works, for whom, and why; the extent to which the intervention is achieving its aims; unintended consequences of the intervention; and future improvements/adaptions. Evaluation is

critical for informing service commissioning, service improvement, and policy decisions. To support this, the WHO (2022) recommends the integration of monitoring and evaluation from the outset, particularly when implementing a new social prescribing programme in the local context.

Having skills, knowledge, and confidence to develop and deliver effective monitoring and evaluation is essential to delivering and reporting trustworthy, usable findings. Yet, as a complex intervention involving multiple stakeholders, varying models and outcome measurement tools, evaluating social prescribing interventions is challenging (Morse et al., 2022; Tierney et al., 2020). Consequently, the social prescribing evidence-base is inconsistent and inconclusive, and previous evaluations have faced criticism for poor quality, limited methodology, and data reporting (Cunningham et al., 2023; Elliott et al., 2022; Pescheny et al., 2020).

Issues of methodological rigour and an absence of transparency lead to challenges in assessing the quality of evidence and difficulties determining ‘who received what, for what duration, with what effect and at what cost’ (Bickerdike et al., 2017, p. 14). Methodological rigour and transparency of social prescribing evaluations must be improved to inform evidence-based practice, decision making, and commissioning (Elliott et al., 2022). Doing so will benefit users, researchers, organisations, decision-makers, and policy-makers through the development, implementation, and delivery of commissioned social prescribing interventions that meet the needs of the local population and context.

At the time of writing, the ACCORD study at WSSPR is addressing these challenges (Elliott and Wallace, 2021). The first phase involved a Realist Review of social prescribing evaluation methods, which identified three components of social prescribing evaluation; preparation, conducting the study, and interpretation (Elliott et al., 2022). The underpinning programme theory as to how social prescribing evaluations worked involved: (1) Co-production, (2) Alignment (3) Researcher agency, (4) Sequential design, and (5) Integration (Fig. 5.7). A Group Concept Mapping consensus study identified principles of good practice in evaluation rated as important and helpful by a multi-stakeholder group. Synthesis of these findings and a Delphi study will inform development of the social prescribing evaluation framework and reporting standards. This will also incorporate an economic evaluation component, through Social Return on Investment (SROI), which have been found useful, especially when using a mixed-methods approach (Makanjuola et al., 2022).

5.4.2 Why Use SROI and the Green Book Approach?

Social Cost-Benefit Analysis The Social Value Act (2012), Procurement Reform (Scotland) Act (2014), and Wellbeing of Future Generations (Wales) Act (2015) entail public bodies taking legitimate responsibility to consider how services improve social, cultural, environmental, and economic wellbeing.

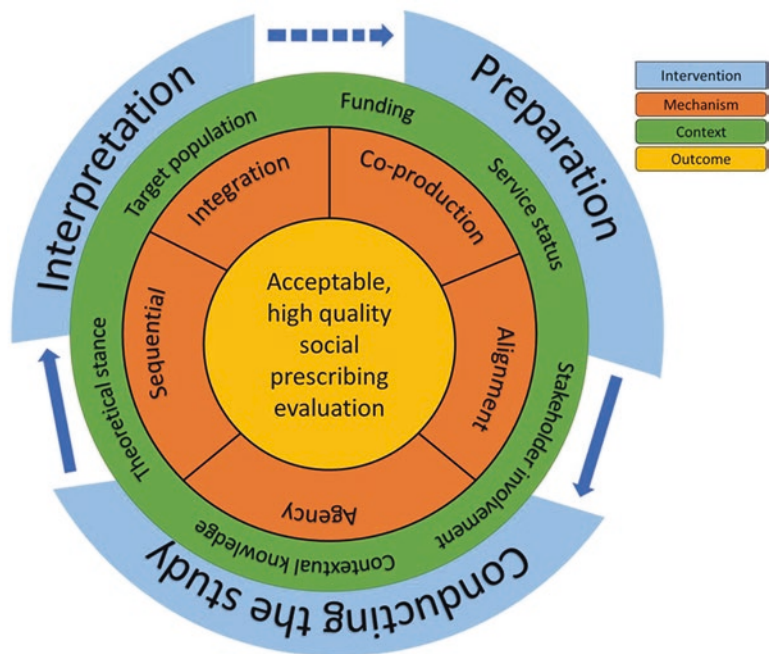


Fig. 5.7 The cyclical relationship between the three components of social prescribing evaluation. (Reproduced from Elliott et al., 2022, Figure 3. With permission from BMJ Publishing Group Ltd. <https://doi.org/10.1136/bmjopen-2021-057009>, licensed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (<http://creativecommons.org/licenses/by-nc/4.0/>))

The National Institute for Health and Care Excellence (NICE) recommend the use of Cost Benefit Analysis (CBA) and Cost Utility Analysis (CUA) (NICE, 2012), and the HM Treasury advise the use of Social Cost Benefit Analysis (SCBA) for the evaluation of public health interventions (HM Treasury, 2022). SCBA is the default and preferred option to ascertain whether the benefits of a programme outweigh the costs. Therefore, it is imperative to determine all costs and benefits which need to be measured, and SCBA can provide additional evidence and understanding on costs to benefits that can be directly compared then converted into monetary terms as outlined by the Green Book (HM Treasury, 2022).

Social Return on Investment (SROI) is still advancing and can provide meaningful insight on economic evaluation of health interventions that is beneficial for policymakers, funders, and practitioners of public health intervention to improve health and wellbeing outcomes. SROI realises, in a monetised form, the value of a wide range of outcomes, whether these already have a financial value or not. SROI analysis produces a narrative for how an organisation creates value for key stakeholders and provides a Social Value Ratio (SVR) that states how much social value (in £) is created for every £1 of investment.

SROI is a pragmatic outcome-focused framework of SCBA, which takes account of the economic, environmental, and social value of interventions combining qualitative narratives and quantitative/financial measurements of real-world research as outlined through eight key steps (Makanjuola et al., 2022). Evidence has identified the benefits of the SROI model (Corvo et al., 2022) and the growing momentum of applying this approach to examine the social value created to improve physical function and slow the progression of dementia (Hartfiel et al., 2022).

In Wales, members of the WSSPR Social Value team have conducted a number of SROI evaluations:

- Assessment of social value generated and value of resulting benefits of the Health Precinct, a community hub in North Wales delivering social prescribing interventions to improve wellbeing of older people with chronic conditions. It identified a base case SROI ratio of £5.07 of social value generated for every £1 invested (Jones et al., 2020).
- Emotion Mind Dynamic (EMD) based in South Wales is a lifestyle coaching programme that supports individuals suffering from anxiety or depression. The SROI evaluation generated positive social value ratios ranging from £4.12–£7.08 for face-to-face clients and between £2.37–£3.35 for online clients for every pound invested (Makanjuola et al., 2022).
- The MY LIFE programme delivered by Conwy West Primary Care Cluster, North Wales, aimed to preventing type 2 diabetes by referring prediabetic patients with a BMI of ≥ 30 to a diabetes technician (DT), who then signposted patients to community-based SP programmes. The SROI evaluation demonstrated that the DT plays a key role in generating social value for prediabetic participants with SROI ratios ranging from £4.67–£4.70 for every £1 invested for DT plus the SP activity (Skinner et al., 2023).
- The Outdoor Partnership in North Wales delivers the Opening Doors to the Outdoors programme, aimed at individuals with low mental wellbeing. The 12-week walking and climbing social prescribing intervention provides opportunity to increase physical activity, confidence, self-esteem, and quality of life. The SROI evaluation identified improved mental wellbeing, increased physical activity, more social trust, and better overall health among participants. For every £1 invested, there was positive social value ratios between £4.90 and £5.36 generated (Makanjuola et al., 2023).

SROI appraisal methods, for monetising social/public value effects should include Revealed Preference techniques i.e., Travel Cost Model and or Stated Preference techniques of Contingent Valuation method applying Willingness To Pay or Willingness To Accept. Merging these approaches within a SROI evaluation facilitate the capture of real-world trade-offs as well as the use, non-use, and option values for goods and services not traded in the open market. In contrast to these preference-based techniques, SROI evaluation includes wellbeing valuation to estimate the value of non-market goods by examining how they impact on reported well-being and life satisfaction (Fujiwara & Campbell, 2011). This is recognised in the Green Book (HM Treasury, 2022) as a robust method for financial estimation

and evaluation. Wellbeing valuation offers a consistent and robust method for estimating the monetary value of outcomes that do not have market values. It can be applied using two social value calculators: the Social Value Calculator derived from the Social Value Bank and the Mental Health Social Value Calculator derived from the Short Warwick Edinburgh Mental Wellbeing Scale (Trotter et al., 2014).

5.4.3 Developing a Local Monitoring Framework

Across 2022/2023, colleagues at the University of South Wales have been working to develop a local monitoring framework for social prescribing in collaboration with local area services and providers. The framework is made up of four key component parts, the initial scoping review, a Group Concept Mapping (GCM) study to identify a core minimum dataset, a Development Matrix (DM), and a Satisfaction Questionnaire, each of which are detailed here.

At the inception of the work, a scoping review was undertaken (Randall & Wallace, 2022b) to conceptualise the literature on service user or patient experience of social prescribing, identifying the nature and extent of existing research evidence. The search comprised academic literature across four databases: CINAHL, Cochrane, ProQuest, and Social Care Online. Due to the nature of a scoping review and the high amount of literature identified from searches, snowballing did not take place. Sixty papers were included in the review. Findings focussed on referral mechanisms, relationships with key stakeholders, and barriers to engagement.

The GCM study was carried out across Wales to generate professional consensus on a core minimum dataset for the framework (Randall & Wallace, 2022a). Key findings included identification of clusters of statements and ranked lists of data items by importance and ease of collection according to professionals in Wales, the top five of these were:

1. What matters to the person
2. Does the person think that the service has helped them with their problem
3. Outcomes and benefits in the person's own words
4. Number of people reporting a positive experience
5. Number of referrals

In tandem, conversations with services were held with local services to inform the DM, which aims to provide a framework for qualitative assessment of progress and is designed so services can assess progress with a set of descriptors and indicators across six domains.

Synthesis of these components led to the structure of 6 domains and 21 indicators related to how domains may be measured or improved, with examples provided (Table 5.1).

The evaluation framework is accompanied by a Satisfaction Questionnaire developed based on the findings. Findings informed modification of a draft developed for a previous study, which was refined by USW with support from a local Patient

Experience Department. The draft then received feedback from key stakeholders resulting in a final Satisfaction Questionnaire of 4 sections and 19 questions, summarised in Table 5.2.

Table 5.1 Domains and indicators included in the Development Matrix (DM)

Domain	Indicator	Example data item from GCM study
1. Relationships	1.1 With senior leaders	Is the person more confident in finding support in the future if needed?
	1.2 With GP surgeries and staff	
	1.3 With clients in the service	
	1.4 With the general public	
2. Community insight and involvement	2.1 Knowledge of the local context	Identifying areas where there are lower levels of take up (i.e., due to gaps in opportunity/provision/link workers)
	2.2 Knowledge of local services and groups	
	2.3 Community presence	
	2.4 Contribution into the community	
3. Staff	3.1 Well-being of the staff team: managing capacity	Right knowledge and skills for project delivery
	3.2 Well-being of the staff team: emotional load	
	3.3 Staff supervision	
	3.4 Staff development	
4. Person-centred approach	4.1 Inclusivity and responsiveness of the service 'offer'	What matters to the person
	4.2 Flexibility and person-centredness of the SP professional	
	4.3 Removing barriers to service access	
	4.4 Client feedback into the service	
5. Service development	5.1 Monitoring of outcome measures or performance indicators, utilisation, and feedback	Patient reported outcome measures
	5.2 Opportunities for co-producing the service with clients	
	5.3 Funding and longevity	
	5.4 Supply and demand	
6. Information governance	6.1 Confidentiality and consent	Safeguarding – DBS checks
	6.2 IT systems	

Table 5.2 Satisfaction questionnaire sections and example questions

Section	Example question
A. Before attending our service	3. How satisfied were you with the time it took from being referred to being initially contacted by us?
B. Whilst attending our service/organisation	11. Was the advice and information provided clear and easy to understand?
C. Your overall view of our service	14. Was there anything that we could change to improve our service/organisation?
D. Your lifestyle	17. What lifestyle changes are you planning to, or have you, made?

5.5 Conclusions

Social Prescribing in Wales is a function which is set within the context of wellbeing legislation and is integrated within existing community and statutory services. It offers a holistic approach for people who cannot otherwise find and engage with their local community activities or services. It uses a strengths-based approach and is aligned with values focussing on prevention and proactively supporting people to manage their wellbeing within their own communities.

This chapter has introduced you to social prescribing in Wales. It has explained how a cross sector and translational approach has helped to identify and develop new knowledge, develop the evidence base, and use it in practice. Social prescribing in Wales has just launched its new National Framework and other parts of its infrastructure, such as the glossary of terms and monitoring and evaluation framework. This includes Social Return on Investment, a Development Matrix, a core dataset, and the voice of the person using social prescribing services through a satisfaction questionnaire. Concentrating on listening to what matters to people who use and work in social prescribing has resulted in a journey where those that build theory (academics and researchers) and those who use the knowledge in practice (practitioners, commissioners, planners, and policy makers) have listened to each other equally, creating the best evidence for social prescribing in Wales.

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Chapter 6

Social Prescribing in the Portuguese Context: Challenges and Strategies to Implement and Evaluate a Complex Intervention



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6.1 Current Challenges to Health Systems in Portugal and the Emergence of Social Prescribing

The ageing of the population and the increased burden of chronic and non-communicable diseases has led to a new health profile of populations worldwide, and this is no different in Portugal. Approximately 22% of the population in Portugal is over 65 years old and 41% of the population aged ≥ 16 years old report suffering from at least one chronic illness. Stroke, ischaemic heart disease, chronic respiratory diseases, cancer, and diabetes are the leading causes of death and disability and are mostly attributed to behavioural and environmental risk factors, such as smoking, dietary risks, alcohol consumption, low level of physical exercise, and air pollution (OECD, 2021). Social and economic factors, including unemployment, low income, low education, social exclusion, and isolation, are also associated with high prevalence of non-communicable diseases and contribute to health inequalities. Additionally, in 2020, the COVID-19 pandemic had immediate health and social impact that disproportionately affected socioeconomically disadvantaged populations. Addressing the demographic changes and the new health profiles, while tackling the social determinants of health, have been major challenges for health services in general.

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In a global overview, the National Health Service (NHS) is the structure managed by the Portuguese State that ensures the right to health to all residents in Portugal, providing universal coverage for a comprehensive set of services (health promotion, prevention, surveillance, and treatment). The main source of funding of the Portuguese NHS is the State Budget, fed by taxes applicable to all residents in Portugal. Out-of-pocket payments, mainly user charges, represent a small part of NHS funding, and have been eliminated from Primary Health Care (PHC) since 2020. The Portuguese NHS is regulated at the central level by the Ministry of Health and its institutions and is managed at the regional level by the Regional Health Administrations (RHAs). The RHAs are responsible for the strategic management of population health, supervision of public hospitals, direct management of NHS PHC centres, and implementation of national health policy objectives (OECD, 2021).

The PHC is the first level of the NHS and it has been strengthened through the ongoing reform initiated in 2006 aimed to improve its accessibility, proximity, quality, and equity of health care (Ministério da Saúde, 2016; World Health Organization, 2008). The creation of Family Health Units in 2007, and the PHC Centre Groups in 2008, restructured the organization of the Portuguese primary care in order to provide integrated primary care for the local population (Simões et al., 2017). The rate of avoidable hospitalizations in Portugal is one of the lowest in the European Union, which may be partially attributed to the changes implemented in the recent years, such as the greater involvement of PHC units in the management of chronic diseases (OECD, 2021). The Portuguese PHC is organized in Health Centre Clusters (ACeS), which are public health services with administrative autonomy, decentralized from the RHAs, and composed of different functional units (Biscaia & Heleno, 2017). One of them, the Family Health Units, is proximity units with voluntary and self-organized multidisciplinary teams (Biscaia & Heleno, 2017). These units are staffed by family doctors, nurses, and clinical secretaries and receive specialized support from social workers, psychologists, physiotherapists, and occupational therapists. The Family Health Units are paid partially through incentive mechanisms that are linked to specific activities of health monitoring and surveillance of patients at risk.

The health sector is an area permeated by increasing complexity and volatile changes in users' needs, besides by constant transformations of knowledge and technologies. In view of current health challenges and the influence of social determinants of health, the clinical approaches only (based on disease treatment and the biomedical model) have shown to be insufficient to meet patients' needs. To achieve better health and well-being, individuals must have their social, economic, and emotional needs taken into account. Effective collaboration with diverse parties across different sectors is urgently required to improve health across society. The Social Prescribing (SP) emerges in this context and represents a change in the way of providing PHC.

6.2 Social Prescribing Implementation in Portugal

SP in Portugal started in 2018 in a primary health care unit located in downtown Lisbon: Baixa Family Health Unit, through the initiative of a family doctor, with a small, local pilot project in a totally bottom-up approach. The social worker based at that PHC unit joined the implementation team and together they started the out-reach approach to raise awareness and support to the stakeholders. Later, another Family Health Unit joined the SP project. These units provide general healthcare to all age groups of the population under their responsibility, which covers approximately 29,000 people. These units' users are composed of people in vulnerable situations, such as elderly in isolation, recently arrived migrants, unemployed adults with low education, and people experiencing homelessness. The SP project was implemented with the aim of responding to users' socioeconomic and emotional needs through the activation of community assets, to improving their health, well-being, and quality of life. The SP project was also aimed at improving communication, articulation, and collaboration between health professionals, social workers, and social partners in the territories covered by these units. From the beginning, the National School of Public Health, NOVA University of Lisbon took part in the project, supporting the health team in the planning and implementation of the project, as well as in the monitoring and evaluation of the implementation process and impact of SP to promote the continuous improvement of the pilot project.

Overall, patients of all age groups and with non-clinical needs, assisted in these units, can be referred to the SP programme by their PHC providers or they can self-refer into the programme (Fig. 6.1). Lately, clinical secretaries were also involved in a proactive referral of eligible patients to the SP programme during their front-desk contacts. During the appointment, the health professional may identify some non-clinical needs and then explain the SP service to the patient, asking about their interests about being referred to an SP appointment. If the patient consents, the health professional completes a referral form on a computer (IT) platform and an automatic email with the referral information is generated and sent to the unit's

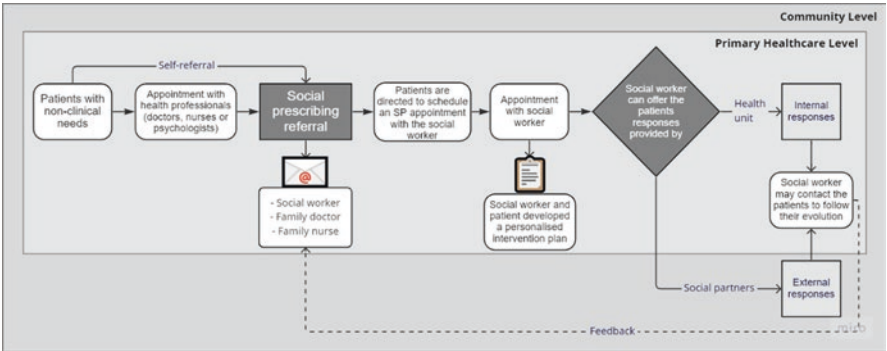


Fig. 6.1 Social prescribing circuit implemented in the pilot project in Lisbon. (Source: Authors)

social worker, as well as the healthcare providers (family doctor and family nurse) that accompany the patient. After the consultation with the health professional, the patient is directed to the service counter in order to schedule an SP appointment with the link worker. If the patient does not book the SP appointment within 2–3 weeks, a clinical secretary will call them to inquire about their interest to still access the SP service.

In the Portuguese context, the role of link worker in SP is undertaken by the social workers based at the Family Health Units, hence, they are the professionals who, technically, receive the referrals to the SP service. During the SP appointment, the link worker develops an individual care plan with the patient through a participative and co-design approach, performing a detailed assessment of the patient's needs and helping to find the best responses available in the service and with partners in the community where the individual lives. The social worker can introduce and offer to the patient some activities provided by the health unit itself, such as walking groups, health literacy sessions, or other internal responses, besides external responses (i.e. those offered by the social partners, from the social/voluntary sector or the community). After the SP appointment and the referral process, the social worker may still contact the patient to follow their pathway and, if necessary, to schedule further appointments. The social worker may also get in touch with the community services to obtain information about the patient's adherence and satisfaction. Besides, the social worker updates and shares information with the health professionals about their referred patient. Finally, the SP intervention can be considered completed or finished once the patients have their needs met, do not attend the scheduled SP appointments, or drop out of agreed activities.

The SP pilot project did not receive additional funding but was implemented using the human resources already allocated in PHC, academia, and the existing community responses in the territory. The implementation of SP in Lisbon depended on the early engagement of the different stakeholders: health sector professionals, social workers, community partners, and end users.

The health sector was the first stakeholder to be approached. As the project started from the initiative of NHS health workers, it was crucial to have support from the Family Health Unit team, because it would be responsible for identifying and referring patients to the SP service during consultations, and also from the executive board of Central Lisbon Health Centre Cluster, as it would be important to promote the added value of the service and ensure a protected time to foster its implementation. The implementation team presented the rationale for SP and organized a reflection group with the Family Health Unit team to discuss about the impact of social determinants of health on the deprived population covered by the Family Health Unit and the pertinence and procedures of the SP approach. As the project progressed, regular meetings with the health team were held to update the referrers about the changes to the electronic referral system, new activities and services available in the community, and the component of monitoring and evaluation of the project.

In the Portuguese context, social workers are the professionals who intervene to respond to socioeconomic needs and to improve social inclusion in connection with

social structures, therefore they seemed to be the obvious profile to take on the SP link worker role. Nevertheless, the SP intervention brought about changes in the conventional function of the social worker in these Family Health Units and expanded it. Patients were usually referred to social workers by health professionals mainly due to administrative requests related to access to social and health benefits, such as support with medicines purchase, functional dependency, or end-of-life support. Within the SP intervention, the role of the social worker was expanded to include advice and support on lifestyle changes (e.g. physical activities, food habits), community engagement, employment and training, mental health promotion, personalized emotional and social support, as well as connecting people to community groups, the voluntary sector, and statutory services.

The engagement of the community sector was a critical requirement for the project implementation and a driving force of SP in Lisbon. The community sector was responsible for offering services and activities addressing the non-clinical needs of patients as part of the SP, in line with the individual care plan co-designed by patient and the link worker. SP was a good opportunity to gather health sector and community sector representatives, including local associations, charities, non-governmental organizations, as well as local authorities like local parish boards, the municipality, and public institutes. The SP project set the stage for promoting a deeper integration of care where both stakeholder sectors could help each other to reach its full potential. On the one hand, the community sector could contribute to improve health outcomes by addressing the social determinants of the health of PHC patients. On the other hand, the health sector could facilitate the identification and recruitment of potential beneficiaries of the services and activities arranged locally by the community sector. The SP implementation team and community stakeholders met regularly to decide on the target population of the project and the inclusion and exclusion criteria, to share the social, emotional, and practical needs of patients and the available community responses, services, and activities more appropriate to successfully address those needs. In these meetings, partners discussed the information to be collected at the digital referral by the health professional, the information to be shared with the community sector representatives by the link worker, and the instruments and procedures of data collection for the monitoring and evaluation component.

Topics such as scientific papers, international SP reports, and news were also commonly part of the meetings' agenda. Every 3–6 months, the SP implementation team and academic partner shared the number and characteristics of referrals to SP to encourage discussion and reflection on the work carried out and the forward strategy. These monthly face-to-face meetings became the most visible element of the strategy for the stakeholders' engagement, but were backed by frequent communications through newsletters and social media publications. The pilot SP project in Lisbon progressively became a joint healthcare, community, and academic movement focused on supporting people to reach their full well-being potential in their community.

With the COVID-19 pandemic and the mandatory lockdown in Portugal, it was necessary to slow down the SP activities and shift the focus of the health team

almost exclusively into COVID-19 surveillance and contact tracing. The SP consultations turned to telephone calls and most of the community activities and services were suspended. Nevertheless, to foster stakeholders' engagement during this period, online workshops and meetings were organized by the SP implementation team, which allowed health professionals and community stakeholders from different Portuguese regions to join the SP movement.

Regarding the end user's engagement in the SP initiative, the fact is that the overall population was not familiarized with the SP concept in Portugal. In Family Health Units offering an in-house SP service, patients were surprised when a family doctor recommended a social prescription instead of, or complementary to, the usual biomedical approach. Several strategies were developed to publicize the SP intervention among the communities. Informative leaflets were helpful to raise awareness and promote SP acceptability among the patients, but they require an ongoing investment of time and resources. Regular social media publications and frequent interviews for national and local newspapers have contributed to a slow and gradual change to the way patients perceive SP within primary healthcare. Lisbon's SP implementation team has participated in local health fairs for the general population and every year celebrates the international SP-day, with campaigns and activities focused on promoting patients' awareness. Nevertheless, the SP stakeholders' meetings are still missing the participation of patients to hear their perceptions and experiences with this novel approach to their social, emotional, and practical needs. Giving voice to SP users in interviews for media or engaging with patients' associations have been recent steps towards improving patient awareness of SP in Portugal.

Through the monitoring of the SP pilot project, the NOVA National School of Public Health research team has followed up the SP referrals in the Family Health Units. Preliminary findings about the SP implementation include number of referrals, characteristics of SP users, most frequent reasons of referral, as well as responses provided by the community sector. Overall, between September 2018 and December 2021, 714 referrals were made to SP in Lisbon, being 50.7% ($n = 362$) before the COVID-19 pandemic and 49.3% ($n = 352$) during the pandemic. Most referrals were made by general practitioners ($n = 654$; 91.6%) and the remainder by nurses. Regarding the characteristics of the patients referred, 66.8% ($n = 477$) were female, 62.7% ($n = 448$) had Portuguese nationality and 37.3% ($n = 266$) were foreign citizens from 23 different countries. The most frequent countries of origin were Bangladesh (11.8%), Nepal (5.2%), and Guinea-Bissau (3.2%). The average age of the SP users was 54.8 years, with the most represented age groups being over 65 years ($n = 272$; 38.1%) and 26–45 years ($n = 182$; 25.5%). Regarding the health profile of SP users, 27.5% ($n = 196$) had no chronic disease and 72.5% ($n = 518$) had at least one chronic disease. The most frequent diseases were cardiovascular disease/hypertension/coronary heart disease/heart failure ($n = 224$, 31.4%), depression/anxiety/other mental illnesses ($n = 210$, 29.4%) and obesity/overweight/hypercholesterolemia/other metabolic diseases ($n = 139$; 19.5%). Overall, 25.9% ($n = 185$) had three or more chronic diseases.

Approximately 70.2% ($n = 501$) of users were referred to SP for at least two reasons, and 16% ($n = 114$) were referred for four or more reasons. The most frequent reasons were related to access to social benefits (40.6%), social isolation (29.1%), access to health benefits (21.7%), and support in finding employment or training (21.1%). Among users with no chronic disease, the most frequent reasons for referral were access to social benefits (44.9%), migrant integration (34.7%), and support in finding employment or training (30.6%). Of the 714 referrals to SP, 47.9% ($n = 342$) correspond to users who attended at least one SP appointment, with a total of 555 consultations made and 189 referrals to social partners. The internal responses provided by the Family Health Units were mainly related to psychosocial support and the provision of information on benefits and services available. Regarding external responses, i.e. provided by the community partners, a total of 48 types of responses were identified, the most frequent being the Senior University, Portuguese classes for migrants, and support with medication. These responses were provided by 40 different social partners, such as the High Commission for Migration, the Food Bank, non-governmental organizations, community associations, local authorities, museum, theatre, and the Institute for Employment and Professional Training.

Box 6.1: Case Study Related to Migrant Mental Health

Patricia (fictitious name) was referred by her GP via the IT platform based on identified concerns related to mental health needs, poor physical activity, and sedentary lifestyle. She is an adult female migrant from Nepal, residing with other migrant families. She has three chronic conditions: obesity, diabetes, and arthrosis. She has been living in Portugal for 15 years and speaks and understands the Portuguese language.

During the initial contact with the link worker, an in-person assessment was conducted. Patricia shared that she was unemployed and was currently concerned about financial difficulties to make ends meet and help pay family bills. She reported feeling sad, anxious, and experiencing a high level of pain due to lumbar arthrosis. Her mother lacked income and she was unable to work due to the pain and mobility limitations. Patricia requested assistance with applying for the Social Integration Income (a support measure provided by the Portuguese Social Security aimed at protecting people who are in an extreme poverty situation). Despite this, Patricia expressed a desire to engage in physical activities to reduce weight and alleviate pain.

The link worker recognized that Patricia was motivated and had the potential to integrate aqua gymnastics or aqua fitness classes. As she couldn't afford the monthly fee, she requested a financial declaration to waive the cost of pool activities. A plan of activities was agreed upon to improve body weight, promote pain management, and enhance social interaction. The link worker referred Patricia to the social department of the local council providing the

(continued)

Box 6.1: (Continued)

swimming pool activities and assisted her in submitting the necessary documents for accessing social benefits.

After approximately 20 days, during the second appointment with the link worker, Patricia shared that she started attending the aqua fitness class three times a week for free and felt more motivated and happier. After 4 months, in a follow-up call, Patricia mentioned that she greatly enjoyed the classes and never missed any of them. She expressed feeling more energized, being able to go for walks outdoors with less pain and having already lost weight. In an interview for the evaluation study, Patricia stated: “I am doing better and taking less pain medication. Now I walk all the time and have lost a significant amount of weight.”

6.3 Evaluating the SP Implementation Process and Impact of the Intervention in the Portuguese Context

Overall, the SP movement in Portugal started with a small, local pilot project. Since 2020, the interest in SP has been growing at the local authority and policy levels. Currently, the SP is being implemented in five Family Health Units in Lisbon and in other organizations in different regions of the country. This expansion of the SP movement has also been supported by local municipalities, through financial investments to promote successful and sustainable implementation of local SP initiatives. The growth of the SP movement in Portugal boosted the recent creation of the Social Prescribing Portugal network, based at the NOVA National School of Public Health.

From the beginning of the SP project planning and implementation, an evaluative component was conducted by the NOVA National School of Public Health, assisting the monitoring of the whole process in a close and systematic manner.

In general, the SP innovative nature, the quality of being a complex intervention and its recent implementation, reinforces the need for and relevance of evaluation studies. These studies provide knowledge on the potential impact of the SP intervention for users, for the collaboration between the health and social sectors, and regarding the health system. SP evaluation studies can also contribute to inform evidence-based practice and policy in national and international contexts and provide knowledge for the implementation of future SP interventions. In this sense, SP evaluation research has been essential to understand the factors associated with the implementation, effectiveness, impact, and sustainability of this intervention.

Despite numerous efforts to increase evidence on SP intervention, the development of robust studies of SP has been challenging due to methodological, generalizability, and practical issues. A variety of studies has been performed, such as randomized controlled trials, case-control studies, case studies, qualitative studies,

among others, using various data collection instruments applied with different periodicities and measuring different outcomes (Bickerdike et al., 2017; Pilkington et al., 2017; Mossabir et al., 2015). This heterogeneity poses a great challenge when designing SP evaluation studies (Bickerdike et al., 2017; Polley et al., 2017).

In the Portuguese context, a mixed-methods research was designed to evaluate the implementation and impact of SP, composed of a set of four studies with specific aims, implemented within a community-based participatory approach (Hoffmeister et al., 2021). The studies planned for evaluation include an exploratory, longitudinal, and prospective pilot study to explore SP's contribution to enhance patients' quality of life, well-being, and activation. In this study, data are collected through a questionnaire applied to patients referred to SP on their sociodemographic characteristics, health status, quality of life, well-being, and activation, at the baseline and in follow-ups on months 3, 6, and 12. Additionally, secondary data is collected from patients' medical records on health status indicators and from SP's forms completed during the intervention about the referral and social responses. A second study consists of a qualitative approach through semi-structured interviews about patients' experiences vis-à-vis the SP activities performed, perceived changes in lifestyle, and perspectives on positive and negative aspects of SP. With the purpose of assessing the SP impact at the health system level, a quantitative study draws on data collected from medical records on patients' use of healthcare services (e.g. number of appointments in primary healthcare units, hospital admissions, and emergency episodes). In a fourth qualitative study aiming to understand the effects of SP on the collaboration between the health and social sectors, semi-structured interviews are carried out with health professionals, social workers, and community partners involved in SP, exploring their experiences of networking as well as their perspectives on the process, barriers, and facilitators of SP implementation and suggestions for improvement.

These studies have been important to generate evidence, models, and tools, with analysis of barriers and facilitating factors, which inform the application and scale-up of SP in other health services and contexts in Portugal. The SP evaluation studies have provided a greater understanding of the role of the participatory approach, with collective construction, for the implementation of an effective complex intervention. Furthermore, the experience of Portuguese SP has contributed to the growth of national and international knowledge on the implementation and evaluation of SP.

6.3.1 Insights from the Implementation Process of SP in Lisbon

During the monitoring of the implementation process of Social Prescribing in Lisbon, several barriers and facilitating factors were identified, based on the perspective of health professionals, social workers, and social partners.

In terms of factors that hindered the implementation of SP, an issue was that such innovative service introduced changes in the working processes of health professionals, PHC social workers, and community organizations. While the way health and

community services were organized and worked together was already quite consolidated in the daily life of these organizations and their professionals, the implementation of the SP provoked changes that translated into some resistance.

Another barrier mentioned was related to the resources available to implement the project. The reduced number of human resources and the scarcity of time impacted negatively on the progress of the project activities. The time constraint, mainly of the social workers, associated with a high number of referrals to the SP service, resulted in increased waiting time for appointments with the link worker. Although the PHC social workers took the role of SP link worker, they had other time-demanding roles like supporting the citizen office in managing the patient complaints related to the Family Health Units or providing social service to patients admitted to the community care unit. Therefore, the time allocated to SP activities was frequently not enough to completely fulfil the link worker role, sacrificing mostly the patients' follow-up after referral to community stakeholders, a more proactive mapping and engagement of community assets, and the social workers availability to independently collect SP monitoring and evaluation data. Overall, this had an impact on the motivation of patients, which translated into reduced adherence of users to SP consultations.

In addition, the lack of funding for both health and community services constrained the ability of the SP service to respond timely to the increased referrals to SP, despite the efforts for motivating health professionals to refer and community stakeholders to welcome patients from the Family Health Units. The community stakeholders involved in SP, in particular, have sources of funding non-related to SP that allow their services to run and support the community. However, the activities they promoted were frequently full and could not accommodate more patients via SP because the partnership did not include any financial package to extend their capacity. During the SP implementation in Lisbon, some community partners applied to national public funding programs in collaboration with the SP implementation team, proposing new activities. These funding applications were successful, and it has motivated other community organizations to apply for different funding opportunities with advice and support from the Lisbon SP pilot project team. Such kind of funding increases community capacity and creates opportunities for developing community-based solutions for primary care patients via SP, helping indirectly the Portuguese NHS. Additionally, the municipalities have started to position themselves as possible funders of SP implementation and evaluation in Portugal. The earliest sign was the partnership between the NOVA National School of Public Health and local municipalities for the monitorization and evaluation of the SP pilot project at the two pioneer Family Health Units in Lisbon. More recently, several other Portuguese municipalities have shown their intention to sponsor the implementation of SP in their territories in partnership with the National School of Public Health, NOVA University of Lisbon. This trend may lead to new models for SP in Portugal, for example, with link workers based in the municipality services or the community sector.

With this regard, a specific factor identified as having an impact on the successful implementation of Social Prescribing projects in the country is related to specific

training on Social Prescribing, and the lack of training for link workers. The SP link worker's role in Portugal is currently under development as well as the training and the professional profile required to become an SP link worker. SP is a very recent approach in Portugal and is not part of the bachelor's or master's curricula in the social work field, so the endorsement of social workers to the SP movement, including those based in PHC, is still limited. The few social workers with experience in SP in Portugal have shared some training needs, for instance, related to motivational interviewing, project management, and community engagement. Social workers and primary care health professionals' organizations have requested training in SP and short courses have been offered ad hoc by the NOVA National School of Public Health. More formal SP training is being designed and developed by this academic partner with specific content for future SP link workers who may have different educational and professional background. This can contribute to the diversification of the SP models in Portugal.

Lastly, a point potentially hindering SP implementation from the perspective of stakeholders is linked to the users' perceptions and expectations regarding health services' responses, mainly the role of the social workers. Users did not expect to be referred to a social worker and receive suggestions for activities in the community when seeking health services. In addition, users sometimes did not understand the influence of social determinants on their health and the importance of acting on these factors. These preconceptions of users were reflected in a lower receptivity and adherence to the activities suggested within the scope of the Social Prescribing. In the face of these barriers, potential strategies for enhancing users' adherence to SP have been discussed by the implementation and evaluation teams, for instance, assuring that the health service contacts the user to schedule the first SP appointment (and not the other way around), as the reputation of the health service would improve adherence to SP appointments.

In terms of factors that facilitate the implementation of SP project in Lisbon, the skills and competencies of the professionals involved, namely, the proactiveness and motivation of the teams, their receptiveness to new ideas, as well as their sensitivity and concern about the influence of social determinants on the users' health status, were referred to as relevant facilitators. Moreover, the main communication strategy used by the SP implementation team was the frequent communication through monthly meetings with social partners, monthly feedbacks to the health unit teams, and publication of newsletters. This communication strategy provided internally, within the health units, transparency about the project being implemented and encouraging the participation of health professionals, and externally, greater proximity and closer ties with the social partners.

The proximity relations and intersectoral work built throughout the implementation of the project were the facilitators most cited by stakeholders involved. The engagement of the community in all phases of project design and implementation and a frequent search for establishing partnerships with these community organizations made the implementation easier. In this same sense, the networking and articulation between the health and social sectors made the work more dynamic and

enabled frequent dialogue between diverse entities and a more agile and effective action to respond to users' needs.

6.3.2 Lessons Learned from the Evaluation of SP in Lisbon

Throughout this period of development of the monitoring and evaluation components of SP in Portugal, lessons have been learned. The first of them is that SP is a complex intervention, aimed at users with diverse characteristics, and therefore requires an evaluation that takes this complexity into account. In addition, SP is an intersectoral intervention involving multiple stakeholders, and for its evaluation to be robust, it is necessary to involve all the stakeholders in data collection, including users, health professionals, social workers, social and voluntary sector professionals, and managers. Another point is described in the literature referring to the fact that in certain realities, studies of high level of evidence, such as randomized controlled trials, do not answer relevant SP evaluation questions, such as the contextual factors and mechanisms that make the intervention work and become successful. From the evaluation experience in Portugal, generating evidence on SP requires coordinated effort from all stakeholders, so that evaluation studies can adequately "capture" how SP develops in practice.

In addition to the learnings, challenges have emerged while monitoring and evaluating SP in the Portuguese context, which required strategies to overcome them (Table 6.1). In the conception and design stage of the evaluation study, the research team identified a great heterogeneity in the publications on the topic, with concerns mainly related to the quality and robustness of the studies. Therefore, an extensive literature review was conducted on the designs, instruments, quality, and limitations of studies on SP to assist the development of the evaluation component in the context of SP in Portugal (Chatterjee et al., 2018; Grant et al., 2000; Carnes et al., 2017; Pescheny et al., 2019; Krska et al., 2013).

Another challenge was the adaptation of the evaluation study to the specificities of the context in which the intervention was being implemented. This adaptation was carried out through collaborative work between the research team and the implementation team. Data collection was adjusted to the stakeholders' work processes and in order to enhance their participation in the study.

The involvement of community partners and the data collection on the adherence of users to the activities is still a challenge to be overcome (Table 6.1). First steps were taken in this direction with meetings with community partners and joint development of data collection instruments. Even with these meetings and the inclusion of community partners in the design of the instruments, adherence was still low.

An adversity encountered concerns the low participation and level of understanding of users in answering the questionnaire by self-completion. As a solution, the research team, together with the health teams, chose to apply the questionnaire by interview, relying on the involvement of link workers and researchers for this activity.

Table 6.1 Challenges and strategies on evaluation of SP in Portugal

Challenge	Strategy
Great heterogeneity in the publications on the topic, with concerns mainly related to the quality and robustness of the studies	An extensive literature review was conducted on the designs, instruments, quality, and limitations of studies on social prescribing The evaluation study was developed based on the results found in this review and the context of social Prescribing in Portugal
Adaptation of the evaluation study to the specificities of the context	Collaborative work between the research team and the implementation team Data collection was adjusted to the stakeholders' work processes and to enhance their participation in the study
Involvement of community partners and data collection on the adherence of users to the activities	Meetings with community partners and joint development of data collection instruments
Concerns about low participation and low level of understanding of users in answering the questionnaire by self-completion	The research team, together with the health teams, chose to apply the questionnaire by interview, relying on the involvement of link workers and researchers for this activity
Reduction of the activities of the social Prescribing service and the suspension of data collection due to the COVID-19 pandemic	In order to continue some of the planned activities, the data collection of one of the qualitative studies, through interviews, was adapted to a distance modality using the videoconferencing platform
Low user participation in longitudinal study	Developing strategies to promote patient participation, such as inclusion of link workers in recruitment and data collection, design of flyers about study aims and benefits, and different contact/scheduling approaches

Source: Authors

A challenge faced in conducting the evaluation of SP concerns the reduction of the activities of the SP service and the suspension of data collection due to the Covid-19 pandemic. The face-to-face data collection, mainly among users, was suspended for several months due to the restrictions of access to health services. In this sense, and in order to continue some of the planned activities, the data collection of one of the qualitative studies was adapted to a distance modality using the videoconferencing platform for conducting the interviews.

The data collection of longitudinal study was resumed in June 2022 and, currently, the users' low participation is still a considerable challenge. Missed appointments, family members attending appointments, mental health instability have been some of the main difficulties in including users in the study baseline. Other barriers to participation include hearing impairments and reduced capacity to understand study scales. Regarding follow-ups, the main barriers have been clinical deterioration, failure to make telephone contact, and the fact that users do not recall that they took part in the study or that they had an SP appointment. Research and Family Health Unit teams are jointly developing strategies to promote patient engagement and to retain hard-to-reach participants in study that include reinforcing the role of link workers in recruitment and data collection, developing communication

materials (e.g. flyers) emphasizing study aims and benefits, and exploring different contact/scheduling approaches.

6.4 Final Considerations

SP focuses on a problem affecting society: addressing the complex health challenges and social determinants of health in a way that promotes the sustainability of health systems. The SP intervention is a way to provide proximity and holistic care to the population. Through SP, the community sector can improve health outcomes by addressing the social determinants of the health of primary care patients. On the other hand, the health sector can facilitate the identification and recruitment of potential beneficiaries of the services and activities arranged locally by the community sector. SP has a great potential to consolidate sustainable partnerships between different sectors, act on non-clinical users' needs, promote well-being and quality of life, and consequently, reduce health inequalities. In addition, it requires placing users at the centre of the system, integrating and considering their needs, preferences, and motivation as a priority. User's awareness and adherence to SP remains a major challenge in our context. Many potential SP users face considerable difficulties in navigating the health system, which calls for strategies that foster proximity and facilitate linkage to services. In a recent project, there has been an opportunity to invest in adapting work processes towards a more proactive and relational proximity approach. This is the case of COPE (Capabilities, Opportunities, Places and Engagement), a European Commission-funded project using social prescribing and relational proximity to support young people Not in Employment, Education or Training (NEET). An example of changes in work processes was the shift from expecting the user to contact the service for initial case screening and scheduling to a face-to-face appointment led by the services (e.g. through phone call). Further strategies based on digital technology can be helpful in increasing users' awareness and adherence to SP. In addition, it is important to develop communication campaigns on the benefits of SP and to engage users, community leaders, and patient organizations in the design and implementation of SP projects.

The implementation of SP is not simple, is complex, and requires many changes. Changes in mentalities, organizational processes, resources, and intersectoral integration. In the Portuguese experience, a broad strategy has been employed to implement SP, with the involvement of stakeholders at different levels, combined with monitoring and evaluating components. In terms of research, the use of an interdisciplinary, multi-method, participatory, and innovative approach has been essential to meet the challenges in monitoring and evaluating complex interventions, such as SP, immersed in structural, contextual, and individual factors. Overall, this has allowed a consistent implementation of the intervention, and the adoption of a continuous improvement model. The creation of a national network and the growing interest of municipalities in implementing SP projects reinforce a more sustainable dissemination of the intervention.

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Chapter 7

Challenges and Opportunities for Social Prescribing in Germany: Policy and Methodological Perspectives



Wolfram J. Herrmann, Konrad Laker, and Hendrik Napierala

7.1 Introduction

It's Monday morning in a typical German GP practice. The waiting room in the single-hand practice is full of patients who have no appointment. The majority seek their GP's help for minor acute illnesses or a simple sick note. One of the patients is Paul. Paul is a 42-year-old postman with no significant chronic diseases. He asks for a sick note because work is too much, pressure has increased, and he does not feel that he is able to cope with the situation. However, he is also afraid of losing his job and having even more financial problems. His GP knows, in case she does not certify his sick leave, he will go to see another GP. The GP thinks that sick leave will not really help Paul; however, she is not aware of any other feasible options. She and Paul agree for him to seek help during his sick leave, although she cannot tell him which type of help and how he might access it. With his visit and the sick leave, Paul is causing costs to the healthcare system without getting any help, and the GP is frustrated with being unable to help.

This is a typical example from the German healthcare system. Sick leave is a common outcome of GP consultations in Germany (Herrmann et al., 2015). A survey by Zimmermann et al. (2018) showed that social problems are common presenting complaints in German GP practices. However, GPs often do not feel confident to manage these types of problems and where they might direct patients. Instead, they choose, e.g. a wait-and-see strategy, certify sick leave, refer to a specialist, or prescribe medication.

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Social prescribing is one approach to deal with these patients and their problems. However, it has not been implemented in the German setting. In this chapter, we discuss why it is difficult to implement social prescribing in Germany, what is needed to implement it, and what alternative approaches and care models are currently being developed in Germany.

7.2 Policy

An analysis of the challenges the burgeoning social prescribing field faces in Germany requires a good understanding of the peculiarities of the German medical and social care system. Germany prides itself on creating the first large social and medical insurance systems in a series of laws passed in the 1880s under the chancellorship of Otto von Bismarck. The current system is a result of incremental changes, rather than radical transformation, which is surprising given the huge social and political revolutions experienced by Germany since its foundation in 1871. This continuity means that the current configurations of laws, regulations, and policies patterning the healthcare system often represent responses to long forgotten crises rather than a deliberate framework to address the challenges Germany faces today. On the other hand, continuity also reflects the persistently strong public support for the principles of solidarity, subsidiarity, and corporatism at the centre of the Bismarckian social security system.

7.2.1 *Solidarity*

Solidarity means that insurance contributions are levied according to financial means and that thereby the healthy support the sick, the young the old, the privileged the disadvantaged. Since its creation, the number of professions covered by a health insurance mandate has widened, albeit slowly, culminating in a universal mandate for everyone to purchase either public or private health insurance in 2009. In 2018, public health insurance covered 87.7% of German residents (Federal Ministry of Health, 2020). Public health insurance is provided by 105 regulated, independent, non-profit organisations, which, in the German context, are referred to as “Krankenkassen” or sickness funds. Certain professional groups, such as civil servants and those earning above a certain income threshold can opt to purchase private health insurance instead. Separate mandatory insurance schemes exist for social care, long-term care, as well as unemployment. These are administered through different and separate providers, which are subject to the different sections of the Sozialgesetzbuch (SGB), a collection of laws governing health and social care (Henssler et al., 2022). The SGB is a collection of codified laws governing the organisation, scope, and benefits provided by the social insurance system. Different sections of the SGB regulate different insurance schemes, meaning there is no

common risk pool between the different insurance schemes. As a result, these services operate independently of each other with little incentive for co-operation. Novel entitlements, such as social prescribing, do not easily fit into the existing and rigid structure of the SGB without significant legislative changes. Social prescribing straddles the boundaries between social and healthcare, potentially requiring changes to different sections of the SGB and further regulatory harmonisation.

7.2.2 *Subsidiarity*

Subsidiarity means that central authorities, such as the Federal Ministry of Health should only perform tasks that cannot be performed by local authorities. This principle is meant to ensure that decisions are taken closest to where they have an impact. Policy decisions regarding healthcare and social care are the devolved responsibility of the 16 “Bundesländer,” which may devolve certain functions to regional agencies, the “Gesundheitsämter.” In practice, this means that federal ministries have an advisory role and cannot impose large scale reforms such as the requirement for delivering proactive social prescribing by Primary Care Networks in the UK mandated in 2022 (NHS, 2019). The announcement of the minister of health Karl Lauterbach in 2022 to scale up the social prescribing pilot “Gesundheitskiosk” (described in detail later) has so far failed, as it lacked funding commitments by the health insurances and immediately triggered questions of jurisdiction. The majority of the funding of social and healthcare is provided by insurance contributions rather than collected through taxation. This means that federal institutions such as the ministry for health have only indirect ways of influencing how this money is spent.

7.2.3 *Corporatism*

Corporatism complicates this policymaking process further by delegating key decisions to elected non-state bodies that represent doctors, hospitals, and insurance providers. The health insurance schemes are largely self-governed by bodies which are politically independent, but bound by strict laws and the demands of other independent regulatory bodies. Government can only regulate how insurance contributions are distributed, rather than allocating funding themselves. Key decisions such as the introduction of new insurance benefits are negotiated between these interest groups. The Joint Federal Committee or GB-A is the central organisation of self-governance of this process. It is itself regulated by further bodies, ensuring its decisions are evidence-based and cost-effective. Primary and secondary care physicians providing outpatient services, hospitals, and rehabilitative services were deliberately organisationally separated in the 1920s in response to doctors’ lobbying (Busse et al., 2017). Today their different methods of compensation (fee for services

for outpatient services, payments for diagnosis-related group for hospitals) reinforce the fragmentation of these sectors. The lobbying arms of healthcare providers are often engaged in zero-sum competition over the shared pool of insurance contributions. A common criticism is that services operate in silos with little incentive for closer integration.

The modern German healthcare system is vast and hugely heterogeneous, featuring a mixture of private, state, and third sector providers (see Fig. 7.1). In 2018, Germany spent €390.6 billion on health, with a per capita expenditure of US\$ 6098 (adjusted to purchasing power), making it one of the top spenders on health worldwide (Blümel et al., 2020). More strikingly, Germany has, by international standards, an excessive number of hospitals with 1927 hospitals providing nearly half a million hospital beds (Federal Ministry of Health, 2020). Primary and secondary care services are provided by 180,581 doctors and psychotherapists both outside of a hospital setting (Kassenärztliche Bundesvereinigung, 2017). Roughly 60% (Busse et al., 2020) of these provide services in single-handed outpatient clinics, meaning there are 101,932 individual practices providing outpatient services (Kassenärztliche Bundesvereinigung, 2017). Furthermore, Germany has an extremely high rate of healthcare utilisation, with four million daily outpatient visits, meaning there are roughly 1 billion outpatient visits yearly. Despite the complexity of this system, patients can access secondary care freely with primary care physicians performing no gate-keeping or signposting function. A further complicating factor is the centrality of data protection laws and medical confidentiality in German medical practice. Even communication between medical providers without written consent is illegal, making any information sharing between social care and healthcare a cumbersome process.

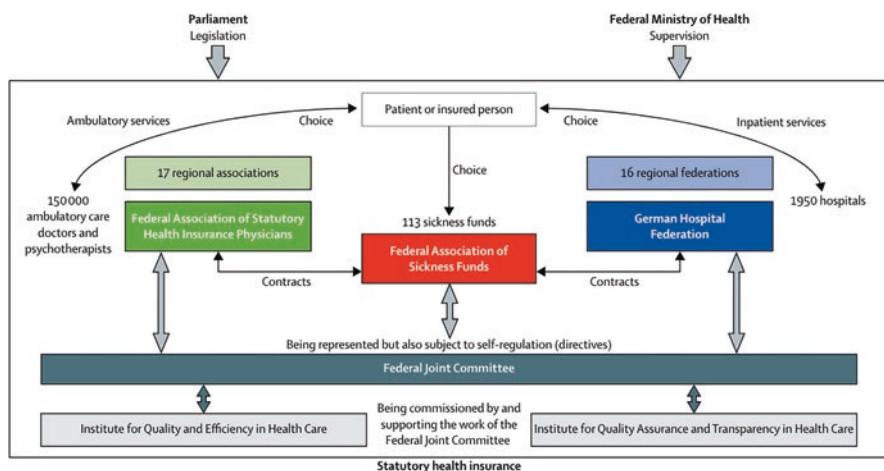


Fig. 7.1 Central actors in Germany's statutory health insurance system. (Reprinted from *The Lancet*, 390 (10097), Reinhard Busse, Miriam Blümel, Franz Knieps, Till Bärnighausen, Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition, 882–97, 2017, with permission from Elsevier)

Social prescribing in Germany is in many ways a response to the convoluted nature of existing medical and social care services provision. This contrasts with the situation in the UK, where social prescribing assists an overwhelmed medical sector and the shrinking welfare state. Also, the connection to the, Voluntary, Community and Social Enterprise (VCSE) sector for social prescribing is different in the German context. Germany is not a traditional volunteering nation in the mould of the United Kingdom or the Netherlands (Mathou, 2010). Corporatist bodies provide many social services, such as home and residential care, as part of the social insurance scheme. Their financing rests on the mandatory insurance contributions and is also regulated by the SGB. Since reunification, volunteering in an organisation outside of corporatist bodies has become more important again, meaning there are now many organisations a social prescribing scheme could refer to. The third sector in Germany is very heterogeneous, ranging from large organisations providing highly regulated services for the state to much smaller voluntary organisations depending on membership contributions, such as local sports clubs. Sources of funding for VSCE sector organisations comprise donations, membership contributions, public funds, and self-generated funds. Even within the social services sector, there is significant heterogeneity in the extent to which organisations depend on public funds. Twenty percent of organisations receive the majority of their funding from public funds, with another 43% receiving some public funding, leaving 37% receiving no support from public funds (Premier et al., 2016, p. 21). In the UK, the main concern is that a retreating social state leaves many of its functions to the VSCE sector. In Germany, the debate focusses more on the outsized importance of public resources and regulation on the VSCE sector.

In summary, we can describe three levels of fragmentation. Firstly, social care and healthcare are administered by different insurance schemes and competing providers leading to poor co-ordination between them. Secondly, the decision-making powers regarding healthcare are fragmented across two dimensions. Federal decision-makers have to co-ordinate to a much larger extent with regional and even local authorities. These decisions then must be negotiated with the independent corporatist bodies representing payers, providers of healthcare services, who themselves must comply with regulators, ensuring decisions are evidence-based and economical. Significant decisions about insurance entitlements can also be initiated by the GB-A. Thirdly, the regulatory framework and re-imbursement practices result in poor communication and integration between primary, secondary care, and rehabilitative services. Effective co-ordination with social services or third sector partners is limited by healthcare and social care being governed by separate insurance schemes and diverging regulatory framework of the SGB. This leads to a policymaking process focussed on consensus rather than radical reform.

The above analysis explains why social prescribing – which cuts across deeply institutionalised divisions – has no natural champion within the German healthcare system. The schemes presented in this chapter have either been introduced as experimental pilots with external charitable funding (e.g. Gesundheitskollektiv funded by the PORT Programme of the Bosch Stiftung) or rest on precarious joint backing by individual insurance companies and subsidies by regional authorities (e.g.

Gesundheitskiosk funded jointly by several public health insurances and communal funding by the city of Hamburg). These pilots themselves slot into a hugely fragmented healthcare and social care landscape, with providers often competing rather than co-operating with social prescribing schemes.

Despite these barriers to implementation of social prescribing in Germany, the unmet social needs are significant. Germany has one of the highest levels of wealth inequality among any OECD country (Dao, 2020). Educational outcomes are pre-determined by parental social position due to selection into academic vs vocational schools at an early age (Balestra & Ciani, 2022). Even though healthcare provision is generous, resources are not necessarily concentrated in areas with the highest need. This German version of Tudor-Hart's Inverse Care Law (Tudor Hart, 1971) is especially prominent in the so-called "new Bundesländer" representing the former GDR, with many areas with high levels of socio-economic deprivation not matched with adequate medical provision particularly in rural areas. However, also in the post-industrial heartlands of West Germany, mismatches between social deprivation and provision of social and medical services are apparent. Even in large urban areas, such as Berlin, there can be significant mismatches between medical need and provision at the district level. A neighbourhood of Berlin-Reinickendorf covering 8149 patients had no GP in 2021 (Herrmann, 2021). A recent study of residual life expectancy in patients >60 years in Germany found that social determinants of health, such as income or academic achievement, were significantly better predictors of longevity than access to primary or secondary care (Siegel et al., 2022). Research confirms that in deprived areas, doctors are often consulted about social problems, such as poverty, work-related issues, and social isolation (Zimmermann et al., 2018).

One route to establishing a wider social prescribing system in Germany would be to utilise the health insurance-backed "Innovationsfonds." The Innovationsfonds dispenses €200 million yearly to implement and evaluate new models of care scientifically. The research projects inform the GB-A in recommending certain models of care to be covered by public health insurance. At the end of each project, the GB-A issues a recommendation as to whether the model or research question should affect which services are covered by public health insurance. In the following section, we want to critically evaluate how this mechanism may be utilised in recommending the establishment of social prescribing in Germany.

7.3 Research and Evaluation

In Germany, according to §2(1) of book V of the SGB (Statutory Health Insurance legislation), the quality and effectiveness of the services covered by the statutory health insurance must correspond to the generally recognised state of medical knowledge and take medical progress into account. Currently in 2023, €200 million per year are available within the framework of the Innovationsfonds to establish New Forms of Care (NVF) for further development of the statutory health insurance system (§92a(11) SGB V). The resources for the fund are borne by the statutory

health insurance funds and from the health fund. Funding is provided for projects that improve the quality and efficiency of care, promote cooperation within and between different areas of care, care facilities, and professional groups, and are interdisciplinary in nature. In addition, the findings should be transferable to other regions or indications and the benefits must be in proportion to the implementation costs.

In addition to the projects funded within the framework of the Innovationsfonds, the previously mentioned G-BA (Joint Federal Committee) has the possibility, through the adoption of directives, to define new medical care services that must be covered by the statutory health insurance. These include measures that further develop cross-sectoral care, optimise intra-sectoral interfaces, or contain approaches to overcome the separation of the sectors. The first aspect applies to SP particularly. This requires a complex consultation process based on internationally recognised criteria and standards of evidence-based medicine. The scientific expertise in this context is provided by IQWiG, (Institute for Quality and Efficiency in Health Care) which supports the G-BA as a professionally independent, scientific institute in the performance of its statutory tasks by issuing scientific recommendations. The scientific principles for IQWiG's work are laid down in a methods paper (IQWiG, 2022). IQWiG argues that randomised controlled trials are the basis of a benefit assessment, as only this type of study can minimise bias due to unequal baseline conditions between the comparison groups. At the same time, IQWiG refutes the argument that alternative study designs are necessary to better reflect everyday conditions – and thus better transferability of the studies – because internal and external validity are not firmly linked. Instead, the experts call for the implementation of pragmatic studies that combine high certainty of results with relevance to everyday life.

In line with the requirements of the methods paper, we conducted a systematic review on the effectiveness of primary care-based referral interventions (Napierala et al., 2022). This systematic review encompassed interventional studies assessing the effectiveness of social prescribing in primary care. The target population consisted of adults with an actual or assumed need for psychosocial support or counselling. Interventions were eligible if they consisted of a community referral intervention aimed at psychosocial support or counselling and if an outpatient medical provider (primary care providers, other physicians, nurses, outpatient clinics, etc.) initiated the referral. Referrals to a facilitator, coordinator, or institution assessing needs and initiating appropriate measures were considered pertinent. We included controlled trials as well as uncontrolled studies with a before-and-after design. We considered all health-related endpoints and surrogate parameters, any other patient reported outcomes, as well as any measures of health care utilisation. Measurements needed to be assessed at least at two different time points and/or in two different groups with no limit to the length of follow-up. We searched the following electronic bibliographic databases: MEDLINE, Embase, SocIndex, Social Care Online, CINAHL, and the Cochrane Library (Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials). We conducted a search on ClinicalTrials.gov and the International Clinical Trials Registry Platform

(ICTRP). Results were screened in a two-step process, followed by data extraction, each by two independent reviewers. If data permitted, effect sizes were calculated. Risk of bias was assessed with the EPHPP and the Cochrane RoB2 tools.

We identified 4934 records (2000–2021) and included 53 studies with 68 publications in our review. Fifty-one studies originated from the UK and two from Australia. Only three studies included control groups: one a randomised controlled trial (Grant et al., 2000), one a quasi-experimental cluster randomised controlled trial (Mercer et al., 2019), and one a non-randomised controlled trial (Carnes et al., 2017).

Study participants were adult, of a wide age range, and mostly female. They showed high levels of social deprivation, unemployment, and were often afflicted with long-term conditions. We could assess a wide variety of endpoints, but only effect sizes for data provided in the domains of mental health and well-being, loneliness, quality of life, general health, self-efficacy, and health care utilisation could be computed. While short-term follow-up data from uncontrolled before–after studies showed large positive effects or large differences between pre- and post-intervention measurements for patient reported outcomes, intermediate to long-term follow-up data or results from controlled studies showed smaller or no effects.

Controlled studies painted a mixed picture for primary care utilisation. Carnes et al. (2017) reported significant longitudinal consultation reductions for SP participants, while controls had significantly more visits in a pre-post-comparison of annual utilisation. Polley et al. reported a significant decline in the mean number of primary care visits in a three-month period for the intervention group, while there was no significant longitudinal change in controls (Polley et al., 2019). GP utilisation was identical for both groups in the only RCT available (Grant et al., 2000).

Overall, clinical relevance of the evidence is difficult to judge. With positive short- but disappearing long-term effects, the results give us reason to question sustainability. However, there is only limited evidence for longer time frames with a high risk of bias (Bickerdicke et al., 2017). Because baseline values of certain outcomes are quite low compared to the general public, regression towards the mean might also be a problem. Most of the authors neither used adequate methods nor properly reported the results of their studies. For example, measures of dispersion (i.e. standard deviation or confidence intervals) were not reported or selective drop-out was not accounted for.

A large portion of the identified projects was not (33/53) or only partially (5/53) peer reviewed and can be counted as grey literature. As most of the studies were not designed to show comparative effectiveness, the available literature does not allow to justify conclusions concerning clinical relevance and sustainability. Because most of the analyses were part of a project evaluation, the implementation of social prescribing initiatives was done from a management point of view and not from a scientific perspective.

Although the grey literature is highly important in providing insights on the implementation of SP in specific contexts, these reports do not contribute to the scientific discourse in the German healthcare context as more rigorous study designs are required by the legislators and self-governing bodies. In addition,

implementation approaches in the UK or other countries cannot simulate the peculiarities of the German primary care system.

Currently, there are several ongoing RCTs. However, they either cater to specific populations such as dementia [University of Exeter, 2022], settings such as community hospitals [Lee et al., 2021], interventions such as nature-based interventions [National Institute for Health and Care Research, 2023], or do have a very limited follow-up [Kiely et al., 2021]. Although some of these studies are conducted outside of the UK (e.g. Singapore, Ireland), results from these healthcare settings cannot necessarily be translated to the German context. Since SP is not a universal offer in Germany, trial designs for RCTs are not limited by lack of a comparison group as in the UK.

In considering how social prescribing may look in Germany, the INVEST Billstedt/Horn project is an example of the establishment and evaluation of a novel care model. An integrated care model was implemented and scientifically evaluated in two socially deprived districts of Hamburg. The aim was to improve access to the health system through multi-professional, integrated, and preventive care and counselling, especially for vulnerable groups. For this purpose, health kiosks (“Gesundheitskiosk”) with particularly low-threshold care and counselling services close to home were established. In addition, a regional health network was established, and interdisciplinary quality improvement groups¹ were conducted in order to implement medical care processes and modular care coordination for vulnerable and chronically ill patients (Erbe, 2019). In a broader sense, the NVF also included elements of SP, as doctors had the possibility to refer patients to the health kiosk by means of a referral (Golubinski et al., 2020). A mixed-methods design was used to evaluate this complex intervention (Gemeinsamer Bundesausschuss, 2022). A pre-post survey design without a control group was used to evaluate the primary end-points of the outcome evaluation (patient satisfaction with health care, patient activation and health-related quality of life). In its decision on the evaluation of INVEST, the G-BA points out the limitations in connection with the evaluation method, such as low sample sizes, missing randomisation or missing controls, resulting in a limited validity of the results.

These results are in line with the findings of the benefit assessment of SP (Napierala et al., 2022) and confirm the need for pragmatic randomised controlled trials to argue for the reimbursement of SP by statutory health insurance in Germany. However, there are methodological difficulties when planning benefit assessments for complex care structures (e.g. “Gesundheitskiosk” or integrated primary care centres), as individual randomisation might be problematic due to contamination. Cluster-randomised controlled trials would entail the establishment of numerous pilot sites, and this could lead to unbearable costs. We argue that this should not be as problematic concerning the establishment of SP schemes, because SP

¹Quality circles are an important instrument for promoting quality in outpatient care in Germany. They offer physicians and psychotherapists the opportunity to exchange professional views with colleagues, to reflect on their own actions and to generate new knowledge. Despite some indications (e.g. “Hausarztzentrierte Versorgung,” family-practitioner-centred care), they are voluntary.

programmes are less resource-intensive. Uncertainties about the methodological approach call for conducting rigorous pilot trials.

An alternative to the way of endorsement by the G-BA, is that new forms of care are established through the adaptation of new legislation. In this case, the generation of adequate evidence is not required, but just as relevant as with the other options. However, policy arguments prevail.

7.4 Alternative Approaches and Conclusion

We conclude that further research and scientific evidence is crucial for the implementation of social prescribing in Germany. Social prescribing is currently not available in Germany. However, there are three alternative approaches: Gesundheitskiosk, Integrated Primary Care Centres, and social workers having consultations in GP practices.

The most well known and most thoroughly evaluated approach is the Gesundheitskiosk, which is part of the INVEST project described above. Gesundheitskiosk is the central pillar of INVEST. It consists of a health-related neighbourhood centre without integrated health care to which doctors can refer to or patients present directly themselves (Heinrich et al., 2022). The concentration of health-related social offers in one neighbourhood centre led to advantages in coordinating and planning community-oriented help (Gibis & Fix, 2022). However, the organisational and legal barriers to implementing such an approach are high (Altin et al., 2022). The main policy long-term goal is to implement such centres in deprived neighbourhoods, especially as additional counselling offers and navigators through the complex system (Eversmann, 2022). Even though the German health minister announced in 2022 the opening of a further 1000 Gesundheitskiosks, efforts have so far floundered due to the high costs of such a widespread implementation and concerns about long-term funding. Several of the public health insurance schemes withdrew their support after the announcement citing concerns about cost-effectiveness. In the case of Paul, his GP would recommend him to visit the Gesundheitskiosk during his sick leave to check out options available for him there.

Another criticism directed at the Gesundheitskiosk is its separation from primary care. This is in favour of a second approach, which integrates both primary care and social services: integrated primary care centres. While integrated primary care centres are common in many countries – such as the Bromley-by-Bow Centre in London (UK) or the Sozialmedizinisches Zentrum in Graz (Austria) – they remain novel in Germany. However, some of these centres have been established lately – well known are the Poliklinik Veddel and Gesundheitskollektiv Neukölln. Both are primarily politically motivated pilot projects to facilitate the integration of health and social care in deprived neighbourhoods. Poliklinik Veddel is such a centre established in a neighbourhood in Hamburg with high levels of social deprivation. The Veddel is an island with about 4800 inhabitants of which 74% were born outside of Germany or have parents born outside of Germany (Beneker, 2021). More recently, a similar

project was established in Neukölln a neighbourhood with similar levels of multiple deprivation in Berlin. Both projects are closely connected to the community and have ambitious goals. They want to serve as role models for integrated care in deprived neighbourhoods, but also face legal problems, e.g. it is not allowed to provide general practice care and other services such as nursing or physiotherapy by the same corporation. In Paul's case, the GP in such an integrated primary care centre would make an appointment for him with the counselling in the integrated primary care centre in the same organization in the same building.

A third approach established in the east of Berlin is also a common model in other countries: Soziale Gesundheit e.V. is an NGO, which employs social workers who in turn offer regular consultations in cooperating GP practices. The social workers help with a wide range of problems from filling out forms to intensive longitudinal case management analogous to social work services in hospitals. However, in Germany, GPs often practise single-handedly, which means there is often little organisational or physical space for social workers. In Paul's case, he could get another appointment in the GP practice with the attending social worker in a room of the GP practice.

All three projects have overlaps with social prescribing, while emphasising different aspects. Gesundheitskiosk and integrated primary care centres focus primarily on highly deprived neighbourhoods. Social prescribing, however, may be implemented in any neighbourhood, irrespective of its level of social deprivation.

Social workers in GP practices are, on the other hand, more difficult to establish in the landscape of single-handed GP practices in Germany. This is different from social prescribing in England, where link workers refer patients to existing offers in the community and where link workers are often recruited from the community. In Germany, social work is an established profession with a specific study programme as a prerequisite. Social work is highly oriented towards solving problems for clients, but less oriented towards connecting into the community.

Overall, we can see there is a need for a social prescribing approach in Germany. However, all these described approaches could benefit Paul and his GP. In our view, these concepts could complement each other. While integrated care approaches could reduce health disparities in areas with high social deprivation, social prescribing and social care provision in GP practices could serve as a comprehensive nationwide approach. However, for the reasons discussed in this chapter, implementation of social prescribing is difficult. Evidence from randomised studies is crucial to convince necessary changes in remuneration and organisation of health care in Germany.

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Chapter 8

Social Prescribing in Ireland: From Ad Hoc to Universal Provision



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8.1 Introduction

This chapter reflects different aspects of social prescribing in Ireland. The first part sketches out the history and policy background of healthcare in Ireland, acknowledging that there are two States on the island of Ireland, with one shared history. Although this story is unique to Ireland, we present learning and experience that may be useful in other countries. This section is the canvas upon which social prescribing in Ireland was drawn.

The second part of the chapter focuses on the evidence of the effectiveness of social prescribing programs in Ireland that have been evaluated to date, published in peer reviewed form or in conference proceedings. It is not intended to be exhaustive but provides an overview of the research conducted to date.

The final part of the chapter moves into describing and discussing the ‘practice’ of social prescribing with two stories. The first is the story of one of the first social prescribing projects which was implemented in a rural part of Ireland; the second is the development of a social prescribing project based in hospital or secondary care. Lastly, an individual participant story illustrates the profound impact social prescribing can have on the participant, and the link worker.

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8.2 The Social Prescribing Policy Context in Ireland

Ireland is now the second country in the world, after England, to have a nationally mandated Social Prescribing programme (HSE, 2021). However, this did not happen overnight but was the culmination of years of building small projects, speaking with influencers in health and policy, gathering evidence, and dissemination at conferences.

Here, we outline the background to health and social care policy in Ireland, and how a ground-up movement became national policy over the course of approximately 10 years.

The island of Ireland is partitioned, and there are now two jurisdictions on the island – Ireland, comprising 26 counties in the South and Northern Ireland, comprising the 6 counties in the North which remain part of the United Kingdom. This fact became fundamental to the development of social prescribing in both parts of the island. This chapter recounts the story of Ireland.

Ireland has one of the older systems of Government in Europe as it was unchanged by the Second World War. The median age of the population is 38.5 years, making it the youngest country in the European Union second only to Cyprus (Eurostat, 2021). In 2021, its population has exceeded five million, for the first time since 1851 (Central Statistics Office, 2022), a landmark for a country whose population has yet to recover from the Great Famine of the nineteenth century.

The Irish Government determines policy while the country's Health Service Executive (HSE) implements this policy and, in many cases, delivers care. As of 2020, social prescribing has been 'mainstreamed' by the HSE and is available countrywide. The blueprint for this rollout is the Health Service Executive's Framework for Social Prescribing (HSE, 2021). The Framework document outlines the development of Social Prescribing in Ireland, defines best practice, and outlines the role and responsibilities of the Link Worker. Crucially, the Framework sets out a delivery model which includes one social prescriber per 50,000 people across the country. This is broadly in line with provision in England where, in 2019, the National Health Service allocated funds to Primary Care Networks (PCN) – groups of GP practices working with a range of other services – to recruit and manage link workers to serve a population ranging between 30,000 and 50,000 people.

As in England, the majority of social prescribing projects in Ireland are now located in the surgeries of general practitioners (GPs), who are either single-handed or more usually part of a larger team. The link workers themselves are often employed by a local community organisation subcontracted by PCNs. However, in Ireland, delivery and funding of care at primary and secondary levels differ according to a person's wealth.

In Ireland, an English NHS-style health care system, free at point of use, was resisted by the Catholic Church who felt it would introduce contraception and by the medical profession who felt it would make them poorer (Wren, 2003). Instead, access to GPs in Ireland is means-tested.

Patients who are poorer receive a medical card paid for through general taxation, while wealthier patients pay their GPs. 30.8% of the population are covered by medical cards which allow for unlimited GP visits and free medication (Vankar, 2022). Ireland is therefore unusual compared to other states in that the majority of the population pays out-of-pocket for GP visits (Nolan & Smith, 2012). Patients with medical cards are poorer, and live in areas with higher rates of deprivation. They visit their GPs more often than non-medical card holders (Madden et al., 2005).

Ireland has a young but ageing population and spends less on health as a percentage of Gross Domestic Product than many other countries (Morgan & Astolfi, 2014). However, the HSE recognised that social determinants of health are a major factor in health utilisation and outcomes, and was determined to shift care from secondary to primary level, from the acute setting to the community, from a focus on treatment to one of prevention. This was set out in the *Sláintecare* report which helped to pave the way for the national roll-out of social prescribing (Government of Ireland, 2019). Importantly, the steering committee for the Irish Framework for social prescribing had representation from the service users, the All Ireland Social Prescribing Network (AISP), and strong voices within the HSE who were part of the first social prescribing projects in Ireland.

As in England, social prescribing began as a ground-up movement with small projects sprouting up here and there with local funding (see the chapter by Husk and Sanderson in this book for more details). The first projects were founded on Ireland's wild Atlantic coast in County Mayo in 2012, and County Donegal in 2013. In Ireland, social prescribing is defined as a means of enabling healthcare professionals and other professionals to refer people to a range of local, non-clinical services, primarily provided by the Voluntary, Community and Social Enterprise (VCSE) sector. Four key components were presented in the HSE Framework document (HSE, 2021):

- (i) A referral from a healthcare professional/other profession or a self-referral into a project.
- (ii) An intervention between the service user and a social prescribing link worker. The intervention can take up to eight sessions.
- (iii) Supporting the service user to access VCSE organisations or statutory services through discussion and joint decision-making.
- (iv) Measuring the impact of social prescribing on the person, the wider community, and the health service.

Each of these key components were subject to debate by the HSE and the AISP. For instance, a healthcare professional may mean a doctor but also includes other allied health professionals such as a public health nurse. Debate emerged about what to call the link worker: social prescribing coordinator was used for some time but seemed unwieldy and, currently, the preferred terms of use are 'link worker' or 'community connector'. Even the term social prescribing, though finally accepted, was debated as it seemed, well, prescriptive.

The term used to describe the person on their individual journey was also debated. They may have been patients for many years, repeatedly attending clinics. When

referred to a link worker, they may be termed participants. The HSE sometimes prefers service user. The term beneficiary was rejected as paternalistic. The link worker of course, sees them as a person.

Finally, evaluation was declared a key component of social prescribing by the HSE. A separate document – Building Capacity for the Evaluation of Social Prescribing – was launched before the Framework for Social Prescribing, such was the importance the HSE attaches to evaluation (HSE, 2020). As part of this work, a minimum data set will be developed.

In Ireland, the key to social prescribing is the link worker. A link worker is a non-medical professional who specialises in knowledge of the individual participant and their hopes and dreams, and knowledge of the resources offered in the community. The link worker will also have knowledge of coaching and other methods to promote individuals' participation in these communities. Link workers are based largely in primary care or within community or voluntary organisations.

Delivery of social prescribing in communities may occur in the community setting or online – Ireland relied heavily on online resources during the pandemic. Examples of community supports include sports groups, exercise groups, music groups, men's shed groups, arts and crafts groups, addiction support, welfare and employment advice or counselling services. These forms of supports may be categorised as informational, instrumental, appraisal, and emotional (Langford et al., 1997). One of the first projects to be developed in Ireland was the Donegal project. It experienced considerable challenges. The county of Donegal is twice the size of Luxembourg but has a population of 160,000: it is intensely rural. As a result, link worker interventions included driving lessons for participants as transport was a considerable issue.

The Donegal project was also the first to be evaluated: the report noted the policy context for social prescribing at the time (National Office for Suicide Prevention, 2015). Results were positive and drove the expansion of social prescribing projects to other parts of the country (see the research section below for more details).

In 2012–2013, the HSE Framework for Social Prescribing was almost a decade away and Social Prescribing did not have a home within national policy. For instance, funding for the Donegal project came from the National Office For Suicide Prevention (NOSP). To be successful, the funding application drew on several themes in unrelated government departments: The Healthy Ireland Framework, the government's strategy for primary care, and the government's mental health strategy.

Social prescribing had no natural 'home' within Government or the Health Service Executive. Individual projects had to scramble and scrimp funding from disparate sources. In the absence of a home for social prescribing, projects had to apply for funding under different strands of policy (e.g. mental health, social inclusion, primary care) for development and implementation. This needed to change. By 2017, there were six projects countrywide, funded through Healthy Ireland (HSE, 2021). However, funding for new projects remained ad hoc. The breakthrough came through the culmination of years of effort of the All Ireland Social Prescribing Network (AISP). The AISP is an informal affiliation of healthcare workers, workers in the community and voluntary sector, link worker practitioners

and interested academics from both Ireland and Northern Ireland. Its function is to share and promote best practice, raise awareness of social prescribing, and foster connections between individuals and sectors with an interest in social prescribing. Like its sister organisation in the United Kingdom, AISPAN began as a grassroots movement, from the ground up: existing projects reached out to each other to learn and reinforce development. A steering committee was formed with participants on the ground, representing link workers, healthcare workers, family support centres, and academia. Crucially, there was representation from the Health Service Executive. This ensured shared learning and pooling of ideas from the different sectors and enabled the hosting of the first AISPAN conference in St James's hospital, Dublin in 2018.

The two jurisdictions on the island (Ireland and Northern Ireland) worked to the Network's advantage. As well as between health and community sectors, learning was exchanged across the island's border. A Co-Chair from Northern Ireland's community and voluntary sector and a counterpart Co-Chair from Ireland's healthcare sector were selected. Politicians on both sides of the border could be approached for support due to the Network's All-Ireland scope. In March 2019, with the support of Senator Máire Devine, the AISPAN was able to present its vision to the Dáil, the elected assembly in the Irish Parliament. This presentation was influential and led to the introduction of the following to the published programme for Government:

In further developing our mental health services, we will: ...

Seek to expand social prescribing where patients are referred to non-clinical activities, as a means of positively influencing mental wellbeing. (Department of the Taoiseach, 2020)

The door had opened: this allowed the Health Service Executive to adopt social prescribing as policy, and funding for social prescribing was included in HSE's formal estimates, overseen by the Health and Wellbeing Division of the organisation.

In summary, in Ireland, social prescribing was a grassroots movement, with six projects having been formed by 2017 supported by Healthy Ireland Funding. The AISPAN had its first annual conference in 2018, followed by a presentation to the Dáil in 2019. In 2020, social prescribing was written into the Programme for Government, and the HSE agreed to fund it from its Health and Well Being Division. Social prescribing in Ireland had found a home.

8.3 The Research Evidence on Social Prescribing in Ireland

As in other Western countries, multimorbidity is a growing concern in Ireland and affects 66.2% of people over the age of 50 years attending primary care in Ireland (Glynn et al., 2011). Those with multimorbidity have poorer health outcomes and they are the patients who are admitted to hospital most frequently. Multimorbidity occurs about 10 years earlier in socially deprived areas compared to affluent areas. This is reflected in higher consultation rates in these areas and may account for unplanned emergency admissions, some of which are preventable (Payne et al.,

2013). The use of social prescribing in primary care was proposed as an intervention to address this multimorbidity, and the deprivation and complex social needs associated with it (Moffatt et al., 2017).

A landmark publication in the field of Social Prescribing in Ireland was the Donegal Evaluation – this documented the impact of social prescribing in a before-and-after cohort of participants in one of the country's first Social Prescribing projects. There were 237 participants, mostly female, unemployed, and receiving a medical card. Participants had high levels of anxiety and depression and visited their GP frequently. The evaluation showed significant positive changes in well-being, community involvement, and reduced anxiety and depression. There was a reduction in GP attendances of 20% in those patients contacted after the intervention (HSE, 2015).

Instinctively, while it made sense that social prescribing should work, a lack of evidence existed to suggest how, when, and for whom social prescribing may be effective (Kiely et al., 2022a). Irish research was undertaken in an attempt to fill this gap in knowledge. Researchers here developed protocols for systematic reviews and randomised controlled trials.

The research also consisted of an uncontrolled pilot study to assess selection of participants, the workload associated with the intervention, and the acceptability of the interventions in a community healthcare setting (Kiely et al., 2021b). A total of 15 patients were included and polypharmacy served as a substitute for multimorbidity. Participants met the link worker at the designated GP practice and followed the Glasgow Deep End Link Worker Program intervention (Mercer et al., 2017). The mean age of participants was 63. In total, 70% were female, 18% were employed, and 36% lived alone. The commonest complaints were musculoskeletal and mental health conditions, with few belonging to a local club or community group.

Analysis demonstrated that using medication as a proxy for co-morbidity excluded some patients, leading the GPs involved to question its applicability. In practice, GPs felt that it would be more inclusive to identify patients whom they believed would benefit from the intervention, more in line with everyday practice. The pilot informed the design of a randomised controlled trial, LinkMM (Kiely et al., 2021a) and a method for evaluation (Kiely et al., 2022b). LinkMM will aim to assess if link worker interventions in primary care can improve health outcomes for those with multimorbidity in socially deprived areas. Additionally, it will gather quantitative data to supplement existing qualitative data on social prescribing.

Primary outcomes will be measured using validated tools for health-related quality of life and a mental health scale. Secondary aims will be to evaluate impact on staff morale and to conduct an economic evaluation. The protocol includes the involvement of 10 GP practices in deprived areas in four different cities in Ireland. Each GP practice will recruit 60 patients. The control group – those who would receive no intervention – will be identified via lists of patients awaiting GP review and will receive 'usual care' from their GP with no contact with a link worker. This study would be the first large-scale pragmatic RCT of a link worker intervention with a particular focus on multi-morbidity. This differs from previous studies

focusing on younger individuals with mental health concerns (National Office for Suicide Prevention, 2015). The proposed intervention period is only 1 month which may not be long enough to demonstrate benefit. The trial will be urban and may not be applicable to rural settings.

As part of the pilot study, Kiely et al. performed a systematic review investigating the effectiveness and costs associated with social prescribing link workers based in a primary care setting (Kiely et al., 2022a). The review amalgamated eight studies, examining any validated tools of health-related quality of life or mental health outcomes. Secondary objectives evaluated social connectedness/isolation, self-rated health, patient experience of care, treatment burden, self-management or behaviour and self-efficacy as well as physical activity, health service utilisation, and cost data. Eight studies were included: five randomised controlled trials, three cost-benefit analyses and one economic evaluation. Participants were predominantly female, and areas of social deprivation were represented in some studies. Intervention groups had a link worker connecting participants to community resources.

There was, however, wide variability in the intensity of the link worker involvement across the studies. The review found no evidence supporting the effectiveness of social prescribing in improving mental health or health-related quality of life. This does not mean that social prescribing does not work – rather it meant that the measures used to examine it did not detect a difference in the included studies.

Of the secondary objectives, there was a suggestion that the interventions lead to improved self-rated health and high ratings for quality of care received. Decreased length of stay in hospital appeared statistically significant in one of the two studies that analysed this (Kangovi et al., 2018).

The review was unable to comment on the cost-effectiveness of social prescribing due to limited reporting on costs. This systematic review identified other limitations in the literature. For instance, intensity of link worker caseload or number of contacts was only cited in two out of seven studies. This makes it difficult to draw comparisons with models of social prescribing where there may be more contact. The limited number of very different studies meant a meta-analysis was not possible, so a narrative synthesis was performed.

The review concluded that there is a need to conduct further robust evaluations embedded into practice. The authors argue that more intense interventions may be beneficial for certain subgroups if delivered against chronic disease management programs that are a key component to delivery of care in the community setting.

This review generated a lot of media debate and the Social Prescribing Other limitations of the review were identified. Three studies were based in the United States, limiting their applicability in the health systems of the UK or Ireland. Three of the eight studies included were conducted before 2017, and the field of social prescribing has changed since then. The choice of outcome measures was narrow, albeit necessarily so when comparing differing studies.

As social prescribing becomes more widespread, there exists an opportunity to collect more data, on many more people, looking at multimorbidity, deprivation, or specific healthcare conditions such as HIV, cancer survivorship, or dementia.

The AISPN has a key role in sharing, disseminating, and promoting this sort of research (Mulholland et al., 2022).

8.3.1 A Rural Pioneering Social Prescribing Project: The Donegal Story

Located in the northwest corner of Ireland, Donegal is the island's northernmost (and most beautiful!) County. It faces the Atlantic with the highest sea cliffs in Europe, and its largest urban centre is the town of Letterkenny, with a population of 19,000. In 2011, a study was commissioned by the National Office for Suicide Prevention on the development of best practice information and guidance on social prescribing for primary care teams with recommendations on how social prescribing could be developed within the framework of the health service (Keenaghan et al., 2012).

The Reach Out National Strategy for Action on Suicide (HSE, 2005) supported community action on mental health promotion and suicide prevention and for a number of years became the primary source of funding for social prescribing in Donegal alongside some resources from the local health service. Furthermore, in 2011, a study was commissioned by the National Office for Suicide Prevention on the development of best practice information and guidance on social prescribing for primary care teams with recommendations on how social prescribing could be developed within the framework of the health service (Keenaghan et al., 2012).

In line with the experience of other countries, social prescribing in Donegal started as a ground-up movement and partnership between the Health Service and the Community and Voluntary sector. It is notable that although Social Prescribing Co-ordinators (i.e. link workers) in Donegal were first employed by GPs, it quickly became obvious that a community organisation was better equipped to do this because of their unique knowledge of the local community infrastructure and capacity to support the Social Prescribing Co-ordinator to establish these important links. Host organisations such as Family Resource Centres and Local Partnership Companies were instrumental in enabling the growth of social prescribing across the county and beyond.

The approach taken in Donegal was to align social prescribing with Primary Care teams as the idea of multidisciplinary Primary Care teams (including community representation) were in development across the county. However, as social prescribing was a very new concept, engagement of GPs and allied health professionals was crucial to building an understanding of the service and addressing issues such as referral pathways, clinical responsibility, confidentiality, and quality assurance. Primary Care Teams applied for the social prescribing service and had to demonstrate a collective bid, including a GP, an allied health professional (Community Mental Health Nurse), and a community representative. The idea was to ensure ownership of the service locally and facilitate referrals and feedback. It was the responsibility of the Primary Care Team to advertise for a Social Prescribing Co-ordinator to work part time: initially, 10 h a week.

A phased approach to implementation was taken and the first Social Prescribing Coordinator was appointed in August 2013. Social Prescribing Coordinators worked in partnership with the Primary Care Team in their area, supported by a programme

structure comprising a Steering Group, Local Working Groups, and regular Social Prescribing Coordinators' meetings. The project was promoted through the Primary Care Team members and more widely, using leaflets, posters, and direct contact with potential recipients of the service. Referral to the service was generally by a healthcare professional and participation was voluntary. The Social Prescribing Coordinator usually worked with the participant over a six-week period to identify activities and opportunities they would like to try or had enjoyed in the past. By 2014, there were ten social prescribing sites across the county. Training and support to Social Prescribing Coordinators was introduced.

The Donegal Social Prescribing project was the first in Ireland to be evaluated (HSE, 2015). These findings were launched at the first national social prescribing conference in 2015, attended by policymakers, health service clinicians, GPs, community workers, and service users. This was a pivotal moment in spreading the word about the potential benefits of social prescribing at a national level.

From 2014 until 2021, there was a steady development of social prescribing in many parts of the country. A Guidance on Developing a Social Prescribing Service which had been completed in Donegal became a blueprint for other services. Despite the growth in social prescribing, the issue of sustainability remained a significant challenge as all sites (including Donegal) had no secure long-term funding. This is no longer the case as social prescribing is now a mainstream service provided through health service funding and the publication of the HSE Social Prescribing Framework offers a coordinated, systematic, and sustainable way forward (HSE, 2015).

Much of the credit for the success of Social Prescribing in Donegal lies in the quality, skills, and resilience of Social Prescribing Coordinators and the commitment of the community host organisations. It has not been an easy journey. Not all clinicians were easily won over, employment contracts and pay scale were issues and the lack of a long-term funding strategy created uncertainty not only for the Social Prescribing Coordinators but for their host organisations too. The leadership provided by the health service was also a critical factor in maintaining momentum until the mainstreaming of social prescription became a reality across the country. However, to have been part of the 'small beginning' of social prescribing in Ireland continues to bring a sense of pride to everyone involved.

8.4 A Hospital-Based Social Prescribing Project: The Local Asset Mapping Project (LAMP)

St James's Hospital is a voluntary (non-HSE) secular hospital located in Dublin's deprived west inner city. It is egalitarian with a history of looking after the "poor and the miserable of Dublin" for almost 900 years (McNeill, 1925).

It is the largest hospital in Ireland, and provides national services in haematology, cancer, and HIV. St James's also provides care to its local catchment of 200,000

people and is deeply embedded in the local community. The hospital wanted to improve links between its medical services and the surrounding community services. Social prescribing became the vehicle for this.

Searching for new ways to integrate with the community, staff from Mercer's Institute for Successful Ageing (MISA) at St James's Hospital studied projects at home and abroad. One such project in Chicago mapped local community services to create a directory of assets that could be used to improve health and well-being. This was the South Side Health and Vitality Studies (SSHVS) group, and in 2012, staff from MISA travelled to Chicago to learn the methodology (Lindau et al., 2011).

In the 'Windy' City, local youth and back-to-work projects were engaged by the University of Chicago to conduct a street-to-street census of all public facing services. This was used to create an online searchable database of assets linked to associated medical conditions. Each patient visiting a participating clinic received a "geographical prescription" of relevant community resources located near to their home (Lindau et al., 2016).

MISA applied this method in Dublin with the Local Asset Mapping Project – LAMP. In Dublin, LAMP partnered with Warrenmount Secondary School, Fatima Groups United, and the South Inner City Community Development Association to create a similar street census. LAMP mapped 700 kms of streets surrounding the hospital, covering a population of 200,000 people and 48 km² of the city, much of it considered deprived. LAMP documented 6000 businesses and services, of which over 600 were directly related to social and health care (Robinson et al., 2014). An online digital tool was created that could be used at point-of-care (St James's Hospital, 2023). This directory can be used as a digital tool to enhance signposting in medical clinics. But there was little human element to the process. The involvement of link workers as part of social prescribing was a natural vehicle for the use of this directory.

MISA staff connected to the UK's Social Prescribing Network at the University of Westminster in 2016, and brought the learning to Dublin. MISA helped connect Rialto Family Practice and the Coombe Family Practice to a local community voluntary organisation, Fatima Groups United. The Dublin 8 Social prescribing project began in 2017.

MISA was keen to develop its own social prescribing service. Momentum was building, but funding remained a challenge. The hospital felt that the project belonged to the community, and external agencies felt that the hospital could or should fund development within existing budgets. One of the challenges for social prescribing is that it does not appear to belong to a specific 'sector' – conversely, it is a bridge between sectors. It does not fit into a "box" – it is the bridge that joins up the boxes. Progress stalled.

However, the launch of the funding programme Sláintecare provided an opportunity for the hospital and LAMP community project. Connecting hospital patients with the community aligned with Sláintecare principles of "the right care, in the right place, at the right time" (Government of Ireland, 2019). In 2019, MISA was successfully awarded Sláintecare funding which led to the recruitment of a link worker. St James's now houses a hospital-based social prescribing project. Referrals

are accepted from within clinics for older people, and from inpatient wards as older people are being discharged home. At time of writing, over 300 patients have been supported by the service.

Participant Case Study: Restoring Purpose and Hope

Noel was referred to the social prescribing programme in August 2022 by the Clinical Nurse Specialist in Dementia Care in the Memory Clinic of St James's Hospital (Dublin). The reason for his referral was documented as follows: *"62 year old gentleman recently diagnosed with Alzheimer disease. Complete loss of social connection, quite depressed, runs every day, outside of that very little activity. Urgent referral"*.

Having tried without success to contact Noel, I spoke with his sister Orla who informed me that her brother rarely answered his phone. From Orla, I received a brief history of Noel's life. He worked as a bricklayer in England for over 20 years and had been in a long-term relationship there. When his relationship ended, he moved back to Dublin and again found work as a bricklayer. He lived with his mother for about 10 years until she died and then continued to live in the same home alone. After his mother's death, Noel decided to renovate the house and planned to do most of the work himself. During this time, Noel suffered from depression and showed signs of cognitive impairment. Work in the house slowed down and finally stopped. Noel was diagnosed with Alzheimer disease in early 2022 and was commenced on medications to improve his memory. He also had a review of his medications for treatment of anxiety and depression.

I arranged a home visit to Noel in the presence of his sister in August 2022. When I arrived at the house, I was struck immediately by the obvious signs of neglect both inside and outside. The garden was overgrown with weeds and debris and old broken furniture lay in piles in the driveway. Inside, the walls and floors had been stripped back and all rooms were devoid of furniture, cold and dark. Orla advised me to take care moving through the house as many of the floorboards were broken.

Noel appeared from one of the rooms and I was immediately struck by his strong physique, his large soft eyes and there was a gentleness about him. For the next 30 min or so we sat together in the bare living room. I explained to him who I was and that I wanted to help him. Initially his eye contact was minimal, he was withdrawn and when he did look at me, I sensed his profound sadness and vulnerability. Gradually he became more at ease and more engaged in our conversation. He was aware of his diagnosis of Alzheimer disease which was why he had to give up work. He didn't feel that his memory issues were impacting on him at present or at least *"not that he was aware of."* He admitted that *"he didn't have any purpose now and that his mood was very low."* He felt that the medication was not working, and after taking his tablets

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in the morning he would sleep for much of the day. I examined his pill box and noticed that he was taking his mirtazapine in the morning instead of at night time which would have accounted for his drowsiness during the day. With his consent, I offered to liaise with the medical team in the hospital and arrange an urgent review of his medications which was organised within a few days.

We discussed the circumstances in the house and the work that needed to be done. In the presence of his sister, I informed them of the Healthy Age Friendly Homes programme (HAFH), explaining that the coordinator would carry out a needs assessment to establish what supports would be required to enable Noel to continue living independently at home. I explained that they would provide information on adapting the existing home and the relevant grants available to make those changes. Both Noel and his sister agreed for me to send a referral on his behalf.

Noel had lost his purpose and was not running as frequently. I visited him again a few days later and discussed the current programme of activities in the local Family Resource Centre (FRC) which was within walking distance of his home. He was in better form, more engaging and I felt his growing sense of hope and trust in the support that he was getting. He was open to suggestions, and he agreed to come to the FRC with me to meet with the Social Prescribing Link Coordinator there and I arranged this meeting over the following few days. All three of us sat together and Noel decided to join a group that went sea swimming twice a week on Mondays and Wednesdays and a Tai Chi class on a Thursday. He marked these days and times into his diary and I also emailed a copy of these times to his sister who could also remind him.

Over the course of the following weeks I contacted Noel weekly. He always answered my phone calls, and I noticed his tone of voice sounded brighter. His medications had been reviewed and he was no longer sleeping for large portions of the day. He was really enjoying the sea swimming and planned to purchase a dry robe, sea gloves and booties. I could sense that Noel was feeling better. The HAFH coordinator had visited him in the presence of his sister and, over the course of the following weeks, they had builders assess the work that needed to be done on the house and they were assisted with grant applications. After approximately 8 weeks of supporting Noel, I discharged him from the programme. I did, however, contact him again just before Christmas. He was in good form and looking forward to the work starting in the house in the new year.

Shortly after Christmas, I was informed that Noel had died earlier that week in his sleep of natural causes. I was naturally very shocked and saddened to hear this news. My initial reaction was to question if there was something more that we could have done for Noel. Then, on reflection, I realised that through the social prescribing programme we had connected Noel with different resources in both the community and the hospital setting which had all helped to give more purpose and a sense of hope to Noel in his final months.

8.5 Conclusion

The story of social prescribing in Ireland is one of small beginnings, from the ground up. Whether it was in remote areas at the edge of the island, or deep in deprived areas of Dublin, practitioners on the ground knew that connecting the health and community sectors was the way forward to helping people we serve.

Factors that helped the journey included the grassroots nature of the movement, which allowed community workers and healthcare professionals to collaborate with the patient's best interest at heart, provide a bridge between various sectors and build bridges across traditional boundaries. Those same boundaries were a hindrance to progress, as funding tended to follow individual sectors and it was difficult to find funding for bridges between sectors.

The All-Ireland Social Prescribing Network learned from each of its members, and from its sister Network in the UK. Representation of the Network in the HSE, and the HSE in the Network, was critical to development and growth of social prescribing in Ireland. A breakthrough came when the AISP presented to the Dáil, and social prescribing became policy. Evaluation was considered a corner stone of good practice, and the challenge for all practitioners is to maintain a culture of rigorous evaluation while we continue this work.

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Chapter 9

Social Prescribing in Canada: Coproduct with Communities



Kate Mulligan

9.1 Introduction

This chapter offers an overview of social prescribing in Canada, a country with a complex and diverse health and social landscape. It starts by presenting a case example that illustrates a typical social prescribing pathway and its outcomes for a person living with chronic pain. It then describes Canada's policy and systems context, which shapes the opportunities and challenges for social prescribing. It highlights how Canada is a federated, postcolonial country with a geographically dispersed and demographically diverse population, and how this influences the design and delivery of health and social services. It also shares diverse, context-specific examples from social prescribing initiatives from across the country, which address different population needs, in different ways, for different populations, by different actors in health and social systems. It shows how these initiatives are linked under principles of individual and community self-determination, shared commitments to health equity, and efforts to integrate care in ways that better resource and recognize community health. It then outlines some of the key challenges and opportunities for social prescribing in Canada, such as working across boundaries in a federated context and developing a more robust evidence base for social prescribing interventions. It emphasizes the need for a realist approach that examines what works, for whom, under what circumstances. It also reviews recent contributions to the social prescribing research by Canadian authors and introduces the work of the Canadian Institute for Social Prescribing, a pan-Canadian network that aims to support the work of social prescribing practitioners, participants, communities, policymakers, and researchers as it scales and spreads across the country.

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9.2 Social Prescribing in Canada: A Pathway to Health Equity?

Despite its global reputation as a champion of peace, security, and well-being, Canada faces significant challenges in addressing the health inequities that persist among its diverse and marginalized populations. The country's relative wealth and universal health care system obscure the stark disparities in health outcomes and access to health-promoting resources that exist across social and geographic gradients. Among the most affected are structurally excluded communities who encounter multiple barriers to receiving timely, culturally safe health care and to achieving the social determinants of health, such as housing, income, belonging, and self-determination. These communities include Indigenous (First Nations, Inuit, and Métis) people who bear the ongoing and intergenerational burden of colonialism on their health, Black and racialized residents who experience various forms of racism in their daily lives and interactions with the health system, LGBTQ2S+ populations who face discrimination and stigma based on their sexual orientation and gender identity, caregivers who provide unpaid and under-recognized health work, people living with disability and chronic illness who are marginalized by a system that prioritizes acute care, and those living in rural and remote communities who lack equitable access to health and social services (Public Health Agency of Canada, 2010).

Canada's health system is often regarded as a model of universal health care, but it falls short of providing equitable health outcomes and access to health-promoting resources for its diverse and marginalized populations. A 2017 report by the Commonwealth Fund ranked Canada ninth out of 11 wealthy Northern countries in terms of health system performance, highlighting the significant disparities in life expectancy – up to 10 years – across regions, provinces, and territories (Commonwealth Fund, 2017; see also Canadian Institute for Health Information, 2018; Public Health Agency of Canada, 2018a, b). These disparities – unnecessary, unjust, and avoidable differences in health experiences, outcomes, and access to the social determinants of health – are known as health inequities (Public Health Ontario, n.d.).

While the term “social prescribing” is relatively new to Canada, many existing health and social care initiatives aim to address these health inequities and their underlying social and structural determinants of health in ways that are consistent with globally accepted conceptual and operational definitions of social prescribing (Muhl et al., 2023) (Fig. 9.1) – an approach that connects people with non-medical sources of support within the community to enhance their health and well-being (Centre for Effective Practice, 2022). A distinctive feature of most social prescribing initiatives in Canada is their an explicit focus on reducing health inequities for a range of populations, by a range of partners, in a range of contexts and settings. Social prescribing in Canada operates using principles of individual and collective self-determination (Bhatti et al., 2021). With the support of community connectors (also known as link workers), participants co-produce their own well-being plans and receive support that enhances their autonomy to make decisions about their

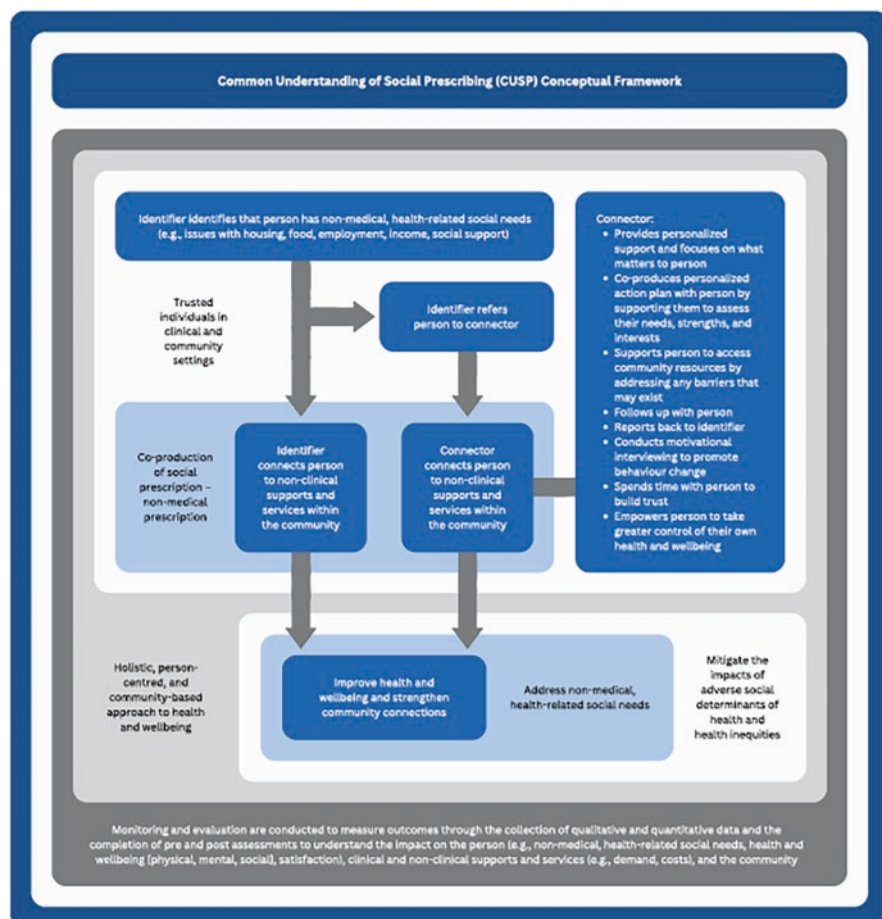


Fig. 9.1 Common understanding of social prescribing (CUSP) conceptual framework (Muhl et al., 2023). (Reproduced from Establishing internationally accepted conceptual and operational definitions of social prescribing through expert consensus: a Delphi study, Muhl et al. (2023), Fig. 3, with permission from BMJ Publishing Group Ltd. <https://doi.org/10.1136/bmjopen-2022-070184>, licensed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (<http://creativecommons.org/licenses/by-nc/4.0/>))

health, self-efficacy, relatedness, and beneficence. Social prescribing in Canada aims to achieve one or more components of the quintuple aim of health care: better care experiences, improved population health, care team well-being, reduced costs, and advances in health equity, and to shift power and resources to local communities (McKeen, 2023).

Social prescribing in Canada is not yet a systematic or widespread practice, but rather a collection of local and ad hoc initiatives that respond to the specific needs, capacities, and contexts of different communities. There are many ways that people can access social prescribing across the country: through primary care providers,

hospitals, long-term care facilities, community and social service agencies, or by self-referral. In general, social prescribing involves people with social needs that affect their health and well-being or their use of health services co-producing social solutions with a connector (such as a link worker, well-being coordinator, community health worker, community connector, etc). Participants are also provided with follow-up and supports for participation, learning, and systems improvement. Canadian social prescribing initiatives aim to achieve multiple benefits at different levels. For individuals, families, and caregivers, social prescribing can enhance their self-determination, well-being, and quality of life. For local communities, it can foster mutual aid within a more well-resourced and coordinated infrastructure for community health. For multisectoral systems, it can facilitate adaptation and innovation address health equity and the social and structural determinants of health through integrated approaches and investments.

9.3 Case Example: Constance's Story

This is an example of how social prescribing can work in practice for a person experiencing social isolation and bereavement in a rural Canadian community, using the steps in the CUSP framework (Fig. 9.1). It is a composite story based on several real SP experiences in primary care; names and locations have been changed to protect confidentiality.

Identification: Constance and her partner retired from their busy urban lives and moved to a small rural town where they hoped to enjoy their golden years. However, their plans were shattered when Constance's partner passed away shortly after their relocation. Constance felt lonely and depressed, with few social ties in her new environment. She lost interest in cooking, which used to be a shared passion with her partner.

Referral: Constance sought help from her primary care physician, who diagnosed her with symptoms of anxiety and depression. The physician discussed with Constance the available options for medical treatment and social support. Constance agreed to try social prescribing and was referred to a community connector who worked in a local neighbourhood organization.

Coproduction: The community connector (also known as a "link worker") met with Constance several times to listen to her story and help her identify what mattered to her most. Using mutual support, motivational interviewing, a strengths-based approach, and a series of trust-building visits, the community connector and Constance co-created a plan that addressed both Constance's health and social needs and also reflected her strengths, interests, and choices.

Community connection: The community connector accompanied Constance on her first visits to a local community food program, which offered nutritious meals, communal food preparation, access to healthy foods for low-income and fixed-income people like Constance, and a specific drop-in program for people experi-

encing bereavement. There Constance found friendship and support among peers from her community who understood what she was going through. She reduced her visits to her primary care doctor as she found upstream supports for her social needs.

Follow-up and learning: Constance's community connector maintained regular contact with her and updated her electronic health records so that she and community partners could monitor the impacts of the social interventions on her health and well-being, her use of health services, and her experiences of health and social care. A learning health systems approach ensured that data sharing, feedback, and improvement were central to the systems infrastructure supporting Constance's social prescription.

Outcomes: Because Constance's community connector enhanced her health by fostering her self-determination, Constance was given opportunities to contribute to her community. Today she is a flourishing peer leader in the local food program for bereaved families.

9.4 Policy and Systems Context: Fragmentation and Colonial Legacies

Canada's health system is a publicly funded, decentralized system that aims to provide universal health care to all Canadians regardless of their income or social status. However, the system is complex and fragmented, as the delivery of most healthcare services is under the jurisdiction of 13 individual provinces and territories, each with their own unique approaches and challenges. These subnational governments operate within the framework of the Canada Health Act (CHA), a federal law that ensures tax-funded coverage for medically necessary hospital and physician services for all Canadians, as well as population-level public health services such as vaccination and disease prevention (Marchildon, 2008; Canadian Institute for Health Information, 2019; Government of Canada, 2020). Municipalities, which are subject to provincial jurisdiction, also deliver a range of public health, emergency services, and social services such as public housing, childcare, and income supports. However, many drugs and specialist services are not covered by the single-payer public system, but rather by private insurance plans or restrictive means- or needs-tested public programs. Indigenous health services are funded by the federal government and delivered by a variety of federal, provincial and Indigenous governments and organizations, including the federal Indigenous Services Canada department (ISC, 2020). Government-funded social services include income supports such as child benefits, older adult pensions, social assistance, and employment insurance; housing supports and services, including outreach, emergency shelters and social housing; mental health and addictions services, including overdose and drug poisoning prevention; accessible transportation, accommodation and financial supports for persons with disabilities; and shelters and supports for people experiencing violence or abuse.

Canada's federated and fragmented approach means that there is variation in how healthcare and social services are delivered across the country, with different provinces and territories having their own unique approaches to healthcare delivery and funding. For example, access to comprehensive primary healthcare teams, which provide a range of services from prevention to chronic disease management, is uneven across different regions and populations. The system also faces strains such as long wait times for specialist and emergency services, high demand for healthcare services, and shortages of healthcare professionals and resources, especially in nursing and primary care. These strains were exacerbated by the COVID-19 pandemic (Marchildon et al., 2020; Canadian Institute for Health Information, 2019; Government of Canada, 2020; Canadian Institute for Health Information, 2023a, b, c).

Despite the principles of universality, equity, and accessibility that guide Canada's health system, there are significant disparities in access to healthcare services and the social and structural determinants of health among different groups and communities. Funding constraints and gaps in service delivery mean that many health and social needs in Canada go unmet. Most community organizations that deliver social and well-being services are under-resourced and unstably funded, relying on project funding to meet core needs. In addition, community-scale health and social services are not typically funded or conceptualized as part of the healthcare system but as part of the not-for-profit social and municipal services sectors (Mulligan, 2022). Most regions have a complex patchwork of discrete programs and a mix of regionalized and centralized services, as well as public and private services, rather than a comprehensive system per se. For example, primary care is primarily delivered on a fee-for-service basis by physicians in private practice, with little emphasis on health promotion and prevention, and some regions have increased the role of the private sector in healthcare delivery.

Many community, health, and social services in Canada deliver services that aim to integrate health and social services or address one or more social determinants of health, but they may not use the term "social prescribing" to describe their work. For example, the Canadian Red Cross, in collaboration with volunteers and partners in primary and community care, provides supports for people living in social housing, people requiring social and economic supports in emergencies, and people with a range of community health needs, including social isolation (Mulligan et al., 2023; see also Canadian Red Cross, 2020; Public Health Agency of Canada, 2018a, b). However, not all social prescribing initiatives in Canada provide comprehensive and holistic supports. Some offer light-touch social prescribing services that simply direct people to available resources rather than co-produce solutions with them. For example, green prescribing is practised by some individual practitioners in family medicine who prescribe park visits (Parx, 2023) or who try to reduce the environmental impacts of medications and clinical services through deprescribing (Cascades Canada, 2023). Similarly, arts and culture on prescription has been explored through one-time activities such as a pilot referral program at the Montreal Museum of Fine Arts/Musée des beaux-arts de Montréal (Mercer, 2018). What sets comprehensive social prescribing apart from signposting, and from more mainstream approaches

such as care navigation and integrated care, is the emphasis on supporting the leadership of people and communities in determining their own way forward. This focus on “self-determination” is fundamental to health promotion, or the process of enabling people to increase control over their health and the conditions for their well-being (World Health Organization, 1986).

9.5 Implementation: Challenges and Opportunities

One of the main challenges for advancing social prescribing in Canada is the need to work across fragmented health and social systems in a federated context that involves 13 provincial and territorial jurisdictions. There is little history of collaboration or sense of shared purpose across professions, sectors, and jurisdictions; collaboration is evolving slowly, at the speed of trust. The systems fragmentation also affects technology and referral systems that are mutually incompatible: implementing social prescribing at scale, and learning about the health and health systems impact of social interventions, will require significantly improved data systems, including referral and tracking technologies implemented within governance regimes, such as the OCAP and EGAP principles for Indigenous and Black health data governance, to reduce potential harms by emphasizing community ownership and control (First Nations Information Governance Centre, 2014; Black Health Equity Working Group, 2021).

For these reasons, social prescribing in Canada is necessarily context-specific and adaptable – to accommodate for the country’s significant social, geographic, and systems diversities. For example, in Toronto, the St. Michael’s Hospital Academic Family Health Team incorporates income security, legal aid, literacy, and social work specialists into social prescribing for vulnerable urban populations; in Calgary, a coalition of health and social partners undertakes community-based social prescribing with older adults living with or at risk of addictions and mental illness (Mulligan et al., 2023). In British Columbia’s lower mainland, the Fraser Health Authority employs “seniors community connectors,” who work in community organizations, to promote healthy ageing and prevent frailty for older adults ageing at home and in post-acute care. Across Ontario, community health centres and equity-focused healthcare providers offer tailored programs with Black populations (Black Health Committee et al., 2022), older adults (Older Adults Centres’ Association of Ontario, 2022), people experiencing food insecurity (Heasley et al., 2021; Wiens et al., 2022), and those requiring mental health supports (Public Health Agency of Canada, 2023). Indigenous health and community organizations have a long history of leadership with similar, parallel approaches within Indigenous ways of knowing and doing; they offer integrated, culturally safe, trauma-informed, self-determined, and decolonizing approaches to Indigenous health in Indigenous hands, such as land-based learning and culture as medicine (NCCIH, 2021; IPHCC, n.d.).

There is no clear consensus among advocates or implementers on the nature and objectives of social prescribing, and some create false oppositions between material

and social needs, such as housing and income versus social needs belonging and inclusion (Nowak & Mulligan, 2021). Moreover, social prescribing faces several challenges in addressing the needs and perspectives of equity-deserving communities, who have legitimate reasons to distrust the health and social systems due to historical and present-day practices of oppression (PHAC, 2018a, b). Some social sector actors have expressed concerns that healthcare-led social prescribing will medicalize social issues and neglect crucial aspects of equity, community/participant leadership, and collaboration (Mulligan & Mehta, 2020).

Overwhelmed by the scarcity of human and material resources, some healthcare providers may feel that adding social needs is beyond the scope of their biomedical training. There is also a risk that a government-imposed approach to social prescribing will undermine the co-production with people and communities that has been essential to grassroots social prescribing in Canada.

Despite these challenges, investment and interest in social prescribing are growing apace. The federal government has funded social prescribing initiatives focused on mental health (Public Health Agency of Canada, 2023), and governments in British Columbia, Alberta, Ontario, Nova Scotia, and Newfoundland and Labrador have either funded or promised to invest in social prescribing, often prioritizing specific populations, health conditions, or interventions (Alberta Health Services, 2022; Bridgeable, 2022; CISP, 2023a, b, c; Health Accord NL, 2022). At the same time, there is an emerging trend towards initiatives that are complementary to or could be inclusive of social prescribing. These include integrated care, accountable population health management, and the creation of primary care teams; each of these initiatives aims to address diminishing returns on investment in acute care, significant health human resources deficits, and barriers to primary care attachment for many Canadian residents (Canadian Medical Association, 2023; Lukey et al., 2021; Pilon & Brouard, 2020).

9.5.1 The Canadian Institute for Social Prescribing: Bridging Gaps, Building Networks

Social prescribing has been expanding rapidly at local and regional levels over the past 5 years, supported by a mix of government and charitable sector agencies or within the existing budgets of health and social services organizations. To connect Canada's dispersed practices and projects into a coherent and mutually supportive network for scaling and spreading social prescribing in Canada, the Canadian Institute for Social Prescribing (CISP), or 'l'Institut canadien de prescription sociale (ICPS)' in French, was established in 2022. CISP promotes promising practices; builds capacity through education and training; generates and shares research evidence; and links funders, researchers, policymakers and implementers. CISP is part of a global movement of people bringing community capacity and healthcare services closer together by directly addressing the social determinants of health, from loneliness and social isolation to racism and ageism to income and housing and

much more (CISP, 2023a, b, c). CISP also collaborates with diverse partners, such as the Canadian Red Cross (2020), to support the mental health of people across the country through social prescribing.

CISP activities are supported by various sources of funding and collaboration, including the Canadian Red Cross (the anchoring organization for collective action), the Public Health Agency of Canada, the Canadian Institutes for Health Research, philanthropic foundations, private donors, and the participatory contributions of more than 25 partner organizations. CISP is guided by organizational partners and by a participant advisory council composed of people with lived and living experience of health inequities and/or social prescribing in action. Their paid participation is facilitated by CISP's partner community organizations, who work directly with them to enable full and equitable engagement. Collaboration partners represent a range of communities impacted by health inequities – such as Black Canadians (the Black Health Alliance), LGBTQ2S+ people (Egale), disabled people (March of Dimes, Abilities Centre), caregivers (Canadian Centre for Caregiving Excellence), and Indigenous people (the Canadian Red Cross Indigenous Health leadership team) – alongside a range of health and social services partners, government agencies, and universities and research organizations (CISP, 2023a, b, c). In order to ensure equitable participation, large partners participate using their existing resources and in-kind support, while smaller organizations receive financial support. Partner relationships are guided by an equitable engagement and accountability framework co-developed and signed by the partnership table. Broader participation by individual members of the CISP network takes place through a pan-Canadian communities of practice and interest focused on research, clinical leadership, policy development, knowledge mobilization, and workforce development and training.

A core evaluation team of university-based researchers is leading formative assessments of social prescribing's relevance, acceptability, feasibility, and evaluability for Canada's diverse stakeholders and contexts. Co-production research – currently underway – further empowers interested participant advisors to take on paid employment and training to participate as peer analysts on the research team. CISP is also building pan-Canadian capacity for education and training in postsecondary, community, and workplace settings, including Canada's first social prescribing graduate course at the University of Toronto (School of Cities, 2023); the Institute houses the Canadian Social Prescribing Student Collective, a network of postsecondary students building a social prescribing student movement across Canada (CISP, 2023a, b, c).

CISP partners have articulated several core principles for social prescribing in Canada, emphasizing social prescribing approaches that are:

Collaborative: They involve deliberate collaboration and consistent communication between healthcare and community service providers and organizations.

Community-led: They recognize the existing expertise, strengths, and innovations in the community, de-medicalize the social determinants of health, adopt tailored and bottom-up approaches, and encourage investment in community-led interventions.

Equitable: They reduce barriers and increase equitable access to appropriate pathways and supports for diverse populations.

Holistic: They include all aspects of health from structural, physical, psychosocial, cultural to spiritual. They integrate and support the whole circle of care, including family caregivers.

Person-driven: They respect and support individual choice, agency, and capacity to engage with and be the driver of their own health outcomes and life direction. They shift the power dynamic between institutions, communities, and individuals.

Relational: They adopt a longitudinal approach that fosters long-term trusted relationships.

9.6 Research

Research on social prescribing in Canada is still in its earliest stages. Although several commentaries have called for more research and action on social prescribing (Nowak & Mulligan, 2021; Park, 2022), few intervention evaluations have been published in the peer-reviewed literature. To address this gap, the Public Health Agency of Canada has commissioned leading Canadian social prescribing researchers to guest edit a special issue of the Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice (the HPCDP Journal), a bilingual, peer-reviewed, open-access scientific journal aimed at researchers, practitioners, and governments across the country (HPCDP, 2023). The special issue will provide an overview of the current state of knowledge and practice on social prescribing in Canada, as well as the opportunities and challenges for its implementation and evaluation.

While the evidence base for effectiveness and mechanisms of action for social prescribing in Canada is still developing, there are some promising examples in the research literature. A recent qualitative study by Bhatti et al. (2021) explored the experiences and outcomes of patients who participated in comprehensive social prescribing programs offered by 11 Community Health Centres in Ontario (Mulligan et al., 2020). Using focus groups and interviews with 88 patient-participants, the researchers identified several benefits of social prescribing, such as enhancing patient agency and self-management of chronic conditions; building trusting and supportive relationships with healthcare providers and peers; improving mental health and emotional well-being; and expanding social support networks and community resources. The study also highlighted some challenges and barriers to social prescribing, including lack of awareness and accessibility; stigma and discrimination; and insufficient funding and coordination.

In addition to this holistic evaluation of social prescribing, there are also more focused studies that examine the impact of specific types of social prescriptions on particular outcomes or populations. For instance, Jones et al. (2017) conducted a chart review study of a program that referred low-income patients from a large urban hospital to “income security health promoters” who provided financial

counselling, budgeting support, and connections to community services. The study found that the program helped patients reduce their expenses, increase their income, and improve their financial literacy. Another example is a food prescription intervention that was implemented in a mid-sized Ontario city for 60 patients who suffered from food insecurity or cardio-metabolic conditions. The intervention provided weekly vouchers to access Community Food Markets that offered fresh and affordable fruits and vegetables. A mixed-methods evaluation by Heasley et al. (2021) showed that the intervention improved food security and fruit and vegetable consumption among the participants. Other food prescription studies, including randomized controlled trials, are currently underway to further test the efficacy and feasibility of food prescribing programs for people with food-related health conditions (Olstad et al., 2021).

Three Canadian-led evidence reviews have synthesized the current state of knowledge and identified some key gaps and directions for future research. Percival et al. (2022) conducted a systematic review of quantitative studies and found that social prescribing had positive effects on physical and psychosocial outcomes related to participation and well-being among older adults. However, the results for health resource use were mixed and inconsistent across studies. Grover et al. (2023) performed a systematic review of qualitative studies and found that social prescribing generally improved health outcomes for older adults, despite the scarcity of studies in this area. They also highlighted some critical factors that influenced the success of social prescribing, including personalization of experiences; strong relationships between link workers and participants; supports for sustainable patient participation; and place-based modifications of neighbourhood environments. A third review by Madani et al. (2022) examined multiple systematic reviews and found that, while social isolation and loneliness are worse for the poorest and most socially disadvantaged older adults, the existing evidence base had failed to consider health equity in disaggregated ways and lacked details on how to tailor interventions for older people who faced systemic barriers and challenges.

9.7 Future Outlook

Social prescribing has the potential to transform the way people and communities across Canada engage with their own health and resilience, with the support of a vibrant and well-connected community and health sector. There are encouraging signs that social prescribing is gaining momentum and recognition in Canada, as evidenced by the interest and investment from government and philanthropic funders, health systems researchers, implementing organizations, and the general public. It is hoped that this growth will catalyse a paradigm shift in government and healthcare systems towards effective, upstream, community-led interventions and services; enhance our knowledge of how social interventions affect health and well-being; reduce health inequities; and foster the relationships and capacity to collaborate within a more inclusive and integrated system.

9.8 Key Resources on Social Prescribing in Canada

Publications

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Podcasts

- CBC The Dose (2023). How can socializing benefit my health?
- The Conversation Podcast (2023). Loneliness is making us physically sick, but social prescribing can treat it

Videos

- Canadian Institute for Social Prescribing (2023). Social Prescribing: A Virtual Tour Across Canada.
- TEDx Whistler (2022). Dr. Karin Kausky: The power of social prescription.
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Chapter 10

Social Prescribing in Singapore: Policy, Research, and Practice



Kheng Hock Lee and Wee Hoe Gan

10.1 Introduction

In Singapore, social prescribing is viewed as a solution to improve the efficiency of the healthcare system through a more fundamental integration between health and social care at the personal health plan level. Social prescribing is seen as being complementary to medical prescribing and an intervention that brings on community resources to improve the health of individuals, thereby improving the health of the population. It is a natural evolution of the policy that emphasizes the role of the individuals and the community and discourages over-reliance on the State. The implementation of new models of care such as social prescribing is characteristically cautious and staged in phases to adapt theory to practice. Unlike many other countries, social prescribing was introduced and tested in the secondary care setting where the return on investment is anticipated to be the highest based on the social determinants of health profile of this segment of the population. It is then scaled to include pilots in primary care team and eventually to community based social prescribing teams. Policies in Singapore are driven by data collected through pilots that are rigorously evaluated before additional resources are committed. It is recognized that social prescribing is a complex intervention that is novel. Leeway is needed for the intervention to be adapted and refined before conclusive evidence of cost effectiveness can be gathered. Evaluation and research in social prescribing is in pace with the phased implementation of social prescribing.

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10.2 Policy

The policy imperative behind the implementation of social prescribing in Singapore is different from other early adopters of social prescribing. Singapore has been ruled by the same political party since independence in 1965. The foundations of the social welfare policy have been consistent since it was conceived by Mr. Lee Kwan Yew, the founding Prime Minister of Singapore. Unlike many countries with frequent changes of government and political ideology, Singapore's political philosophy towards welfare has been consistent with measured adjustments made in response to its improving economy and stage of development. It has been described by scholars as a model that supports "productivism" where social policies are formulated with a view to optimizing production and facilitating economic development. By typology, it has been referred to as the "East Asian welfare regime" (Lee & Qian, 2017).

10.2.1 *Productivism and Self-Reliance*

Notwithstanding its similarities to many high income East Asian countries, Singapore's approach to social care has many unique characteristics. Direct expenditure on protective social care is deliberately low. In one study on social protection in Asian countries, Singapore's social protection spending was 3.5% of GDP. This was the lowest when compared to high income Asian countries such as Japan (19.3%) and South Korea (7.9%). The level of expenditure was low even when compared to less developed countries in the region such as Vietnam (4.7%), Malaysia (3.7%), and Thailand (3.6%) (Asian Development Bank, 2013). Instead of solving problems merely by increasing funding, the strategy was to constantly adjust and innovate with social policies that seek to maximize the impact of social care spending. The policy innovations adhere to the fundamental government policy of emphasizing on reliance of self, family, community, and lastly, the state for support. Despite the low level of government expenditure, the outcome in health, public housing and education is comparable to other countries that spend considerably more on social care. The Bloomberg Global Health Index ranked Singapore as the eighth healthiest country in the world (Healthiest Countries 2023, [n.d.](#)). Public housing is heavily subsidized and of good quality. Home ownership is ranked among the highest in the world at 90%. Singapore's public housing was ranked the most affordable in a study of 28 cities in five countries in East Asia and Australia (ULI Asia Pacific, 2022). Similarly, the performance of the education system is highly regarded with good ranking in various international studies. In one study comparing the performance of teenage students in science, reading, and mathematics, Singapore was ranked first among 70 countries (Coughlan, 2016). These outcomes were largely attributed to innovative policies that adapt international best practices to Singapore's context. The emphasis on personal responsibility, family as the first line

of support and the community organizations coming in to complement government funded programmes is credited as the winning formula (Ministry of Finance, 2022). The success of this approach has won over many admirers and the model has been described as “a fascinating alternative to the European style welfare state” (Goodman, 2015).

10.2.2 Solidarity and the Social Safety Net

The concept of solidarity features strongly in Singapore’s social care policy. In sociology, solidarity is viewed as the cohesive social bonding that holds a group together. This is achieved via common understanding among the citizens. Before 1959, Singapore was a British Colony with an immigrant population of diverse ethnicity, culture, and religious beliefs. Any attempt to build a national identity was considered subversive in the pre-independence days. Independence came suddenly first with self-governing status and subsequently independence as part of Malaysia. In 1965, full independence was thrust upon Singapore when the country was abruptly separated from the Malaysian federation. Nation building through the forging of solidarity amongst members of the diverse population became intentional at a policy level since independence (Ministry of Communications and Information, 2018). This had a strong and pervasive influence on Singapore’s social policy. In addition to supporting “productivism” and providing welfare, social policy concurrently takes into consideration the need to build solidarity amongst the citizens. This had evolved into the promotion of the concept of a social compact in Singapore where there is an ongoing effort to make explicit, the implicit agreement between the Government and the people on the roles and responsibilities in providing welfare and the development of community support (Ministry of Social and Family Development, n.d.-a). In addition to “productivism” and self-reliance, social policies are designed with a view to promote solidarity.

The provision of protective social service is delivered under the five pillars of asset building, home ownership, education, employment, and healthcare (Sim et al., 2015). In support of these, a social safety net was created to help those who fall through the cracks of these pillars. The safety net is created using what has been described as “Many Helping Hands.” In this approach, the government goes into partnership with community organizations that represent a diverse range of interests, including charities for special causes, faith-based organizations, cultural groups, citizen groups, and even private companies that wish to promote their corporate social responsibility agenda. As a result, a range of grant makers, donors, professionals, and volunteers from government agencies and civil society come together to provide assistance to the socially disadvantaged. Many of them come together to form Social Service Agencies which are non-profit organizations that provide welfare services. The government provides subsidies for specific services and grants to enhance the capability and capacity of social service agencies. These measures ensure that these agencies, which are often supported by charities, receive

sufficient funding to sustain their operations effectively (Ministry of Social and Family Development, [n.d.-b](#)). The activities of these organizations are co-ordinated by the National Council of Social Services, which is a statutory board under the Ministry of Social and Family Development (Ministry of Social and Family Development, [n.d.-c](#)).

A social care model that places emphasis on personal responsibility runs the risk of “blaming the victim,” ignoring structural causes of social disadvantage, and hindering the building of social cohesion (Siow & Kwek, [2018](#)). The “Many Helping Hands” approach is aimed at countering this by bringing such issues to the attention of community organizations and individuals with the means to help, allowing them to participate actively in supporting the less fortunate members of the community (Ministry of Social and Family Development, [2018](#)).

10.2.3 Social Prescribing in the Context of Singapore’s Health and Social Care System

Notwithstanding the good track record, Singapore’s health and social care system is coming under increasing pressure with the changing environment. As the population becomes more affluent and interested in issues beyond economic survival, the expectations of welfare and the role of the government are changing.

With the restructuring of the economy and the tendency towards a widening income gap, a segment of low-income workers will find it increasingly difficult to afford health, education, housing, and other social care needs at current levels of government help. At the same time, the rapid ageing of the population will accelerate demand for health and social care to an unprecedented level that will create pressure to increase direct spending on health and social care. This is compounded by the change in family structure brought on by the falling fertility rate. Many frail elderly persons live alone. Furthermore, the wages of the elderly workers are relatively lower. Monthly median gross income peaks at age 40 and falls to the level of new entrants to the workforce after age 60 (Koo & Teng, [2023](#)). Thus, the current model that relies heavily on self and family to meet health and social care needs is increasingly difficult to sustain. This gives impetus to the continuing search for new ideas to increase the cost-effectiveness of spending on welfare.

In the late 1990s, the inefficiencies caused by care fragmentation in the health-care system were recognized as an area where innovative solutions were needed. New models of care aimed at integrating care within hospitals and between health care settings were piloted and proven successful (Lee, [2008](#); Lee et al., [2011](#); Low et al., [2015](#), [2017](#)). This led to major policy changes advocating for integration of care and shifting care to the community. In 2008, the Agency for Integrated Care (AIC) was formed. It is a statutory board tasked with improving the transitions of care of patients from the hospital to the community (Agency for Integrated Care, [n.d.](#)). However, the focus of early initiatives remained healthcare centric (Nurjono

et al., 2018). In recent years, there is recognition of this shortcoming in the care integration effort. Focus had shifted beyond integrating within the healthcare system to more effective integration between health and social care. Transitional care models become more community oriented. A community of care approach emerged where the healthcare providers, including hospitals, are seen as part of an overall community effort to improve the health of the residents (SingHealth, 2019). In 2018, structural changes were made at the Ministry of Health and the Ministry of Social and Family Development to foster better integration between health and social care for seniors (Ministry of Health, 2019). AIC's role was expanded to include the co-ordination of aged care services and the facilitation of service development and capability-building across both the health and social care sectors. In 2019, the first social prescribing pilot was started in a community hospital in Singapore. Interestingly, the programme was aimed at supporting patients with poor social determinants of health. The social prescriptions were co-developed with patients to complement their clinical prescription, which are then dispensed by social care providers in the community (Lee et al., 2022).

10.3 Research

Social prescribing is a relatively new approach in healthcare, and there is still much to learn about its effectiveness, implementation, and impact on patient outcomes. Early adopters of social prescribing face numerous challenges, including the scarcity of evidence of its effectiveness and the complexity of developing evidence due to the nature of social prescribing. Most effective interventions are built on sound theory and practice until sufficient evidence is accumulated to establish them as evidence-based practices. Social prescribing is a good theory that meets several criteria for being coherent, congruent with experiences, testable, simple, generalizable, and supportive of the development of other theories (McKnight & Russell, 2022). It explains the observation of poor outcomes resulting from medical prescription and predicts that additional interventions targeting the social determinants of health can lead to improvements. The theory is waiting for evidence to accumulate, and practitioners and programme leaders should include evaluations in their programme design and follow best practices for implementation. Social prescribing programmes are being implemented worldwide, each with the potential to contribute to the evidence pool that will inform future best practices in social prescribing.

Due to its complex nature, the study of social prescribing presents several challenges, such as the involvement of multiple stakeholders, variability of practice, interdependence of outcomes, and the influence of practitioners' and care recipients' behaviour. A rigid definition of social prescribing is not feasible, as it must be tailored to the person, culture, community, healthcare system, and practice setting. As a result, it is necessary to establish a functional definition for evaluation that aligns with the broader definition, while also being specific enough to support the creation of practical processes within the programme.

In the context of SCH, social prescribing is defined as an intervention that involves identifying patients with inadequate social determinants of health and facilitating the connection to community assets to enhance patients' well-being. An iterative approach based on double-loop learning was employed in designing the programme. This approach involved regularly evaluating existing practices and underlying assumptions by gathering feedback from stakeholders involved in the implementation. The feedback and data collected were then utilized to modify the initial hypotheses.

Although this approach allows the development of a social prescribing model that is pragmatic and contextualized to care setting and patient needs, it creates difficulties for programme evaluation and research. An effective study of a complex intervention requires for the components to be defined and consistently applied. Even a pragmatic randomized controlled study would be difficult to design with a care model that changes frequently over time. Even if reliable results can be obtained, it would be difficult to explain which components of the intervention are necessary and how they interact with one another in achieving the outcome. More important questions like who should receive the intervention and how the interventions work will remain unanswered. The initial idea of conducting a randomized controlled study was shelved for a later date, until we achieve better understanding of how social prescribing works and the intervention can be refined and implemented consistently.

The evaluation currently underway has two components. The first is to use fuzzy set qualitative comparative analysis (fsQCA) to better understand how social prescribing works. This method of research is used in social science research, allows for the analysis of complex causal relationships between multiple conditions and a particular outcome. It uses Boolean algebra and fuzzy set theory to analyse data derived from a large numbers of case studies. Commonly used methods such as regression analysis assume causal pathways to be linear and additive. This can limit the ability to capture complex causal relationships. In contrast, fsQCA allows for a more flexible approach, in which causal pathways can be non-linear, interactive, and even contradictory. fsQCA identifies conditions that may contribute to a particular outcome into different sets, and then using mathematical algorithms to identify the different pathways and combinations of conditions that may lead to the outcome. Social prescribing have the multiple pathways that can lead to the outcome of interest and there is a need to identify key conditions and factors that contribute to these pathways. Causal configurations will be derived from data obtained from a large number of case studies. Causal factors or conditions that potentially affect the outcome of the intervention are identified in each case study and compared across cases. In effect, qualitative data collected is converted to quantitative data and then analysed to understand how the various conditions interact to produce an outcome. The result of this analysis is a set of pathways that describe how various combinations of causal conditions can lead to the anticipated positive outcome. This will enable the extension of theory and allow for the development of a more effective intervention.

The second component of our evaluation will study the programme using implementation science. An implementation framework is selected to study the existing programme with a view to determining implementation determinants, develop implementation strategies, and evaluate the implementation. A better understanding of the active components of the intervention and an improved implementation strategy will lead to a social prescribing programme that is well defined and consistent. This in turn will enable the use of study methods such as randomized control trials and provide us with more definitive evidence on the effectiveness of social prescribing.

The development, implementation, and research on Singapore's adaptation of social prescribing is part of a long-term plan to integrate health and social care for better cost-effective care. Research in this area will similarly take a long-term view as social prescribing progresses with time. Future direction will include studies that measure the long-term outcomes of social prescribing programmes. Social prescribing programmes will continue to evolve with time and changing needs of the country. Programmes will differ in terms of care setting, target population, modality of activities, and even disease conditions. The cost-effectiveness of such programme variations will also need to be studied. Evaluating the cost-effectiveness of social prescribing will probably remain the main focus of research as resources to provide health and social care for the population will always be less than adequate. Research in social prescribing will deepen our understanding of the effectiveness, implementation, and impact of social prescribing programmes. By focusing on these areas, social prescribing will eventually become an integral part of personalized healthcare and improve the health of our population.

10.4 Practice

Elderly patients often require longer recovery and rehabilitation periods after major illnesses. This need is higher for patients with poor social determinants of health and lacking in family support. In Singapore, which emphasizes self-reliance and family support, such patients may be even more disadvantaged and will require additional support from the healthcare system after suffering a major illness. Singapore's healthcare system has community hospitals that provide such patients with inpatient care, post-acute continuing care, and rehabilitative care. Consistent with the drive for efficiency, patients are transferred to the community hospitals after a short stay in the relatively higher cost tertiary hospital where complex diagnostic and therapeutic interventions are carried out.

SingHealth Community Hospitals (SCH) is the largest provider of community hospital services in Singapore and operates three community hospitals with a total of 1100 beds. These hospitals attend to patients' medical, psychological, and social needs so that they can reintegrate into their communities after they leave the hospital. In 2016, the Ministerial Committee on Ageing developed an action plan for successful ageing, which calls for reorganizing care delivery to support seniors in

receiving health and social care near their homes. Responding to this plan, SCH developed a new model of delivering community hospital care and implemented a social prescribing programme in July 2019. This programme aims to improve the health and well-being of patients by providing them with a social prescription that connects them to community assets near their home that can support their personalized care plan after they leave the hospital. These community assets are as described by the theory of asset-based community development (Lee, 2021). They include helpful individuals, informal associations, social service agencies, community health services, institutions, and a whole range of local community organizations.

Just like how patients have unique qualities, the characteristics of communities and health systems vary between different countries. Therefore, universal concepts such as social determinants of health and social prescribing need to be translated to the context of each country and adapt them accordingly to ensure effective implementation. The SCH social prescribing initiative started with the establishment of an implementation team consisting of senior management and clinicians tasked with developing and leading the social prescribing initiative. This team studied social prescribing through literature review, consultation with subject matter experts, and visits to best practices in the United Kingdom. They then derived an adapted programme theory through consultation with local stakeholders from both the health and social care sectors. During the engagement process, the resources required, work processes, and intended programme outcomes were considered prior to implementation.

The initial plan was to implement social prescribing in all three community hospitals in SCH. However, since there were no established programmes of social prescribing in the country, there was uncertainty about stakeholder acceptance, integration issues with the existing care model, and competencies of practitioners of social prescribing. Instead of full implementation, the decision was to first gather the necessary resources, develop new work processes, and pilot the programme at one of the three hospitals. During this process, it was realized that entirely new competencies were required for social prescribing, leading to the creation of a new professional role – the well-being coordinator. The well-being coordinator is responsible for identifying issues in the social determinants of health that impact patients' well-being, collaborating with patients to create a care plan that meets their needs, and referring them to appropriate community resources after discharge.

To support the building of these competencies, an interim training programme was started, which included lectures, peer-led case discussions, and multi-disciplinary team meetings. These sessions covered a range of topics, including the biopsychosocial model of care, social determinants of health, theory of social prescribing, assessment tools of social prescribing, and well-being based on the concepts of positive psychology. These team meetings were also useful for the well-being coordinators and clinical teams to develop shared understanding of patient problems and co-create strategies to better support them.

Initially, the selection of the Patient Activation Measure-13 (PAM-13) as an indicator of programme outcome was influenced by experiences from practices overseas. However, when we tested the tool in our context, we discovered that it was not

appropriate for the community hospital setting. Practitioners expressed the opinion that the tool was more focused on managing chronic diseases in a primary care environment. A search was made for new measurement tools that were more appropriate to the adapted programme theory. New tools assessed include the Brief Inventory of Thriving (BIT), Medical Outcome Studies: Social Support Survey (MOS-SSS), the Zarit Burden Interview, the World Health Organization – Five Well-Being Index (WHO-5), and the UCLA Loneliness Scale.

The collaboration between the implementation team and the clinical team to develop solutions underscores the importance of teamwork in process improvements and overcoming unanticipated ground issues. During implementation, the Covid-19 pandemic reached Singapore and social distancing as well as other infection control measures brought unanticipated new challenges. One such challenge was the emergence and recognition of digital inclusion as a new social determinant of health that the social prescribing intervention must address. Safe access to many community resources required the use of QR code scanning and contact tracing apps. The team rapidly developed and implemented an initiative to teach seniors on the use of smartphones to overcome social isolation imposed by the infection control measures. Lessons created adhered to adult learning principles and topics included competencies such as connecting to wireless networks, using contact tracing applications, scanning QR codes, and utilizing social media applications to interact with others. The successful rapid adjustment to the care model to meet emerging needs was recognized and the initiative won an international award (SingHealth, 2021).

During implementation, it was realized that one effective way of engagement and supporting positive change was to use motivational interviewing (MI) techniques during social prescribing conversations. A programme to train well-being coordinators to use MI in their conversations and care planning was developed. This approach prioritizes the patient's needs and aims to stimulate positive behavioural changes through reflective listening and joint decision-making. By establishing a trusting and respectful relationship with the patient, care plans can be developed collaboratively.

Another lesson learned was the criticality of being able to find community resources. Asset-based community development was used as an approach to identify the strengths, skills, and capacities present in the community where patients live. The community's resources are assets that can be discovered, partnered with, and maintained through the accumulation of social capital. The team set out to develop an asset-mapping methodology using community sourcing of information and geographical information systems to locate them on a digital map. This was coupled with a programme of fostering community partnership through curating of positive interactions to build long term relationship.

Throughout the implementation phase, the competency-based curriculum for social prescribing was constantly reviewed and transformed into a training system to provide the staff with the necessary skills and confidence to perform their new job role. The programme achieved accreditation by SkillsFuture Singapore, a statutory board under the Ministry of Education that promotes industry-relevant training for

the workforce. The course was made available to all workers in Singapore involved in the integration of health and social care (Hekler et al., 2016).

As the implementation of the programme was expanded to two additional community hospitals in SCH, it became apparent that focus on quality assurance was important. Inexperienced implementers may alter the practice inappropriately, resulting in unsatisfactory variation. Hence, skilled staff are required to oversee the programme's deployment at new sites. The fidelity of processes must be maintained at each iteration so that programme evaluation is feasible. Based on an accurate comprehension of what worked well and what did not, the programme can then be improved and implemented consistently with verifiable outcome.

The significance of leadership in facilitating adaptive change during implementation is widely acknowledged as an important ingredient of success. The Agile method is used in software development. This approach has gained widespread usage for efficiently producing multiple versions and enabling ongoing improvements based on feedback from stakeholders. Its focus on agility, adaptability, and speedy iteration makes it particularly suitable for creating intricate programmes with multiple components that must accommodate behavioural and organizational complexities in the real world (Williams & Brown, 2018). Specifically, the implementation team employed the adaptive leadership approach and Agile methodology to swiftly identify and tackle challenges that arose during the programme's implementation. Moreover, gaining support and recognition from the larger organizational leadership facilitated the integration of the programme into the clinical setting and promoted cooperation across different professional fields, extending beyond the leadership within the social prescribing implementation team.

After gaining experience in implementing social prescribing in community hospitals, social prescribing was introduced to the primary care setting. One crucial consideration is the difference in the care model between primary care clinics and community hospitals. In primary care, patient interaction time is shorter but takes place over a more extended period, necessitating distinct work processes and outcome measures. Drawing on lessons learned and utilizing the concept of double-loop learning (Higgins, 2004) we have developed a contextualized programme theory for social prescribing in primary care for Singapore. This is currently in the pilot implementation phase at two primary care sites in our regional health system.

There are many lessons learned in the Singapore experience of implementing social prescribing. Firstly, social prescribing is a complex intervention that is best implemented in stages over time, which is likely to span over several years. It is beneficial for planners and practitioners to have a shared understanding of the programme and the iterative nature of successful implementation. A framework that enables exploration in the initial phases will facilitate evaluation and future quality improvement. Secondly, constant refinement of the theory during the implementation of social prescribing is essential for improving the programme. There is an opportunity to collect data and feedback as programmes are running, which contributes to programme improvement and the evidence of effectiveness. Thirdly, the

emerging evidence will inform us on what works in social prescribing, why it works, and for whom. However, refining the intervention takes time and caution is needed when it is scaled to include different settings. Expectations must be managed for programmes that operate in policy environments that emphasize achieving timely results and return on investment.

Finally, pooling evidence will be challenging due to the heterogeneous nature of social prescribing as an intervention. Nevertheless, social prescribing is a sound theory, and evidence will grow with an increasing number of well-documented and evaluated studies. A systematic and contextualized approach to implementation is crucial for social prescribing to be effective. Programme evaluation should be thought through during the exploratory phase before it is carried out when full implementation of social prescribing is in place.

10.5 Conclusion

Singapore was fortunate to be able to introduce social prescribing based on the best practice lessons learned from the international social prescribing community. The social care policy which evolved according to needs of our society has laid the foundations of a community-based social care system that places a strong emphasis on delivery by voluntary welfare organizations, supported by funding from a combination of charity dollars and targeted government subsidies. At the same time, public health institutions were organized into regional health systems and directed to explore new models of care that integrate health and social care. Building on our earlier experiences in care integration, we were able to rapidly implement and evolve our model of social prescribing to meet local needs.

Currently, the social prescribing model is under evaluation using research methods that will guide further refinement of the model. This will enable subsequent controlled study designs that will evaluate the cost-effectiveness and clinical efficacy of social prescribing. The training of a non-clinical workforce that will support social prescribing is underway based on competencies that were defined through needs analysis conducted after early phases of the implementation. This was translated into a competency-based curriculum using adult learning principles and delivered through stackable modules that allows for optional articulation into accredited diplomas and degrees.

Social prescribing is envisioned as an approach that will strengthen the healthcare system and enhance its ability to improve the health of the population. In such a care model, individuals are empowered to become healthier, improve their quality of life through preventive care, supported by the community, the social care system, and the healthcare system. It is part of a long-term plan to build a healthier population that will minimize the avoidable and ineffective use of the healthcare system to manage social care problems.

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Chapter 11

Conclusion: The Present and Future of Social Prescribing



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11.1 Introduction

The chapters in this book have examined the policy development, research, and practice of social prescribing across England, Wales, Ireland, Portugal, Germany, Canada, and Singapore. This is the first collection published on how social prescribing has been adapted across different countries with different healthcare and political systems. The book also approached social prescribing policy development, research, and practice with a critical lens attempting to identify its positive characteristics as well as its challenges. This chapter is structured around the key three themes of the book, including social prescribing policy development, its research and evaluation, and its practical implementation on the ground. In this final chapter, we will briefly summarise these three themes and discuss the key similarities and differences across countries and consider some reflections for the future.

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11.2 The Development of Social Prescribing Policy Across Countries

In this book, the policy sections have examined the delivery models of social prescribing in seven different countries and highlighted a number of recurring policy principles, which match overall trends in healthcare delivery globally. As described in the Introduction (see Chap. 1), social prescribing is a great example of transformative healthcare, despite some substantive issues that we will discuss in this section.

11.2.1 *Healthcare Infrastructure and Social Prescribing*

The nature and development of different healthcare systems across the seven countries in this book have a considerable impact on social prescribing (which we set out in Table 11.1). With the exception of Ireland, where about 50% of citizens pay for private insurance, the vast majority of citizens in the other countries in this book have free access to healthcare, paid through general taxation (England, Wales, Portugal, Canada) and delivered directly by the state. Our single exception to this is Germany, where payments are made by employers, employees, and the government into insurance organisations responsible for delivering healthcare. In some countries, there are additional funds to cover for either people who are on low income (Singapore).

In the case of Germany, the fact that healthcare is delivered by 105 regulated, independent, non-profit organisations would make implementation of social

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Table 11.1 Healthcare infrastructure and funding across countries

Countries	Healthcare infrastructure	Healthcare funding
England	NHS delivers healthcare through Integrated Care Boards, NHS Trusts and Primary Care Networks and 317 local authorities delivering housing, leisure, and social services, including public health (e.g. health inequalities, healthy lifestyles)	Mainly through general taxation; out-of-pocket; health insurance
Wales	NHS Wales delivers healthcare through 11 organisations, including Local Health Boards (LHBs), Trusts and Public Health Wales. Twenty-two local authorities deliver social services. The voluntary sector plays a major role in the delivery of health and social care through WCVA (Wales Council for Voluntary Associations). Seven Regional Partnership Boards (RPBs) provide leadership, planning, and coordinate delivery of integrated health and social care services	Mainly through general taxation; out-of-pocket; health insurance
Germany	Policy decisions about health and social care are taken at the regional level (Bundesländer) with devolution of some functions to the local level (Gesundheitsämter)	Combination of statutory health insurance (compulsory) paid by employees, employers, and government. In 2018, public health insurance covered 88% of German residents. Private health insurance offers additional coverage for individuals above certain income thresholds or in specific professional groups
Ireland	Health Service Executive (HSE) delivers healthcare. HSE is divided into seven regions, each with its own management structure. There is some flexibility in how national policies are adopted at regional level.	Combination of public and private sources; 40% covered by a means-tested medical card funded by general taxation providing free access to primary care, hospital care, and medication. Otherwise primary care is pay-out-of-pocket, and medications are subject to a monthly price cap. Hospital care is funded by general taxation. Fifty percent of the population opt for private healthcare for improved access to procedures and specialists or part-coverage of fees.

(continued)

Table 11.1 (continued)

Countries	Healthcare infrastructure	Healthcare funding
Portugal	The Portuguese NHS provides universal and comprehensive healthcare services coordinated by a centralized NHS Executive Direction. NHS is managed by the five regional health administrations (RHAs). Primary health care is delivered by 55 health Centre clusters (ACeS) comprising mostly family health units (FHU) – Small teams of family doctors, nurses, and administrative professionals with functional autonomy.	The Portuguese NHS is mainly free at the point of delivery and mostly funded by general taxation. PHC services like consultations and diagnostic tests are free. The most vulnerable patients are exempt of all user charges, except for medication co-payments. Out-of-pocket spending is relatively high in Portugal, including dental care. ACeS lack financial autonomy and depend on the corresponding RHAs. Most FHU have a pay-per-performance payment model.
Canada	Healthcare delivery is devolved to 13 provinces and territories who receive funding from national government on the basis of healthcare needs and follow legislation (Canadian Health Act) in delivery of health services	Through general taxation (Medicare). However, many drugs and specialist services are not covered by the single-payer public system, but rather by private insurance plans or restrictive means- or needs-tested public programmes.
Singapore	Singapore's public healthcare system is centralised, with the Ministry of Health governing policy and regulation. Three integrated regional health systems manage hospitals, clinics, and healthcare services, ensuring accessible and high-quality care for all citizens. Community hospitals play a vital role in providing post-acute and rehabilitative care.	Combination of public and private funding: Medisave deducted from salary and covers basic expenses. MediShield life is a national insurance policy to cover large medical expenses; MediFund is a safety net to help people with lower income to afford medical bills.

Source: Authors

prescribing more complex as it would require coordination between many different institutional actors. Furthermore, in Germany, the devolution of healthcare to regional authorities prevents coordination of social prescribing at a national level.

The extent to which healthcare policy decisions are decentralised from national to regional and local levels plays an important role in shaping the implementation of social prescribing. While all countries adhere to national policies often set through legislation, some flexibility exists to accommodate the specific needs of different regions.

For instance, Singapore as a small, densely populated city state has a more centralised healthcare policy approach. On the other hand, Canada has 13 provinces and territories which have a high degree of autonomy in setting healthcare policies. In England and Ireland, the delivery of social prescribing occurs at a sub-regional level, organised through Primary Care Networks (PCNs). These networks,

primarily led by GP practices, provide primary healthcare services to communities with populations ranging from 30,000 to 50,000 individuals.

Regional and local priorities drive decision about the type of groups who receive social prescribing, often depending on local strategies and priorities. In Canada, for instance, social prescribing has been directed towards providing support for the Black population. Similarly, the devolution of social prescribing to smaller geographical areas covered by PCNs in England and Ireland and Regional Partnership Boards in Wales is primarily to respond to local needs and capacities which can vary from area to area, particularly in terms of referral options (primary or secondary care and social service agencies or self-referral).

Historical trajectories in policy development also shape the way in which social prescribing is implemented. For example, the trajectory of social prescribing in Wales has been greatly influenced by the VCFSE sector, which has substantial influence on healthcare policy design and delivery, including the implementation of social prescribing. In contrast, both Germany and Singapore have traditionally had a smaller VCFSE sector as most services are delivered through the public sector. However, in Germany, this appears to be changing post-reunification with a growing number of VCFSE organisations taking part in delivering health and social care services, potentially including social prescribing.

11.2.2 The Guiding Principles of Social Prescribing

In previous chapters, we outline that at the policy level, there are many common principles underpinning social prescribing across case study countries. However, several challenges to developing such principles remain.

11.2.2.1 Universality, Equity, and Accessibility

Key shared principles of social prescribing across the case study countries include *universality, equity, and accessibility*. These terms have slightly different meanings, but also overlap. In England and Wales, the term ‘universal’ has been used in policymaking to suggest that social prescribing is not just for adults but for all ages, including children and young people (NHS England, 2022; Welsh Government, 2023). Whilst some steps forward on the development of social prescribing for children and young people have been made in England, in other case study countries, social prescribing for children and young people still appears to be at very early stages of development.

In terms of the principle of equity and accessibility, much policy literature refers to social prescribing as an approach to tackle health inequalities. However, the reality is more complex. In principle, social prescribing is designed to support a person with their health and social needs, thus it contributes to tackling their health inequalities. It does so not just by supporting people to address their health issues through

behaviour change but also addressing their social issues by increasing access to employment, housing, debt advice which contribute to tackling the roots of their health inequalities, the so-called ‘causes of the causes’ of health inequalities. Some evidence shows that social prescribing has been effective in this sense (Hassan et al., 2020).

However, the chapter from Koser Khan and Stephanie Tierney (Chap. 3) raises doubts about the effectiveness of current models of social prescribing in reaching vulnerable groups disproportionately experiencing the impact of health inequalities. They argue that some groups do not access social prescribing in the first place and even when they do, they may still find it difficult to access services unless they are able to liaise with and relate to a link worker.

Overall, few studies exist about these issues across the case study countries. An exception to this is Canada, which has more directly targeted social prescribing towards the most vulnerable groups such as older adults ageing at home, rural and remote communities, and some ethnic minorities such as African/Caribbean/Black. Yet even here, the conclusion from Kate Mulligan is that significant disparities in access to health care services still exist (see Chap. 9).

In England, in partial recognition of these issues, the English NHS has introduced ‘proactive’ social prescribing. It provides funding for vulnerable groups who may lack access to social prescribing and where experimentation with different models may be needed to reach such individuals.

11.2.2.2 Individual Self-Determination

An important principle of social prescribing is individual self-determination. There is a general consensus across the chapters in this book that personal choice is paramount for the success of social prescribing. The relationship between social prescribing users and link workers is key to this process. The empathetic approach of link workers and the flexibility in number of sessions enable users to be listened to, identify their choices, and be supported to take these forward compatibly with community assets available in their locality.

In England, the notion of personal choice has been translated into policy with the term ‘personalisation’ as Kerryn Husk and James Sanderson discuss in their chapter on the development of social prescribing policy in England (Chap. 2). Some of the key reasons for emphasis on personalisation are branded as the increase agency and participation in one’s choice. At the same time, however, personalisation has also been branded as a way to increase self-management and self-reliance and, as a result, reducing over-reliance on the State as raised by Keng Hock Lee and colleagues in their chapter (Chap. 10). One of the key implications of ‘personalisation’ is that whilst it increases agency, it also increases individual responsibility and can be a way to blame individuals for their own failure, forgetting that structural issues (e.g. health inequalities) may be at the root of the problem.

One pertinent example of such structural issues is the lack of a sufficient number of non-clinical and/or statutory services for social prescribing users to be referred to. Is personal choice even possible if not enough VCFSE services to support individuals, following referral from link workers to the community, exist? Many non-clinical services are delivered by the VCFSE sector, which does not normally receive funding from social prescribing interventions. There is an assumption from commissioners that VCFSE-run activities are resourced through alternative funding streams and are disconnected from social prescribing. Hence, one of the recurring debates about social prescribing, particularly in England, Canada, and Ireland, is the need for additional funding to increase the number of non-clinical activities and health and social services available to social prescribing users.

Normally, funding for the VCFSE sector comes from many sources, but primarily the local authority, at least in England. However, government grants to local authorities in England have declined in real terms by 40% in the period between 2009 and 2020, from £46.5bn to £28bn (Atkins & Hoddinott, 2020). More recently, this trend has been reversed due to the pandemic, but the effect of years of neglect cannot be denied and has had an impact on the capacity of the VCFSE sector. Given that macroeconomic factors affect national budgets in other countries, the example of England may highlight a wider problem of under-investment in the VCFSE sector that needs to be considered by policymakers not just in England but in other countries too.

An additional issue raised in all chapters, and that has an impact on the ability of social prescribing users to act on their personal choice, is their lack of agency in relation to the issues they experience, particularly those rooted in the social determinants of health, which may be structural in nature such as poor housing, poor air quality, unemployment, and unequal access to health services.

One possible answer to start addressing such structural issues of inequality – at least in England – would be for social prescribing models to support the creation of peer groups that coalesce around a common theme (e.g. housing issues) as suggested by Prof Rochelle Burgess (Lewis, 2023) and operationalised by organisations active in lobbying local government agencies such as the Wandsworth Community Empowerment Network (CEN). In building on that idea, the role of link workers would be extended to facilitate the creation of peer groups and putting such groups in touch with local organisations such as CEN. Relevant VCFSE organisations would then train social prescribing users with lobbying and organising skills to raise common issues locally and act as a mediator between individuals and local government agencies. This would bring together currently disparate individuals sharing similar problems with relevant assets in the community and effectively empower communities to act on health inequalities. This plan would take forward one of the founding principles of the World Health Organization, namely, ‘self-determination’, to increase people and communities’ control over their health and the conditions for their well-being and is discussed further by Kate Mulligan in her chapter on social prescribing in Canada (Chap. 9).

11.2.2.3 Community-Centred Approaches

Social prescribing is based on the attendance of individuals to non-clinical activities delivered by the VCFSE sector in the community. Thus, another important theme discussed in all chapters in this book is the role of communities in health; primarily the link between primary care and community assets, and more generally, the link between communities and health. The involvement of communities in health is important for at least three reasons: first, the need to improve democratic participation so that citizens have a voice in decisions that affect them; second, community involvement in decision-making can improve the effectiveness of interventions, and the health and well-being of participants (Bild & Pachana, 2022); third, as Kate Mulligan highlights in her chapter (Chap. 9), social sector actors in Canada are concerned about the medicalisation of social issues. Greater community involvement would help to mitigate this issue.

There are different degrees of community participation in health from ‘manipulation’ to ‘citizen control’ (Arnstein, 1968). Healthcare institutions do not have a great tradition of community involvement, despite attempts to improve that by creating public participation groups in primary and secondary care. In paraphrasing Russell, Kerry Husk and James Sanderson (see Chap. 2) argue for the need to move from health ‘done to’ communities to health being ‘done by’ communities themselves (Russell, 2020).

At best, social prescribing currently fits somewhere between the term ‘done for’ and ‘done with’ communities as individuals have – or should have – a high level of ‘agency’ in determining their journey to health and well-being. Overall, there is a high degree of variability across countries and within countries too in this respect. As mentioned above, policy decisions that are often devolved to regional and local areas, as well as historical policy developments, influence the degree of involvement of communities in the decision-making process.

Greater community participation, particularly in the co-production of social prescribing, would help to move closer to the health ‘done by’ communities (Russell, 2020). This would involve communities – particularly the beneficiaries of social prescribing – in the co-design of social prescribing interventions and then throughout their implementation and adjustments (Dayson, 2017b). For example, many social prescribing steering groups involve link workers, commissioners, healthcare professionals, representatives from local authorities, and the VCFSE sector, but do not tend to involve groups of beneficiaries. These groups could be very helpful in determining priorities for evaluation, helping researchers to identify outcomes, and playing the role of a ‘critical friend’.

11.2.2.4 Different Levels and Types of Integration

As mentioned in the introduction to this book, integration is an important aspect of the transformation of health systems. In the context of this book, integration is discussed across four interrelated levels all of which have important implications for

the development of social prescribing. First, at the individual level, integration involves link workers taking a holistic approach to address both health and social issues faced by individuals. This goes beyond the usual focus of primary care, which mainly addresses health concerns. Second, at the local level,¹ social prescribing is also an example of integration between primary care – and other referring agents – and the VCFSE sector, including other local assets. The involvement of the VCFSE has been sought as it has particularly good knowledge of local residents and their needs and aspirations. As such, the VCFSE sector can provide activities and services that are more in tune with the needs of the local population. Third, within the local healthcare system, integration bridges various functions such as physiotherapy, nursing, and psychological support. In this book, examples of this include Multi-Disciplinary Teams in England and Wales, and Primary Health Care in Portugal. Fourth, the term integration extends to combining health and social care, occurring across different spatial scales. In England, for example, recently introduced Integrated Care Boards aim to integrate a wide range of health and social services across a population of about 1.5 million people (Dunn et al., 2022). Or the Regional Partnership Boards in Wales which ensure that local health boards, local authorities, and the third sector work together to deliver health and social care, especially for vulnerable groups.

Social prescribing represents the practical translation of integration at these different levels. The link worker may be integrated in health services by participating in Multi-Disciplinary Teams and also representing the link between health and social care not just in primary but also in secondary care, as in Singapore or Ireland. In England, social prescribing can be seen as an example of practical implementation of integration where local public sector organisations come together to fund and implement social prescribing. In Portugal, social prescribing has been an opportunity for primary healthcare to work much more closely with local authorities, municipality, NGOs, VCFSE, and local associations and build a network for the referral of social prescribing users.

11.3 Research Across Countries

11.3.1 *The State of Research on Social Prescribing Across the Countries in the Book*

Research on social prescribing is progressing apace, with a range of journal articles and reports produced and large-scale research projects underway. One recent systematic review from contributors to this book (Napierala et al., 2022) examined

¹What is considered ‘local’ may vary from country to country and from time to time. It is typically associated with the geography of a local authority (serving 50,000–200,000 residents) and rooted in historical reasons.

outcomes from a wide range of published research. They found that studies tend to focus on outcomes related to mental health and well-being, loneliness, quality of life, general health, self-efficacy, and health care utilisation. They concluded that much research on social prescribing is available but of limited quality, made up of uncontrolled studies with short follow up data and mostly recording positive outcomes. A few controlled and longer-term studies are available and these have shown much less positive outcomes overall.

A number of systematic reviews have criticised the current social prescribing literature on effectiveness for its lack of use of Randomised Controlled Trials (RCTs) (Bickerdike et al., 2017; Costa et al., 2021). As Wolfram Herrmann and colleague point out in their chapter (Chap. 7), a wide range of challenges exist when conducting RCTs in social prescribing. One of the key issues is the identification of what the primary ‘active’ ingredient actually is (e.g. mental health or else) and who is ‘administering’ it (the link worker, the VCFSE sector through community activities, or both)? An additional complication with conducting an RCT, as Kerry Husk and James Sanderson have argued in their chapter (Chap. 2), is that social prescribing varies considerably – it is not cloned but more like an idea that has been implemented differently in different areas. As a result, it is difficult to suggest that outcomes from one RCT may be applicable to social prescribing as a whole.

It is also important to stress that most systematic reviews do not include qualitative studies, thus conclusions from such reviews should be treated with caution. Qualitative research can provide insights on a wider spectrum of outcomes than quantitative studies and support an overall assessment of the impact of social prescribing (see for example, Liebmann et al. 2022).

As a result of the points above, it may be more fruitful to concentrate research and evaluation on the social prescribing pathway and outcomes, and certainly study the implementation of social prescribing, including its facilitating factors and barriers, who benefits the most and who is left out, how and under what circumstances rather than expecting evidence-based policy to be driven by RCTs alone.

In addition to effectiveness evaluations, in the last few years, case study countries (Wales and Canada, and to some extent, England) have also focussed on clarifying the concept of social prescribing and developing minimum datasets to underpin its rigorous evaluation. Both Canada and Wales have adopted translational models of research to do this, involving a wide range of stakeholders.

11.3.2 Monitoring and Evaluation

As explored earlier, the selection of outcomes and methodology used to conduct an evaluation of social prescribing has strengths and weaknesses. Different countries have adopted different strategies to evaluate and monitor social prescribing, and we outline these arguments in-depth in the chapter from Marie Polley (Chap. 4). It focuses on creating a logic model (also known as theory of change) as this helps to determine the outcomes of interest and the components working together to reach

the outcomes. Polley paid particular attention to the range of outcomes that should be collected to fully assess social prescribing, the training needed to support this effort, and the data infrastructure required. By adopting a Group Concept Mapping Methodology which relies on the opinion of a wide range of stakeholders, Carolyn Wallace and colleagues (see Chap. 5) have developed six domains and 21 indicators to monitor the progress in the implementation of social prescribing (also see [Elliott et al., 2022]). Furthermore, in systematically assessing the impact of social prescribing on health inequalities, Koser Khan and Stephanie Tierney suggested the use of Marmot indicators (see Chap. 3).

The effective monitoring and evaluation of social prescribing heavily relies on access to data. Data can be found in various sources, especially within primary care where a substantial amount of routine patient information is collected and stored. Some evaluations of social prescribing, particularly in England, have successfully utilised such information (e.g. Dayson & Bennett, 2016). However, accessing this data often requires complex collaborations and data-sharing agreements which require time and resources to be pursued. Facilitating this process would provide much greater balance and better quality evaluation of social prescribing in each country.

In many countries, a significant challenge remains around the collection of data regarding the attendance at social prescribing activities. Many social prescribing interventions collect routine data about the number and type of referrals to VCFSE activities, but are unable to collect data on actual attendance of those who have been referred. This is due to a variety of reasons, including the fact that VCFSE organisations rarely receive any payment from the social prescribing intervention and sometimes the lack of skills in the VCFSE sector to collect this information. Yet, establishing a connection between actual attendance and outcomes is pivotal to understanding what activity has the most impact and who benefit the most from social prescribing.

11.3.3 Health Inequalities and Social Prescribing

A common aim of social prescribing is to make a substantial contribution to tackling health inequalities. In policy documents, social prescribing's impact on health inequalities is taken for granted rather than evidenced. In analysing health inequalities and social prescribing, the chapter by Koser Khan and Stephanie Tierney highlighted that the term health inequality can have different meanings (Chap. 3). Interventions aimed at improving the health of the population (e.g. smoking cessation classes, healthy eating, physical activity) are seen as addressing health inequalities just because they are implemented in areas of high deprivation that traditionally experience health inequalities. However, tackling health inequalities also crucially means to address 'the causes of the causes' of health inequalities, including poor housing conditions, unemployment, education, debt, poor natural environment. In supporting this point further, Wolfram Herrmann and colleagues highlight a recent

study of residual life expectancy in patients >60 years in Germany (see Chap. 7). It found that social determinants of health, such as income or academic achievement, were significantly better predictors of longevity than access to primary or secondary care (Siegel et al., 2022).

Koser Khan and Stephanie Tierney examined how health inequalities can impact on social prescribing in England by highlighting a number of key points (see Chap. 3). First, higher demand of services in deprived areas leads to less time for GP consultations. Second, cuts in funding to VCFSE services disproportionately affect the most deprived areas; this is problematic given the central role they play in providing social prescribing activities. Third, the important themes of relatedness of link workers and the importance of personal resources driving the capacity of the individual social prescribing user to be 'agentic'. In some circumstances, social prescribing may increase health inequalities by focussing support on those who have more 'agentic' capacity (e.g. personal, social, and economic resources) as they are easier to mobilise and involve into meaningful actions to benefit their health.

Evidence is very limited, particularly around the impact of social prescribing on housing, employment, and other social outcomes. In Chap. 3, Koser Khan and Stephanie Tierney refer to work published by (Jani et al., 2021) from a representative sample of GP practice data in England. It shows that social prescribing referrals are mainly White, 65+ years, and whilst referrals are high in the most deprived areas, declines are also higher in the same areas.

One of the key conclusions from this work is that social prescribing cannot be seen as a 'panacea' to tackle health inequalities as it requires considerable investment and further integration to contribute more substantively to tackle the social determinants of health such as unemployment and housing. Future research in this area should aim at collecting more in-depth data on the socio-demographic profiles of social prescribing users, their engagement level, reasons for declining referrals, and compare these with the socio-demographic profile of the local population to identify potential discrepancies of access.

11.3.4 Future Research

The evidence on the effectiveness and cost-effectiveness of social prescribing is developing at different rates across the countries in this book. Overall, more consideration of research methodologies and methods in designing evaluation and cost-utility is needed as social prescribing is a complex intervention with many different components.

The development of evidence and research about social prescribing is driven by our knowledge about different models and their characteristics. Despite growing research available on such different models and their characteristics, a nationally specific (or international) mapping and repository highlighting different models, sources of funding, number and functions of link workers, types of activities delivered would be particularly useful in continuing to grow the evidence base and

inform further research. These could be led by public sector health agencies in each country or by an international organisation such as the World Health Organization.

All countries and interventions within them could really benefit from co-design, co-production, and co-assessment of social prescribing as growing evidence shows the importance of stakeholders' involvement in design, implementation, and assessment of social prescribing and other interventions. More than other countries, Wales has adopted the principle of co-production in the initial stages of development of social prescribing, involving different stakeholders in the creation of terms for social prescribing, a Development Matrix to inform monitoring of the implementation of social prescribing, and a questionnaire to investigate the experiences of social prescribing users.

11.4 The Practical Implementation of Social Prescribing

Whilst practical implementation of social prescribing is particularly influenced by differences in local healthcare infrastructure, culture, third sector history, and infrastructure, there are also common elements that can be applied to all countries. Most of these have been described in detail by Marie Polley in her chapter on the implementation of social prescribing in England (Chap. 4).

As social prescribing is patient-centred, holistic, based on emotional buy-in at different levels, and connecting different parts of the health and social sectors, its practical implementation is necessarily complex and requires continuous improvement. The development of social prescribing as a complex eco-system requires an iterative model where new social prescribing interventions are allowed to start small and 'fail fast' (Syed, 2015).

As discussed by Marie Polley, the starting point is to be realistic about the time implementation takes. In all chapters of this book, substantial emphasis was placed over the relationship between different stakeholders as the key 'glue' of social prescribing. Attention to power differentials between different stakeholders is quite important (equity of voice). Given the wider evidence from the literature on health and social care interventions, co-production and co-design are preferred methods (more detail in Sect. 11.2.2.3), but the evidence of their current use in social prescribing is limited; we do not really know how much co-design and co-production is really used in the design and implementation of social prescribing.

One of the critical responsibilities of stakeholders at the initial stage of implementation is the identification of the target group. As noted by Koser Khan and Stephanie Tierney, some groups may be left out from social prescribing altogether (see Chap. 3). It is therefore crucial to clarify the target group and the strategies to recruit and engage them in social prescribing. From the initial stages of implementation, an agile method of implementation was adopted by Singapore and England to help identify and resolve implementation challenges and learn from these in an iterative manner.

Overall, as indicated by Marie Polley, social networks of relations are key to determining successful implementation (see Chap. 4). Critical System Thinking (CST) is particularly concerned with the importance of social networks and a corollary to this is the importance of emotions and ‘relationality’ in establishing and growing a network of connections that ranges from the relationship between link worker and user and extends to coordinators, commissioners, VCFSE sector representatives, referring sources (e.g. GP and nurses, local authority staff).

Simultaneously, asset mapping at the local level can be initiated. For instance, Ireland developed the LAMP project, creating an online tool to map available assets for signposting from medical clinics. While often underestimated, asset mapping is crucial in understanding the range of options for social prescribing users. Implementers can use this to grasp the spectrum of available local assets, thus maximising the impact of social prescribing.

11.4.1 Similarities and Differences Between Social Prescribing Models Across Countries

A close assessment of the similarities and differences of social prescribing models across countries would require several pages and more detail can be found in each chapter of this book (see also Khan & Chiva Giurca, 2023; Morse et al., 2022). Here, we try to summarise the key similarities and differences between social prescribing models to offer an overall picture. Characteristics of the social prescribing in each country are summarised in the Table 11.2. An analysis of the key similarities and differences and unresolved issues is provided below and structured around the three key components of social prescribing – referring sources, the role and function of link workers, and the role of the VCFSE sector. Finally, we discuss the funding models for social prescribing in each country.

11.4.1.1 Referring Sources

In all the mentioned countries (England, Wales, Portugal, Ireland, Canada, Singapore), social prescribing clients are referred from various sources, including primary care providers, healthcare professionals, and sometimes self-referrals. Although Germany does not yet have social prescribing, the alternative models described do still include primary care and self-referrals.

In some countries, referral points include local authorities, secondary, and tertiary care (e.g. general hospitals, specialised hospitals to treat complex and rare medical conditions). Hence, social prescribing has developed to include a variety of referral pathways.

Table 11.2 Social prescribing across countries in the book

Countries	SP funding models	Referring source	Link worker	Voluntary, Community, Faith, and Social Enterprise sector
England	Funding primarily from PCNs with 3000 link workers across England; funding for VCFSE sector independent from this; some co-commissioning and local authority funding in some areas. VCFSE may be funded to manage link workers, but they are not normally funded to deliver activities people are referred to.	Social prescribing clients are normally referred through primary care and PCNs, but sometimes can also self-refer. Referral points may include local authorities, secondary care, tertiary care, VCFSE sector. There is also pro-active social prescribing, which supports underserved groups.	Link workers, community navigators. Mainly through PCNs delivering social prescribing to a population of approximately 30,000 people. Link workers are primarily employed by PCNs, but local authorities and VCFSE organisations also employ them. VCFSE organisations may be sub-contracted link workers through contracts with the PCN or local authority.	Strong VCFSE sector, from very small to extremely large organisations. Many delivering public sector services. Receiving funding from many sources, particularly local authorities and the NHS.
Wales	Various and sometimes blended: Welsh Government (Senedd) provides funding through budgets like their Regional Integration Fund. Other funds may originate from regional partnership boards, local health boards, local primary care, public health and local authority budgets.	Five pathways: Self-referral, healthcare, statutory, third sector, and targeted.	Social prescribing practitioner is the umbrella term for community connector, link worker, social well-being coordinator as per the official glossary of terms. A strength-based, person-centred, relationship building role, which includes ‘what matters’ conversation and support plan, and referring to community activities. Social prescribing practitioners can be employed by different organisations – Health boards, local authorities, or the VCFSE sector.	Social prescribing practitioners, often with the title Community Connector. They are based within the third sector. Community assets, ranging from very small to very large, include mental health support, befriending, nature-based, healthy lifestyle, financial support.

(continued)

Table 11.2 (continued)

Countries	SP funding models	Referring source	Link worker	Voluntary, Community, Faith, and Social Enterprise sector
Germany	No investment in social prescribing at the moment, but Wolfram Herrmann et al. (Chap. 7) suggested health insurance-backed Innovationsfonds which allocates €200 million yearly to implement and evaluate new models of care which could be used to provide research funding on the feasibility of social prescribing in Germany.	No social prescribing per se, but similar models: Gesundheitskiosk (health-related neighbourhood Centre in underserved areas); Poliklinik Veddel: Integrated primary care, i.e. co-location of primary care and social/voluntary services; Soziale gesundheit: Social workers acting as link workers	No formal social prescribing but Soziale gesundheit: Social workers acting as link workers	VCFSE sector has not traditionally been very strong; services being delivered by the state. However, since reunification, VCFSE sector organisations have grown.
Ireland	Primarily through PCNs. Link workers are often employed by a local community organisation sub-contracted by the PCN. VCFSE is not funded to deliver social prescribing.	GP practices, although there are examples of secondary care referrals (see Robinson et al.'s chapter [Chap. 8] in this book).	One link worker per PCN located in GP practices. Sessions between link worker and social prescribing user can take up to eight sessions; joint decision-making; non-medical; connect to VCFSE sector.	Very active in the creation of asset mapping to aid referral of social prescribing users (e.g. LAMP, see Robinson et al. in this book).

(continued)

Table 11.2 (continued)

Countries	SP funding models	Referring source	Link worker	Voluntary, Community, Faith, and Social Enterprise sector
Portugal	There is no regulated funding model for social prescribing. Social prescribing is delivered by primary healthcare units (PHC) at the local authority level without any specific additional funding. Local authorities and third sector partners usually have their own funding sources. However, social prescribing has supported some third sector partners to access specific grants for social prescribing activities. Local authorities have started to invest directly into the development and evaluation of social prescribing initiatives.	Social prescribing users can be referred by PHC professionals (GP, nurse, psychologist, clinical secretaries) and can also self-refer.	The role of link worker is taken on by social workers based at the PHC, who typically serve a population of 2–3 family health units. Within the social prescribing intervention, the role of the social worker was expanded to include advice and support on lifestyle changes (e.g. physical activities, food habits), community engagement, employment and training, mental health promotion, personalised emotional and social support, as well as connecting people to community groups, voluntary sector, and statutory services.	Social prescribing provides an opportunity to create assets by working with third sector organisations. VCFSE is very diverse, ranging from local associations, charities, non-governmental organisations, as well as local authorities such as parish councils, municipalities, and public institutes. Third sector organisations receive funding from various sources, such as public sources, local authorities, and specific grants.

(continued)

Table 11.2 (continued)

Countries	SP funding models	Referring source	Link worker	Voluntary, Community, Faith, and Social Enterprise sector
Canada	Social prescribing is funded ad hoc through a mix of regionalised and centralised programmes. Some provinces fund health and voluntary sector organisations to deliver social prescribing. Federal government has funded social prescribing initiatives focused on mental health. Other provinces and territories have pledged to invest in social prescribing targeting specific equity-deserving groups.	Primary care providers, hospitals, long-term care facilities, community and social service agencies, or by self-referral.	Community connectors, but a mix of support from light touch signposting to in-depth referral involving co-production and long-term support.	A wide variety of VCFSE organisations exist with long histories. Community organisations participate actively in the development of social prescribing in Canada, particularly through the recently introduced Canadian Institute for Social Prescribing (CISP).
Singapore	Due to strong partnership between government and civil society (social service agencies), funding for social prescribing comes from different sources, although primarily from the government.	As social prescribing started in hospitals, referrals come from community hospitals (SingHealth) and are dispensed by social care providers in the community. Social prescribing in primary care is currently under development.	Social prescribing coordinators sit in as social care providers in the community. They work closely with well-being co-ordinators within the regional health systems. Primarily focussed on the social determinants of health. Well-being coordinators and clinical teams co-create strategies to better support individuals.	Singapore's social service agencies (SSAs) are formed by both governmental and non-governmental organisations. They include various ministries, statutory boards, voluntary welfare organisations (VWOs), and charitable institutions. They provide social prescribing by integrating health and social care with the aim of supporting population health initiatives.

Source: Authors

All countries appear to be moving towards a more targeted approach that tries to better serve those who have been less well-engaged. However, as mentioned above, there are some issues of accessibility, as currently, not all vulnerable and underserved groups access primary care and so cannot be helped through social prescribing.

11.4.1.2 Link Workers

The role of link worker in social prescribing appears to be central in all countries. Some countries concentrated on developing a specific link worker role (England, Ireland, Wales, Singapore), whilst other countries concentrated more on the function of a link worker (Portugal and Germany), although Germany is only at the social prescribing development planning stage. Social prescribing interventions in Portugal have chosen to train existing social workers and placed them in Primary Health Care units, serving a similar size population to PCNs in England and Ireland.

Key differences between the role and/or function of a link worker and existing professions include:

Focus on health and social issues: although link workers are often funded by primary or secondary care, their role involves ‘holistic’ care and focuses on psychosocial needs, flexible number of sessions to individuals which is patient-centred and, at least in England and Wales, to a ‘what matters conversation’. Patient-centredness is driving the types of activities and/or services people are referred to rather than any pre-existing role description dictated by health and care agencies and the VCFSE sector.

Flexibility in the number of sessions: patient-centredness also means that link workers (or their function) need to be flexible to a wide range of different individual needs and aspirations. Whilst in many countries (e.g. Wales), there is no limit to the number of sessions provided by link workers (it is proportionate to individual need and derived from the ‘what matters conversation’), it is recognised in some countries that a limit must be posed for a range of reasons, including resource limitation and the danger of over-dependency of individuals on link workers. In England, lack of consultation time is a problem highlighted in different reports and documents (Bertotti et al., 2022; NALW, 2019).

Knowledge of the VCFSE sector: all contributors to this book agree that the link worker must have an in-depth knowledge of local activities and services to support choice for individuals. The link worker needs to keep in contact with local organisations. In some social prescribing interventions, link workers are responsible for identifying gaps in community activities and work with local organisations to set up new non-clinical activities of benefit to social prescribing users and the wider community.

Skills of link worker: a link worker needs to have, above all, empathetic orientation towards individuals seeking support. They have to be able to build ‘trust’, ‘care’, and ‘stability’ with individuals who often present with complex personal circumstances. Various theories from psychology and sociology described in this

book and from the wider literature (e.g. attachment theory, critical system theory, social capital, Normalisation Process Theory) provide explanatory frameworks for the positive development of the key relationship between the link worker and the individual. Many chapters in this book emphasised the importance and complexity of this role, training in motivational interviewing and on basic psychological coaching skills as a way to equip link workers to carry out their job in the best way possible.

11.4.1.3 Voluntary, Community, Faith, and Social Enterprise Sector

The VCFSE sector plays a considerable role in delivering social prescribing services in all countries in this book (Table 11.2). VCFSE organisations are involved in providing various types of support to individuals, including mental health support, befriending, nature-based activities, arts, healthy lifestyle programmes, financial assistance, employment, and housing support.

Social prescribing interventions may involve the VCFSE sector in the process of co-design, which provides a voice to them too. However, evidence about the real level of involvement of the VCFSE sector in decision-making in social prescribing is not clear. In Portugal, the level of involvement of the community sector is still unclear as many activities are run within the Family Health Unit, a part of the primary healthcare unit. In Germany, the VCFSE sector is not very strong and most non-clinical activities are run by public sector agencies. On the other hand, Wales has shown a considerable level of involvement of the VCFSE sector in determining the shape of social prescribing. Community organisations actively participate in developing social prescribing in Canada through initiatives like the Canadian Institute for Social Prescribing (CISP).

11.4.1.4 Funding Models for Social Prescribing

Unsurprisingly, most countries in this book (England, Ireland, Canada, Portugal, Ireland) mentioned primary care providers play a prominent role in the funding of social prescribing initiatives. Wales and Portugal have progressively diversified their sources of funding for social prescribing, which can also come from local authorities. England has always had a diversified funding structure from local authority, NHS Trusts, and other sources.

All countries have an involvement of the VCFSE sector but the level and nature of funding for the VCFSE sector varies. Many countries do not have specific direct funding for the delivery of VCFSE activities as part of social prescribing, but rely on VCFSE organisations arranging funding from alternative sources. As a result, with the growth of social prescribing, the VCFSE sector finds it increasingly problematic to support additional social prescribing users. Moreover, as Marie Polley stated in her chapter, much funding for the implementation of social prescribing is short term (1–2 years), leading to short-term contracts for link workers, high staff

turnover, and loss of capacity and skills accumulated. Similarly, in Wales, the most frequently awarded contract to link workers is between 6 and 12 months (Wallace et al., 2021). Although the evidence on the level of funding for the VCFSE sector is limited in most countries, it has certainly been at the centre of heated debate in England over a number of years. Kerry Husk and James Sanderson conclude that in England, initiatives to fund social prescribing have increased but, given the overall demand, resources are still not sufficient (see Chap. 2).

11.5 Final Remarks

This book on social prescribing, drawing on international case studies, sheds light on the multifaceted nature of this approach to healthcare. Throughout the chapters, we have explored the implementation and impact of social prescribing in various countries, including England, Wales, Ireland, Portugal, Germany, Canada, and Singapore. By examining these diverse contexts, we have provided valuable insights into common themes, challenges, and potential benefits of social prescribing across borders.

First and foremost, the case studies have highlighted the growing recognition of social prescribing as a valuable complement to traditional medical interventions worldwide. In each country, healthcare systems have acknowledged the importance of addressing the broader determinants of health and have sought to integrate community resources and activities into patient care. The introduction of social prescribing has provided an avenue for healthcare professionals to bridge the gap between clinical services and non-medical support, emphasising the significance of holistic care and patient well-being.

Furthermore, the international case studies have revealed the key components of successful social prescribing interventions. One recurring theme is the role of collaboration and partnership between healthcare providers, community organisations, and local authorities. The establishment of strong networks and referral pathways has been crucial in ensuring effective implementation and access to a wide range of non-medical interventions. Additionally, the involvement of trained professionals, such as Community Link Workers, has proven instrumental in connecting individuals with appropriate resources and providing ongoing support.

The case studies have also illuminated the potential benefits of social prescribing for individuals and communities. By addressing social isolation, mental health challenges, and the social determinants of health, social prescribing has demonstrated its capacity to improve overall well-being and quality of life. Patients have reported enhanced self-confidence, increased social connections, and a greater sense of empowerment and agency in managing their health. Moreover, communities have experienced strengthened social cohesion, improved community engagement, and the cultivation of a supportive environment.

However, it is essential to acknowledge the challenges and considerations that arise in implementing and sustaining social prescribing initiatives. The case studies

have highlighted issues such as funding constraints, coordination between health-care and community sectors, and the need for rigorous evaluation and research to assess long-term outcomes. It is crucial that policymakers, practitioners, and stakeholders address these challenges to ensure the continued success and scalability of social prescribing programmes.

Overall, we suggest the international case studies presented in this book have highlighted the transformative potential of social prescribing in healthcare. Drawing on the experiences of various countries, we have seen how social prescribing can bridge the gap between medical and non-medical support, empower individuals, and enhance community well-being. By summarising these valuable insights, we hope to inspire further exploration, research, and collaboration in the field of social prescribing, ultimately contributing to the advancement of community health interventions, and holistic healthcare approaches worldwide.

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