SUSTAINABLE DEVELOPMENT GOALS

GOOD HEALTH & WELLBEING – Social Prescribing

GLOBAL SOCIAL PRESCRIBING ALLIANCE PLAYBOOK

In a world operating beyond the pandemic, traditional approaches to health and wellbeing might no longer be enough.



3 GOOD HEALTH AND WELL-BEING

2021

FOREWORD

Gareth Presch, CEO, WHIS; James Sanderson, CEO, NASP; Roland Schatz, CEO, UNGSII; Isabelle Wachsmuth, WHO

We want start by thanking our healthcare colleagues around the world who have been working tirelessly to help and support patients and families during the COVID-19 pandemic. It's been a huge challenge but one that has shown that by working together, we can bring empathy and solutions.

This book builds on the momentum and vision set out by global leaders in September 2015 at the UN General Assembly when the Sustainable Development Goals were announced in New York.

The goal is simple - "Leave No One Behind". While we're experiencing significant challenges during the COVID-19 pandemic, we believe we can achieve our goals by 2030 and that Good Health & Wellbeing can provide a platform for sustainable development.

The opportunities outlined in this book are to create new ethical platforms that add value to our citizens' health and wellbeing while supporting existing public services to deliver high-quality patient centred care around the world. Bridging all sectors of society to embrace healthy living as a way of improving our quality of life.

We will showcase best practices and highlight shared learning that can support health systems around the world navigate and deliver Good Health and Wellbeing during and after the pandemic.

Coronavirus disease 2019 (COVID-19) has pushed the world's health systems, health workforce, social and political systems to their limits, and sometimes beyond. It has also exposed underlying health inequality and the fragility of some systems.

However, the response across the world to the COVID-19 pandemic has also demonstrated the amazing achievements that are possible when governments, communities and people work together against common challenges.

We have seen astonishing examples of high-quality healthcare delivery in extremely challenging circumstances, and the resilience of governments, healthcare systems and people - but in a world operating beyond the pandemic, traditional approaches to health and wellbeing might no longer be enough.

Ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth – all while tackling climate change and working to preserve our oceans and forests.

Together, we can achieve peace and prosperity for people and the planet.



SDG3
GOOD HEALTH & WELLBEING

We believe the opportunity exists to establish a new healthcare model that creates value based on prevention, early intervention and using different types of resources. This approach will enable people and communities to thrive and improve their health and wellbeing, support the existing health services, and create new and meaningful jobs, all while supporting the implementation of the UN's 17 sustainable development goals.

Who's Involved?

World Health Innovation Summit (WHIS)
www.whis.uk

World Health Innovation Summit is a platform that supports the implementation of the UN's sustainable development goal 3 Good Health & Wellbeing.

National Academy for Social Prescribing (UK)
www.socialprescribingacademy.org.uk

The National Academy for Social Prescribing (UK) exists for people to live the best life they can. To do this it wants social prescribing to thrive. Its activity focuses on 5 key areas: making some noise, finding resources, building relationships across all sectors, shaping and sharing the evidence base and spreading what works.

UNGSII Foundation
www.ungsii.org

In September 2015, 193 heads of state pledged their commitment to implement the 17 Sustainable Development Goals at the United Nations. The UNGSII FOUNDATION was created to assist and accelerate the implementation process. Our mission is to ensure that the world reaches its goal, at the latest, by 2030.

World Health Organisation (WHO)
www.who.int

WHO's primary role is to direct international health within the United Nations' system and to lead partners in global health responses.



6 PRINCIPLES TO CREATING SDG3 OPPORTUNITIES

The Global Social Prescribing Alliance will create partnerships across the arts, health, sports and leisure, and the natural environment ,alongside other aspects of our lives, to promote health and wellbeing at a local, national and international level. The GSPA has six main areas of work:

1

Creating a Universal Narrative for redefining health and wellbeing through ‘rethinking medicine’, ‘Personalised Care’, and ‘social prescribing’ in support of Good Health & Wellbeing

We will create a greater awareness of a broader view of health as an essential investment to deliver SDG3. This can help highlight waste and low-value care and help shift to delivering high impact, value creating and sustainable healthcare initiatives. We will support the creation of Learning Communities, including communities of health professionals, to bring together the best expertise, experiences and practices, contribute to change of attitudes and to learn from each other by measuring, benchmarking and implementing actions across the world, including through the G7/G20.

2

Delivering Clinical Leadership through the development of a global network of clinical champions

Health professionals hold a key role in advocating a change of culture towards social cohesion and connectedness that will support SDG3. We will encourage health professionals to take responsibility and feel accountable for increasing value in healthcare. We will support the training of “change agents” (leaders) who feel accountable for the health of the population, including equitable distribution of resources across diseases. This will result in the freeing of resources from high-value cost of care to reinvest in low-cost and high impact initiatives that support a person’s health and wellbeing.

3

Creating innovative Community Development approaches focussed on existing assets and sustainable financial structures (economic model)

Working with financial institutions, government agencies, faith communities and many others we will support investments (such as SCR500) that deliver high impact SDG3 Good Health and Wellbeing solutions. These will bring about value creation, improving people’s health and wellbeing, creating new and meaningful jobs, all whilst implementing SDG3.

25+5 SDG Cities Leadership Platform

4

Implementing the Building Blocks for Social Prescribing and developing the four zones: Art, Nature, Physical Activity, Practical Help and Knowledge

We will develop a long-term strategy for a value-based approach towards change of culture. This will use established best practice and learning from partners in different member countries, including NASP, WHIS, WHO, and UNGSII best practices. This strategy will include a “playbook” that practically supports the long-term objective of change (change needs investment and time) and moving forward in steps (work plans). This includes the implementation and monitoring of effects by use of existing data sources and methodologies as well as the creation of mechanisms to further guide the direction of change towards high impact good health and wellbeing.

5

Creating Workforce Solutions for healthcare institutions via new platforms

Building an ecosystem that supports health systems retain and recruit staff through innovative ways of collaborating with communitiesto support new and meaningful jobs. (currently 18m shortfall predicted by 2030) - while supporting the COVID-19 recovery.

6

Harnessing Digital Solutions to enhance information and meaning

Support digital initiatives for patients’ engagement in shared decision-making, recognising the importance of patients’ goals, values and preferences, informed by high quality information to implement empowering practices and goal- oriented personalised care that deliver high quality and lasting results.

The opportunity exists to create a sustainable health and social care model that generates value, creating new and meaningful jobs while implementing SDG3.

OUR PLAYBOOK CONTENTS

> **Our strength lies not only in the words we stand by, but most importantly through the actions of our initiatives.**

OUR MISSION

To establish a global working group dedicated to the advancement of social prescribing through promotion, collaboration and innovation.



THE VISION

Enable thriving communities to deliver a social revolution for their health and wellbeing while generating value.

We'd like to express our gratitude to our many contributors and partners who have helped us to create this document: Dr Mike Dixon, Dr Bogdan Chiva Giurca, Deirdre Carbery, Lydia Taylor, Prof Leif Edvinsson, David Dickinson, Hank Kune, Emily Dodd, Josh Entwistle, Bev Taylor, Dr Amir Hannan, Sunita Pandya, Ben Wilkins, Soni Cox, Manuela Boyle and everyone supporting our work. We look forward to working together with our local communities to achieve Good Health & Wellbeing for all around the world.

Gareth Presch
– Founder of Global Social Prescribing Alliance

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- Community development and support for local community groups
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WHO IS THIS DOCUMENT FOR?

This document is aimed at people and organisations leading local, national, and international implementation of social prescribing. It aims to:

- Explain what social prescribing is and clarify the role of the link worker
- Help leaders to plan how they can work with community groups, voluntary organisations and civic society to increase the number of community activities available, including across physical activity, financial wellbeing, arts and culture and nature
- Outline the impact of social prescribing and the opportunity it brings to people, society, economy and healthcare system
- Outline the building blocks of social prescribing
- Provide helpful self-assessment checklists and tools to help leaders to work co-productively with communities
- Support leaders to get clinical engagement and develop clinical champions for social prescribing
- Outline helpful ways to set up impact monitoring for social prescribing



The Global Social Prescribing Playbook has been put together by members of the Global Social Prescribing Alliance. The Global Social Prescribing Alliance (GSPA) is a group of worldwide partners who recognise that what keeps us well is more than medicine. The Alliance's vision is to: "Enable thriving communities to deliver a social revolution for their health and wellbeing while generating value". Its mission is to establish a global working group dedicated to the advancement of social prescribing through promotion, collaboration and innovation. The Alliance's work supports the implementation of UN sustainable development goal 3 – "good health and wellbeing".

GSPA PLAYBOOK: SUMMARY PAGE

> **By working together, we can overcome our challenges much more efficiently.**

This book highlights revolutionary initiatives to alleviate pressures on the healthcare system through prevention and early intervention with advancements in Social Prescribing. Together, we can improve people's health and support our healthcare services while generating value and creating new and meaningful jobs at the same time.

GET INVOLVED
In a social revolution and implement Social Prescribing in your community.

Be a part of the social revolution to drive positive change in your local community and support the UN's Sustainable Development Goal 3, 'Good Health and Wellbeing'.



WHAT **IS SOCIAL PRESCRIBING**

Social prescribing enables all local agencies to refer people to a link worker. Link workers give people time to focus on what matters to the person using a personalised care approach, and connect people to community groups and agencies that will support their health and wellbeing.

Social Prescribing has the ability to transform patients into people by focusing on what matters to them, their whole needs and strengths, not just their biomedical ones that need 'fixing'.



WHAT **IS THE IMPACT OF SOCIAL PRESCRIBING**

On people
- Gain a sense of belonging to a community
- Peer support
- Reduce loneliness
- Improve mental and physical health

On the healthcare service & economy
- Decrease in patient admissions, A&E attendances and GP consultations
- Significant financial savings

On society and community
- Stronger, inclusive communities
- People empowerment
- Development of new groups & community activities

HOW **CAN LEADERS ACROSS THE WORLD START TO BUILD LOCAL SOCIAL PRESCRIBING APPROACHES**

1. Bring everyone together to build Social Prescribing locally
2. Community development and support for local community groups
3. The role of the social prescribing link worker or community connector
4. Create shared plans with the person
5. Training and workforce development
6. Ensure clinical engagement
7. Measure impact



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HOW CAN LEADERS ACROSS THE WORLD START TO BUILD LOCAL SOCIAL PRESCRIBING APPROACHES?



i Bring everyone together to build Social Prescribing locally

ii Community development & support for local community groups

iii The role of the social prescribing link worker or community connector

iv Create shared plans with the person

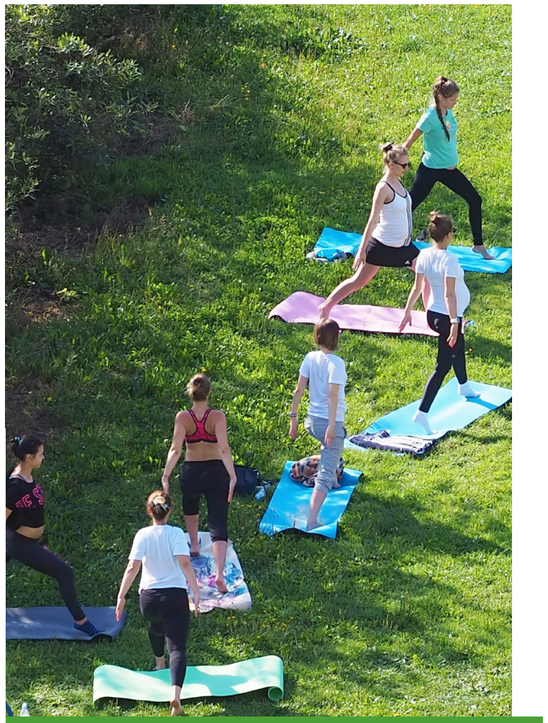
v Training & workforce development

vi Ensure clinical engagement

vii Measure impact

i. BRINGING EVERYONE TOGETHER TO BUILD SOCIAL PRESCRIBING LOCALLY

Good social prescribing happens when all local partners work together to build on existing community assets and services. This 'strengths-based' approach starts with a shared understanding of the biggest issues we face together as communities, together with mapping of what people and resources we have to find shared solutions.





Who should be involved?

Social prescribing needs to be co-produced with communities and people most impacted. All voices need to be heard, in order to ensure that all communities get a fair share of resources and support.

Voluntary organisations, community and faith groups and social enterprise partners should be supported to work alongside general practices, health and local authority commissioners, housing providers, social care services, hospital discharge teams, emergency services and other partners, to co-produce a shared social prescribing programme that works for all.

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ii. COMMUNITY DEVELOPMENT & SUPPORT FOR LOCAL COMMUNITY GROUPS

Commissioning local organisations

Local organisations with deep-rooted community networks need to be commissioned to provide social prescribing services. By respecting current local relationships and developing these further, stronger community networks are being built.

Mapping out community assets & recognising gaps

Good social prescribing relies on the local community groups to receive referrals and provide support. Such community groups typically rely on small grants for survival. For social prescribing to work locally, ongoing support is needed for community groups and organisations.

Where gaps exist, local infrastructure agencies and link workers need to work closely together to find creative ways of encouraging and supporting local development. In areas where there is less community capacity or little infrastructure support, more capacity building support may be needed.

Investment in community groups & recognising gaps

At the heart of social prescribing is a shared commitment to invest in local communities, to increase capacity and to ensure that all communities are fairly supported. Funding remains an important topic of discussion. There are different ways that local commissioners can provide funding:



- provide small grants for volunteer-led community groups providing peer support and activities, such as walking groups, choirs and art classes
- develop a 'shared investment fund', bringing together all local partners who can provide funding to charities and community groups, including the private sector.
- commission existing, voluntary, community, faith and social enterprise organisations, which provide services such as welfare benefits advice and befriending, to deliver community support and social prescribing link worker services
- micro-commission new groups where there are gaps in community provision which may be in the form of a start-up grant and development support
- enable people to use their Personal Health Budget to pay for support in the voluntary, community, faith and social enterprise sector
- explore social investment opportunities, as well as outcome-based commissioning. This is particularly suited to co-commissioning with health and social care, where a set of outcomes are agreed, money is loaned and paid back when outcomes are achieved.

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iii. THE ROLE OF THE SOCIAL PRESCRIBING LINK WORKER OR COMMUNITY CONNECTOR

At the core of good Social Prescribing is the Link Worker. They have time to listen to people, visit them in their homes and start with whatever matters most to the person.

By working with the person and introducing them to community support, including taking them to their first community group meeting (where needed), link workers strengthen community resilience, reduce health inequalities by addressing wider determinants of health, and increase people's active involvement within their local communities.

In the UK, the link worker role has been developed as a new paid role over the past few years and has mainly been pioneered by voluntary sector organisations, working in partnership with general practices and other referral agencies. Link workers are recruited for their listening skills, empathy and ability to support people. For a sample link worker job description with specific information regarding their salary, workload, and recruitment, see Annex A of this guide[1].

Crucially, link workers work as part of multidisciplinary teams. In the UK, they are part of groups of general practices across the UK working together to focus on local patient care (referred to as Primary Care Networks).

We are aware that healthcare systems across the world are organised differently, and therefore an important starting point for international colleagues would be considering and asking themselves whether there are any current existing similar connecting roles within their own local communities.





iv. CREATE SHARED PLANS WITH THE PERSON (Personalised Care Approach)

Social prescribing is deeply rooted within Personalised Care. Shared decision making, co-creation, and co-design are vital elements at the core of social prescribing.

Working together with the person to co-produce a simple support plan is a key element of good social prescribing. This is a good way of capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the person. Support plans should be flexible and adaptable to a person's health conditions, situation, care and support needs.

The plan should outline:

- What matters to the person: their priorities, interest, values, and motivations
- What range of community groups and services they can be connected to
- What the person can expect of community support and services
- What the person can do for themselves in order to stay well and active
- What assets people already have in place that they can draw upon such as family, friends, hobbies, skills, and passions

Good social prescribing empowers people and builds upon their knowledge, skills, and confidence. The person is seen within the context of their whole life, valuing their skills, strengths, experience and important relationships.

Examples of personalised care and support plans are available on the NHS England website.

v. TRAINING & WORKFORCE DEVELOPMENT

Formal training and accredited learning for link workers

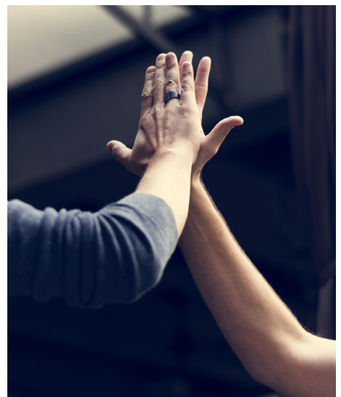
Formal training, informal peer support networks, accredited learning and link worker qualifications are vital in ensuring social prescribing link workers have a good understanding of what good social prescribing looks like to enable appropriate referrals.

A series of courses and resources have been developed within the UK including learning modules provided by the Personalised Care Institute[2]. A formal link worker welcome pack[3] has also been developed by the UK NHS to support introducing link workers to their new role and to aid their understanding of social prescribing. NHS England employs Regional Learning Coordinators to bring link workers together to create informal peer support opportunities.

Clinical supervision for link workers

It is also important that link workers have access to regular clinical supervision to support them in their connecting role. This is especially because link workers often deal with individuals in crisis and highly vulnerable situations (e.g. difficult family dynamics, self-harm and suicidal though, sexual abuse, domestic violence, and many others).

Adequate support and clear safeguarding procedures to deal with such circumstances are crucial to ensuring good social prescribing.



Support for referrers

Finally, it is important to raise awareness regarding the role of the link worker and provide adequate training to all referring agencies (including, but not limited to clinicians, pharmacies, local authorities, hospital discharge teams, allied healthcare professionals, fire service, police, job centres, housing associations, and voluntary sector organisations). This ensures referring agencies understand what makes a good social prescribing referral.

The referral process from all local agencies should be made as clear and as easy as possible ensuring informed decision making to ensure people can exercise choice and have awareness of what to expect from social prescribing and whether it is the right option for them.

vi. ENSURE CLINICAL ENGAGEMENT



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Clinicians receive extensive clinical training throughout their careers and therefore are bound to consider clinical routes of treatment first. This is of course beneficial when the problem is biomedical in nature, but not so much when patients present with social and psychological issues.

Good social prescribing requires adequate training for clinicians to recognise and be able to refer those who could benefit from social prescribing. Multidisciplinary healthcare professionals involvement and 'buy-in' is crucial.

Studies have reported that time can often act as a barrier for personalised care, however, evidence has demonstrated that those who have been trained and educated about personalised care are able to identify and refer those in need to link workers without any difficulty. Furthermore, those with previous experience of social prescribing have reported that link worker referral simplifies their work and allows them to focus on biomedical issues.

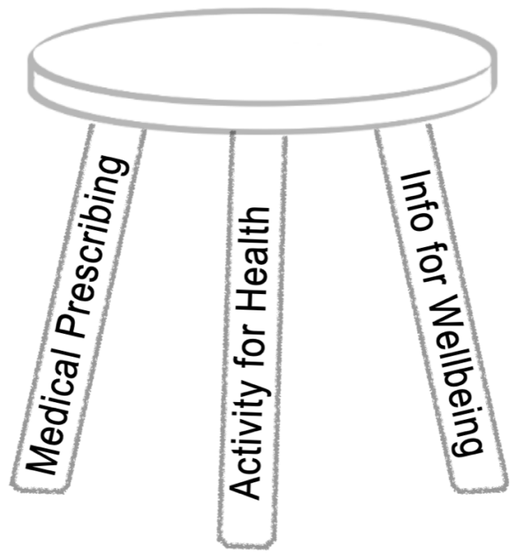
To support clinician buy-in and strengthen the movement of social prescribing and personalised care, clinical champion schemes have been proposed within the UK and internationally. These are currently being developed to:

- Raise awareness of the role that Social Prescribing can play in reducing health inequalities, giving people more control, allowing them to work on what truly matters to them
- Connect multidisciplinary professionals who have a shared goal in changing the conversation around health to fully emphasise the biopsychosocial model
- Unify multidisciplinary parties with a shared leadership emphasis, trying to ensure core learning happens in a multi- and interprofessional environment.



INTRODUCING INFORMATION FOR WELLBEING.

– An initiative of the World Health Innovation Summit.



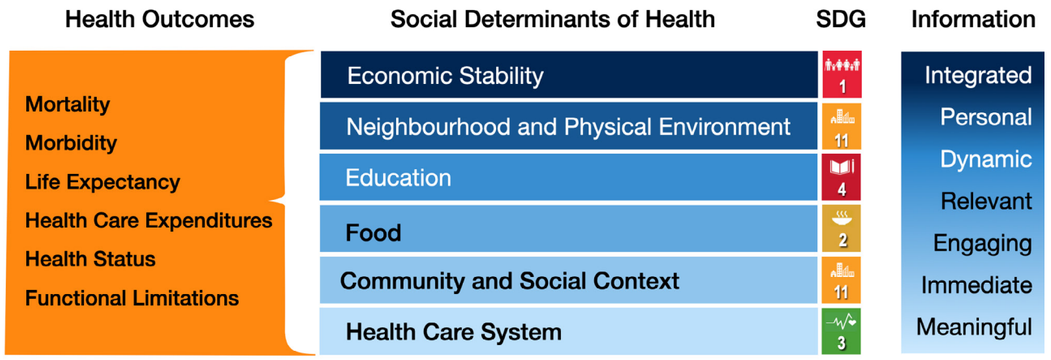
Activity for Health (Social Prescribing).

Doctors are increasingly encouraged to prescribe activity, often as an alternative to drugs, in a process commonly known as social prescribing. This process is backed up by community champions whose role it is to match people with local opportunities such as walking groups, choirs and gardening, etc., monitoring their engagement and feeding it back to the healthcare professionals. The initial success of this movement, fronted by the Global Social Prescribing Alliance, has been exhilarating. Particularly gratifying has been the way in which student doctors have taken this healthcare strategy to heart. Activity prescribing is now a driving force alongside medical prescribing, further engaging and involving patients in their own health and wellbeing.

Information for Wellbeing.

To provide additional stability for the people's healthcare, this paper introduces a third leg to the stool - Information for Wellbeing. There is ample research to suggest that people cope with illness more effectively if they are properly informed and emotionally prepared. This has a bearing on hospital bed occupancy, the prescription of pain relief drugs and, perhaps topically, the management of epidemics and the aftermath. That preparation requires a new approach to information, so that each person can gain relevant, timely, focused messages and make meaning from them in the context of their own lives.





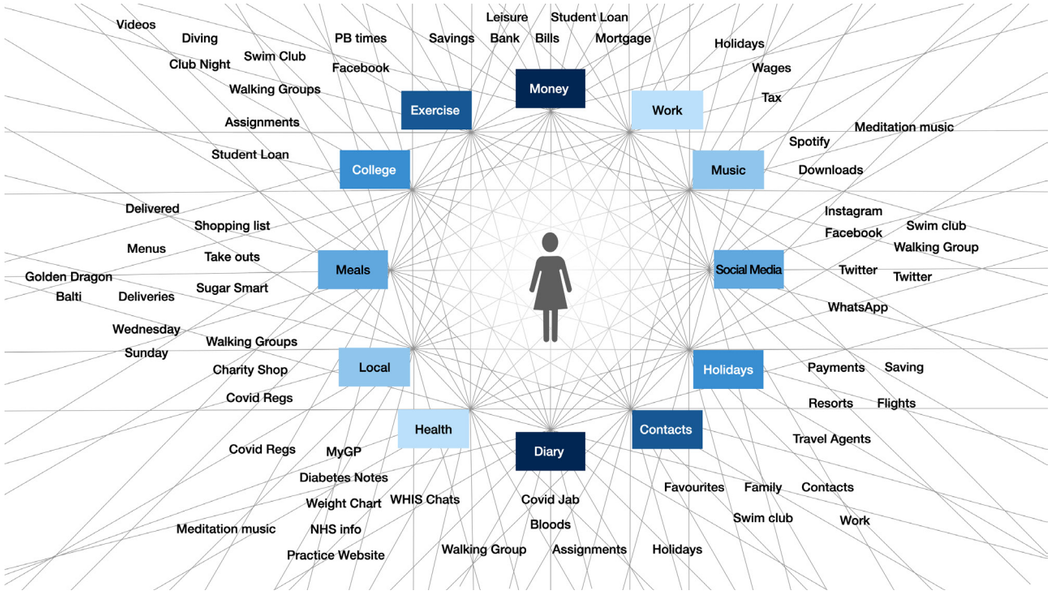
Adapted from the Kaiser Family Foundation model of the Social Determinants of Health

Yet for people living in poverty, without enough money, poor food, inadequate relationships, accommodation, environment etc., their health can often be of secondary concern. To mitigate this with information, it needs to be perceived as personally relevant, in order to engage, enable and support everyone in mapping their lives. The opportunity is to encourage people to orientate and navigate their responses to the situations in which they find themselves. Their information also needs to be integrated into the way they plan their day-to-day activities and interactions. Current models of information handling, websites, social media platforms etc., are inadequate for the task, exacerbated by the fact that those in most need are typically the least information-enabled and dealing with the most complex life-situations.



– INFORMATION FOR WELLBEING

With the assistance of UNGSII, WHIS and a specialist partner Unlike Minds have designed an information navigator app, effectively wrapping the relevant content of the Internet around each person.



Just as a satnav on a car shows only the terrain that is immediately relevant, this information navigation app ensures that just enough information appears on the screen at any one time.

There's far more to this navigation concept. Imagine teachers helping children to learn by building and navigating the information they learn. As learners construct and refine their understanding, they are building and modifying a personal information platform that grows with them, transcending changes of schools, further education and work, as well as illnesses and other disruptions to their lives. Experience from the WHIS Kids initiatives has already indicated the potential impact of this approach.



Imagine doctors at the click of a button being able to assist the husband of a stroke patient modify his app, immediately connecting him with the local support network. Further, think of a care professional sitting down with early onset dementia patients, helping them to reshape their navigation to better suit their new reality. Think also of a man having just being alerted to his pre-diabetic state, in dialogue with a link-worker to access dietary information, details of scheduled interventions and also to the availability of other relevant social prescribing opportunities in the area.

Think of a flash flood affecting a small village, or a large community devastated by a tsunami. Once the mobile networks have been restored, contextualised navigation to relevant content could be achieved far more quickly than through websites. Personal and community resilience is a major goal of the developers. Climate disruption is recognised as an increasingly important social determinant of health and wellbeing, impacting not only individuals but also their communities. The Kaiser model referenced earlier is not exhaustive and there are many opportunities to support the breadth of the SDG programme with this citizen-centric approach.

While it might appear that this will require a vast amount of new content, that's not the case. The content is already sitting in various websites. All that is required is to help people quickly and simply navigate to it.



As with all apps, the Personal information Platform is infinitely scalable and the desire is to make it free to end users. The unique architecture makes its translation into other languages very straightforward and should it need to be icon-driven rather than textual - no problem.

However, the first step (beginning the thousand mile march) is to trial it as a new means of navigating WHIS content. Following the success of that limited trial it will be available initially to support the various initiatives driven by participating communities in the UNGSII SDG Cities programme.

A good candidate for this would be the Young Academic Platform currently under development in the Democratic Republic of Congo. It could be used for collaboration and information management.

Experience from the WHIS Kids initiatives has already indicated the potential impact of this approach.

A similar use might be considered for student doctors involved in the Global Social Prescribing Alliance.

It is probable that personal data will be required to enable the app to function. In context, all appropriate protocols for security and data protection would be present.

Current plans would see the navigation of WHIS content using the app being demonstrable later this year. In the meantime, comments and observations are welcomed including suggestions of priority areas beyond medical and social prescribing.

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vii.

MEASURE IMPACT



Bromley by Bow Centre

> **“I don’t think it’s too much to say that I wouldn’t be here now if it wasn’t for the process of social prescribing, the process of that feeling of community, … of feeling that there’s someone who understands”**

Daz Dooler
– Patient and Social Prescribing Link Worker

The impact of social prescribing on people

Social prescribing can deliver a range of benefits to people who are connected to community support by link workers. Understanding how this works for different groups is important as this can inform us of how we can better use it.

Evaluation of local social prescribing programmes show that by being heard, being connected and being supported to develop new skills, people can gain a sense of belonging to a community, which in turn provides peer support, reduces loneliness and improves both mental and physical health.

There is emerging evidence from the UK that social prescribing can lead to a range of positive health and wellbeing outcomes for people, such as improved quality of life and emotional wellbeing[4]

During a recent year-long pilot developed in Ontario Canada, over 1,100 individuals were provided a total of nearly 3,300 social prescriptions. Patients reported overall improvements to their mental health and a greater capacity to self-manage their health, as well as decreased loneliness and an increased sense of connectedness and belonging. The pilot study also showed that healthcare providers found social prescribing useful for improving client wellbeing and decreasing repeat visits.

Clients Reported

12%
Increase in mental health



49%
Decrease in loneliness



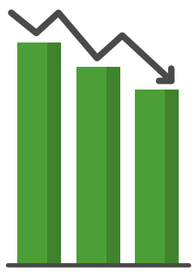
19%
Increase in social activities



Social prescribing gives individuals the chance to find a new purpose, develop a new skill or find a new activity that they enjoy, from physical activities such as walking, running and gardening to creative ones such as the arts and singing.

The impact of social prescribing on the healthcare service and economy

Apart from the health and wellbeing benefits to the patients, social prescribing may positively impact the healthcare system and economy by decreasing inpatient admissions as well as decreasing A&E attendances[4]. An evaluation conducted by Sheffield Hallam University found a 7 per cent fall in inpatient admissions and a 17 per cent drop in A&E attendances. When service users aged over 80 were excluded, the reductions were 19 per cent and 23 per cent respectively. The same evaluation of social prescribing in Rotherham where over 4,000 patients have benefitted from social prescribing also looked at the economic benefit. Between 2012 and 2015 it was estimated that the scheme had saved more than £500,000. This equates to a return on investment of 43p for every £1 spent. Furthermore, a recent evidence summary published by the University of Westminster suggests that where a person has support through social prescribing, their GP consultations reduce by an average of 28% and A&E attendances by 24%[5]. Similar findings were shared by the recent pilot conducted by colleagues in Canada where health providers reported that social prescribing decreased the number of repeat by patients by 5% at three months and 42% at nine months[6].



5%
At three months

42%
At nine months

Health providers reported social prescribing decreased number of repeat visits by clients

Good social prescribing supports people, local communities, and clinicians by expanding their clinical toolkit and expanding their options when dealing with patients whose needs go beyond the biomedical sphere.

The impact of social prescribing on society and community

When adequate support is available, social prescribing can strengthen communities by engaging with people from all backgrounds and walks of life, empowering them to volunteer and give their time to others. Through this collaborative effort, local community assets are further harnessed and developed.

Resources available through social prescribing can be used to target gaps in community provision and develop new groups and community activities for the local neighbourhood. This will not only reach those in greatest need but will reduce health inequalities, enabling people to take more control of their lives and make positive connections within their local area.

During COVID-19 more people have volunteered to support their local communities, working alongside social prescribing link workers to deliver medicines, food and connect people to online community support, reducing loneliness. The need for a strong community infrastructure in the coming decade has become clear in a recent UK review of the long-term societal impact of COVID-19. A series of cases illustrating the positive impact made by social prescribing on local communities during COVID-19 can be found via the following link.

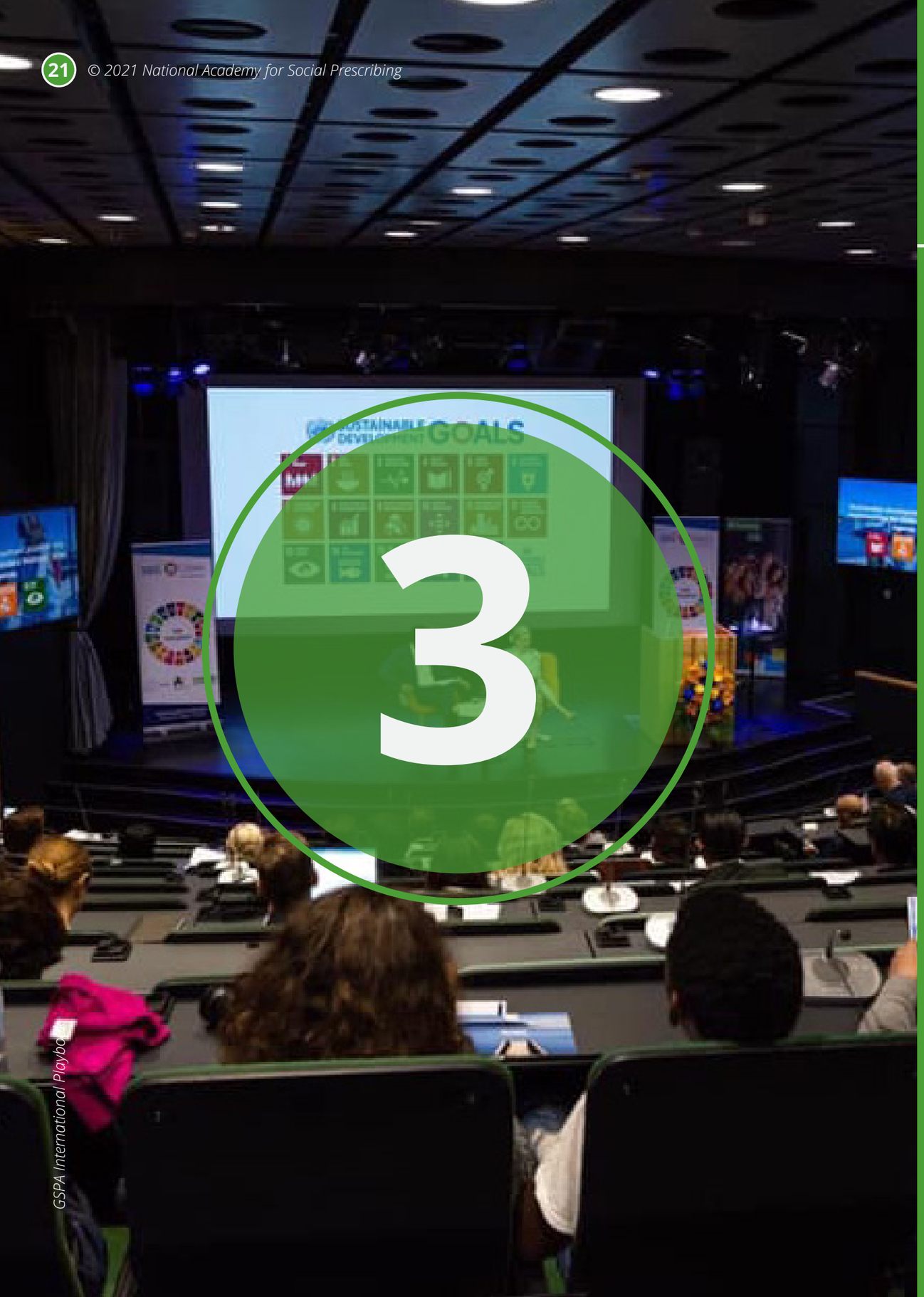
Given that social prescribing is locally driven, there is a clear need for a standardised evaluation framework to document the impact of social prescribing schemes.

A Social Prescribing Common Outcomes Framework has been developed by the English National Health Service, together with a wide range of stakeholders in order to encourage consistent data gathering and reporting of outcomes. Practical support for collecting data on the impact of social prescribing can be found in this framework.

Dr Marie Anne Essam
– General Practitioner

> **“In the 30 years I have spent as a family doctor, social prescribing represents the most effective, wide reaching and life changing of all initiatives to date.”**

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BACKGROUND

3.1 21st CENTURY HEALTHCARE NEEDS & THE SHORT–COMINGS OF THE PATHOGENIC APPROACH TO HEALTHCARE

Technological and medical advances have dramatically increased human lifespan over the past century. The world is facing an unprecedented epidemiologic transition with the gradual decrease of infectious and acute diseases, and the rise of chronic and degenerative diseases in all countries irrespective of their income. Driven by plummeting fertility rates and increases in life expectancy, for the first time in history, the number of people aged 65 and older will outnumber children under 5 years old. Statistically, the number of people aged 60 and over is set to double by 2050 with the majority of 80% living in low- and middle-income countries.

Although this can be thought of as one of society's greatest achievements, the dramatic increase in life expectancy is also linked with a broad set of unanticipated challenges. As people live longer, the need arises to ensure that the extra years they have are spent in good health. One problem remains however: The current healthcare system is based predominantly on a sick-care model, the system is essentially one that waits until we have fallen ill. Today's 'medicocentric culture' has led to the false belief that consumption of formal healthcare services leads to the production of population health (Evans and Stoddart 1990).

This clearly points towards a confusion amongst the general public and experts alike between the concepts of 'medicine' and 'health' as the 'sick care' model of care practiced world-wide is merely defined as the absence of disease. The World Health Organization's 1986 report[7] is however describing health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. As the father of saltuogenicity long ago described it, 'the current situation now calls for a health revolution on the basis of a view of health as a "resource for everyday life", "not merely the absence of disease and infirmity"' (Antonovsky, 1979).

Many healthcare professionals now understand that medicine- despite its successes- has over-reached itself. This is manifest in many ways: around the world there are groups interested in overdiagnosis and overtreatment, in 'lifestyle medicine', in multimorbidity and so-called 'treatment burden' and in evidence based medicine- which has always acknowledged the complexities and uncertainties inherent in the delivery of healthcare. Yet more groups are interested in high value care and in shifting the centre of gravity of healthcare delivery upstream- focussing on prevention and wellness. What binds all of these groups together is a belief that health is more than the absence of illness and that medicine itself- or perhaps more correctly an unwavering adherence to the medical model- is financially unsustainable and certainly leads to waste and to harm. Around the world, many of these interest groups have come together as broad based social movements - Choosing Wisely in a number of countries, Realistic Medicine in Scotland, Slow Medicine in Italy and Rethinking Medicine in England. And all of these social movements share a common interest in shared decision making, personalised care and social prescribing.



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THE SHORT-COMINGS OF THE PATHOGENIC APPROACH TO HEALTH

Healthcare systems across the world face unprecedented challenges with staff shortages predicted to be 18m by 2030. Healthcare costs have been rapidly rising over the past few decades. As well as this, a one-size-fits-all approach to health doesn't work. Both consumer preferences for convenience and affordability are shifting, as well as demand for a more efficient, personalised delivery model is growing. In part victim of its own success, medicalisation has led to higher expectations from the general public who are willing to look beyond disease with a desire for and expectation of life-long wellness. The pathogenic model of care falls short of meeting these expectations due to several reasons as highlighted next.

***Adapted from Healing Health Care: From Sick Care Towards Salutogenic Healing Systems*[8]**



1

Individualisation of Health

When health is considered mere absence of disease, it is only understood at the level of the individual therefore becoming a matter of biology and behaviour. Attention is therefore only paid to the given disease, not the human being with the particular problem, nor their life situation, their environment, social, psychological, economical and spiritual circumstances. The "magic bullet" approach (one disease – one cure) fails to appreciate the complexity of human health (Antonovsky 1979, p37, 66).

2

Exclusion of the Non-diseased

The pathogenic approach to health excludes individuals who are non-diseased who amount for two-thirds of the general population. The concept of self-care is therefore overlooked as a crucial population health promotion mechanism. Proactive involvement of healthy individuals in designing their own health and wellbeing, preventing ill-health and contributing to health creation needs to be encouraged.

3

Retroactive Response to Illness

The pathogenic approach to health is focusing on investing funding, resources and effort in designing the formal health care system as a sort of 'repair shop' (Kickbusch 2007), relieving suffering and disease once it occurs. Therefore, instead of focusing on fostering and creating health, we end up creating 'sick care'.

4

Promotion of Medicalisation and Medical Dominance

The main focus of the pathogenic approach to health remains the already sick individuals placed within costly and highly technological institutions where they can be managed by the hands of 'medical experts'. This sets from the beginning a clear message reinforcing the message that the 'doctor-knows-it-all', leading to lack of engagement and activation of those non-diseased until disease appears.





"Social Prescribing is making a difference to the lives of so many people, they go from feeling alone and helpless to thankful and hopeful, that makes me feel that my role is making a difference, each step is a ripple effect into a wider system of change"

Gay Palmer
– Social Prescriber Link Worker,
South Southwark
Primary Care Network



Disease care is, of course, both necessary and invaluable. However, the pathogenic approach to health was not established to meet the arising major health issues facing us all in today's day and age (Breslow 2004). The formal healthcare approach was previously set up in response to infectious and acute diseases. The opposite is true nowadays with chronic, long term diseases linked to lifestyle and environmental factors which represent a new problem that the sick care system falls short of resolving. Furthermore, the widespread increase in long term diseases does indeed represent a marker of failure in our healthcare system. Polypharmacy, the exponential increase in opiate prescriptions (and associated deaths) as well as the ever-growing antibiotic resistance are only a few of the wide range of problems we have created ourselves whilst pursuing the sick-care model.

Coronavirus disease 2019 (COVID-19) has dramatically unveiled the fragile state of the world's health, health workforce, political and social systems. First and foremost, the pandemic has exposed and amplified the impact of health inequalities and social determinants of health on people across the world. But the truth is, our social and health care systems were failing even before the global pandemic. In a world operating beyond the pandemic, traditional approaches to health and wellbeing will no longer be enough.



3.2 SOCIAL PRESCRIBING & PERSONALISED CARE:

–The opportunity to ignite a social revolution in health and wellbeing



As we move away from a system based on fixing what is wrong, to one that helps build and promote what is healthy, a societal and cultural shift challenging medical dominance and shifting the power to local communities is therefore necessary, mobilising health resources and capabilities of patients within the community setting, making them direct agents of change involved in co-creating, co-designing, and co-producing their own wellbeing.

What would it look like for the healthcare system to see a patient as a whole person, instead of focusing on just their medical diagnoses? What if, along with medication, doctors and nurse practitioners were enabled to prescribe housing and financial wellbeing advice, dance lessons, cooking classes, volunteer roles, caregiver supports, single-parent groups, and connections to bereavement networks? What if instead of providing care for those already experiencing disease, we could support local communities to engage individuals in preventing ill-health and tackling social determinants of ill health? In recent years, this kind of 'Social Prescription' has become national policy within the UK's National Healthcare System.

Access to healthy food, education, employment, income, housing, and opportunities for connectedness all have significant impacts on a person's overall health and wellbeing. This asset-based approach goes beyond treating illnesses. It recognises people as not just patients with needs, but as community members with gifts to share, while supporting them to engage with and contribute back to their communities. It starts with their strengths, not their weaknesses.

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The concept of Social Prescribing is deeply rooted within the idea of Personalised Care which has recently become resurgent at least in part due to the limitations of the pathogenic model of care.



"In simple terms, Personalised Care is about recognising and acknowledging that in light of demographic changes, the one-size-fits all approach to health will not suffice and that each individual should be treated on a case-by-case basis. Personalised care means people have choice and control over the way their care is planned and delivered[9]*. It is based on 'what matters' to them and their individual strengths and needs. This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences. Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities.*

A Comprehensive Model for Personalised Care made of six core components has been developed in England to ensure patient needs are truly met using a biopsychosocial approach. This includes

1. *Shared decision making;*
2. *Personalised care and support planning;*
3. *Enabling choice;*
4. *Social prescribing and community-based support;*
5. *Supported self-management; and finally*
6. *Personal health budgets and integrated personal budgets)"*

A link to this section of 'Universal, Personalised Care' is in the reference section.

A bold new global agenda to end poverty by 2030 and pursue a sustainable future was unanimously adopted in September 2015 by the 193 Member States of the United Nations at the start of a three-day Summit on Sustainable Development (reference). A total of 17 Sustainable Development Goals (SDGs) were born. These represent a call for action by all countries – poor, rich and middle-income – to promote prosperity while protecting the planet. They recognise that ending poverty must go hand-in-hand with strategies that build economic growth and address a range of social needs including education, health, social protection, and job opportunities, while tackling climate change and environmental protection. More important than ever, the goals provide a critical framework for COVID-19 recovery.

As health touches on every sector (education, transport, science and technology, arts and culture, food and agriculture, housing, waste, energy, industry, urbanisation, water, radiation, nutrition), an opportunity arises to develop a common narrative: A new model that creates value based on health creation, prevention, early intervention and using different types of resources that will enable people and communities to thrive and improve their health and wellbeing, support the existing health services, create new and meaningful jobs while supporting the implementation of the 17 sustainable development goals.

By bringing patients, clinicians, managers, voluntary sector, education and businesses together to exchange knowledge, inspire and innovate together through principles of Social Prescribing, we can all learn and our health service will benefit.

The central and transformative promise of the 2030 agenda for the SDGs is the message of 'leave no one behind'. This message resonates highly with the emphasis that social prescribing bears on supporting the resolution of social determinants of ill health and in reaching disadvantaged communities, and combating discrimination and rising inequalities which are on the rise across the world.

BUT WHAT IS SOCIAL PRESCRIBING?

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4

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WHAT IS SOCIAL PRESCRIBING?

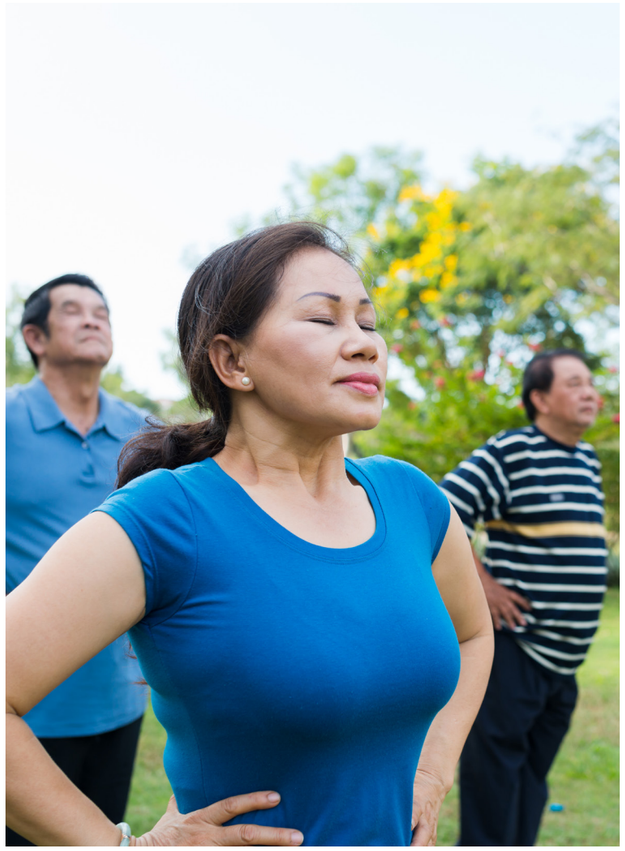
Social prescribing enables all local agencies to refer people to a link worker. Link workers give people time, focus on what matters to the person using a personalised care approach, and connect people to community groups and agencies that will support their health and wellbeing.



Social Prescribing has the ability to transform patients into people by focusing on what matters to them, their whole needs and strengths, not just their biomedical ones that need 'fixing'.

4.1 THE ROLE OF THE SOCIAL PRESCRIBING LINK WORKER

Social prescribing enables all local agencies * to refer people to a 'link worker'. Link workers are empathetic individuals embedded within primary care multi-disciplinary teams and local communities who offer people time, take a holistic approach by listening and focus on what truly matters to the person.



Link workers work collaboratively with local voluntary, community, faith and social enterprise groups, to co-produce a menu of community support and activities, they can connect people to for health and wellbeing. This local 'eco-system' of peer-support, community and faith groups, practical services and emotional support, is vital. Link workers need to connect with all local partners, including local authorities, police, fire services, social workers, general practices, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, job centres, social care services, housing associations and voluntary, community and social enterprise (VCFSE) organisations (to name a few) to integrate support around the person.

Through principles of personalised care, link workers enable people to have more control over their lives, develop skills and give their time to others, through involvement in community groups. This could include creative activities such as art, dance, and singing. Or it could be walking football, gardening, fishing, knitting groups. And it might also be to services such as debt counselling, housing and other practical support agencies. It will depend on what that person's own priorities are.

The term 'social prescribing link worker' is used generically and is the term used within England, where link workers are embedded in primary care network multi-disciplinary teams, using national investment. However, local areas have also invested in social prescribing over the past ten years. There are many different names used to describe the link worker role, as a result of local innovation. These include community connector, wellbeing advisor, health advisor, depending on local preference. Different terms have emerged as local areas have developed their own local schemes.

* Local agencies include general practice, local authorities, pharmacies, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community, faith and social enterprise (VCFSE) organisations. Self-referral is also encouraged.

4.2 WHO IS SOCIAL PRESCRIBING FOR?

Social prescribing works best for people who need help to connect to community groups and local services. They may:

- Be living with one or more long term health conditions
- Need help with money, legal and practical issues
- Be recovering from or impacted by COVID-19
- Need help to be more physically active, to connect with others, to overcome loneliness or isolation
- Need support with their mental health

Increasingly, social prescribing link workers are supporting children and young people, as well as adults. Some areas have developed specialist social prescribing link workers roles for children and young people, in hospitals to support people who attend Accident and Emergency and assist the Hospital Discharge team. There is potential to extend to people in prisons and, in England, a Green Social Prescribing pilot launched in 2020 is helping local mental health services to strengthen the support they can offer to organisations in the natural environment[10]. Led by the Department for Environment, Food, and Rural Affairs (DEFRA) in collaboration with multiple national partners, this two-year programme is currently testing how to embed green social prescribing into communities in order to improve mental health outcomes, reduce health inequalities, reduce demand on the health and social care system, and develop best practice in making green social activities more resilient and accessible.



4.3 HOW DOES SOCIAL PRESCRIBING WORK?

This NHS Social Prescribing Model below helps to illustrate the key ingredients of good social prescribing in England. This model was co-produced by a wide range of stakeholders including people with lived experience, primary care doctors, local authority commissioners, social prescribing link workers, voluntary, community, faith and social enterprise leaders.

Just as one size does not fit all when it comes to people and their support needs, we are aware that healthcare systems across the world differ significantly. Although the above social prescribing model may not fit perfectly across the world, we hope it will provide a good start in aiding understanding and in supporting international colleagues in addition to the practical suggestions we have made in the next section of this document.

We will discuss some of the above core elements of good social prescribing as well as offering practical suggestions on how to set up social prescribing schemes in the next section of this document. Further reading and a full description of each of the elements of the English Social Prescribing model can be found here[11].

- Social prescribing link worker employed to give time (part of primary care and local social prescribing connector scheme).
- Collaborative commissioning and partnership working.
- Easy referral from all local agencies.
- Workforce development.
- Common outcomes framework.
- What matters to me – Create a personalised plan.
- Support for community groups.

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5

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THE HISTORY OF SOCIAL PRESCRIBING – WHERE DID IT COME FROM?

The ideas behind Social Prescribing are ancient, but it has rapidly evolved as a social movement across the UK in recent years. Some date it back to the “Peckham Experiment” in South London, (1926-1950). This was a health centre, run by doctors, which aimed to improve the health of patients by giving them access to activities such as physical exercise, swimming, games, workshops and a café producing nutritious food and whose activities were organised by the patients themselves. In spite of international interest, the centre was unable to get support or funding from the newly formed NHS and was closed in 1950.



THE HISTORY OF SOCIAL PRESCRIBING – WHERE DID IT COME FROM?



The beginning of the 21st century saw a number of GP practices developing new ways to improve the health of their patients beyond the then current medical model. These included Bromley by Bow Centre in East London offering welfare advice and employment support to young people; Voluntary Action Rotherham, embedding social prescribing link workers in all GP practices, Halton, Leeds, Gloucestershire and Hertfordshire Clinical Commissioning Groups enabling every GP to refer people to social prescribing and individual practices, such as the Culm Valley Centre for Integrated Health in Devon developing a wide range of patient groups, with its own cafe and gardens. There were many examples of locally commissioned social prescribing schemes, many commissioned by local authorities and/or Clinical Commissioning Groups. Some Community Connector programmes were funded by partnerships, such as the British Red Cross and Coop Foundation. Each scheme had the core ingredient of a 'social prescribing link worker' or 'connector' at the core of the programme.



In Scotland, social prescribing has been used since the 1990s and has become more widely used with the embedding of Community Link Workers (CLWs) and Welfare Rights Workers within general practices as well as the commitment of the Scottish Government to a general practice Link Worker Programme since pilots in 2014. In 2016, the Scottish National Party announced the recruitment of at least 250 Community Link Workers to support Scotland's most deprived communities[12]. The Community Link Worker programme in Scotland has been led by the NHS Scotland's Public Health Network (ScotPHN)[13].



In early 2016, the newly formed National Social Prescribing Network was launched in the House of Commons. They organised a national conference for social prescribing pioneers, which was well attended. Following this, NHS England's Personalised Care team supported the development of regional social prescribing networks, where social prescribing leaders could share what good looks like and leaders from across the social prescribing movement assisted the cross-government loneliness team to include a commitment to universal social prescribing, in its first cross-government loneliness strategy[14] and NHS England made Personalised Care a key commitment within the NHS Long Term Plan[15], which included 1000 additional social prescribing link workers funded within primary care by April 2021 and enabling over 900,000 people to access social prescribing by April 2024.

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At the second National Social Prescribing Conference at the King's Fund held by the Network, the new Secretary of State for Health, Matt Hancock, announced that he intended to establish a Social Prescribing Academy. The National Academy for Social Prescribing was officially launched in October 2019.

Today, social prescribing is attracting ever increasing interest from the international community as a response to the inequalities we face. A social prescribing pilot was started since October 2019 in Singapore at SingHealth Community Hospitals (SCH) to support the nation's ageing population[16]. A small group of wellbeing coordinators (non-clinical staff) identify and support patients with adverse social determinants of health. Patients are screened and recruited upon admission followed by active participation in in-house activities that promote activities such as gardening, exercising, singing, and reading. Prior to discharge, patients are linked to community care providers and through collaboration with community partners they ensure patient reintegration into their own communities. Evidence from the pilot suggests improvements in quality of life measures as well as a reduction in hospital and primary care utilisation.

Similar findings were reported by colleagues in Ontario, Canada during their first Social Prescribing pilot between 2018 and 2019 where over 1,100 people were provided over 3,300 social prescriptions[17]. Social prescribing is gaining momentum in Canada among healthcare providers, community partners, researchers, funders, and policymakers with an opportunity to scale social prescribing broadly to support a more integrated health system and to build more connected communities.

Several other countries across the world started to work on establishing a national framework for social prescribing (e.g. the Republic of Ireland with a very successful programme in Donegal)[18], and others (e.g. Portugal, Australia, Finland, and the Netherlands), are rapidly developing social prescribing which is supported by an increasing number of municipalities. In the Netherlands, social prescribing is called 'Wellbeing on Prescription' and is articulated by specially designated social workers via municipalities with 110 out of 350 municipalities now embracing it.

Increasingly, social prescribing is also being recognised as a tool to help people to have more control over their lives, to develop skills and confidence, which enables people to become community leaders and work with others to build a more sustainable future. Whilst early social prescribing projects enabled GPs to make referrals to link workers, people are increasingly referred by a widening range of local agencies including social workers, pharmacists, fire service, police, job centres, social services, housing associations and voluntary, community, faith and social enterprise organisations. Self-referral is becoming more widespread and during COVID-19 many link workers have proactively engaged with those who are isolated, shielding or vulnerable, as well as supporting the running of vaccination clinics.





6

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www.gspalliance.com

GLOBAL SOCIAL PRESCRIBING ALLIANCE PLAYBOOK

The opportunity exists to create a sustainable health and social care model that generates value, creating new and meaningful jobs while implementing SDG3.



“THERE IS NO PLANET B”