A Desk Review of Social Prescribing: from origins to opportunities

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Executive Summary

This report explores the current reality and potential development of **social prescribing** in and beyond Scotland, which can be defined as the practice of individuals accessing non-clinical support in their communities, either through a link worker in a health service or via other means.

In particular, the report explores what the role of social prescribing is or could be in the development of a citizen-centred approach to health and wellbeing in the aftermath of the COVID-19 pandemic.

The research for this report consisted of three complementary elements: a desk study of social prescribing's history and examples of best practice in Scotland; a survey of those involved in delivering, facilitating and accessing support through social prescribing; and online interviews with key figures in social prescribing in and beyond Scotland.

The report finds that social prescribing is a highly diverse practice in Scotland, comprising many different forms with each making an important contribution to the Scottish public service landscape. It also identifies three major barriers to the continuing development and upscaling of social prescribing as a practice: resources, awareness, and knowledge.

Further, whilst evidence points to social prescribing having had a positive impact on citizens and services, it will require continued investment and active development to fulfil its potential as a citizen-centred approach to health and wellbeing.

The report concludes with four Recommendations:

1. Improve awareness of social prescribing
2. Recognise the diversity of social prescribing
3. Resource statutory and voluntary services to deliver sustainable social prescribing
4. Improve accessibility and inclusion

1. Introduction and background

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1.1. Context and Focus

The impact of the COVID-19 pandemic on Scotland's public services has been profound, and the recovery from the crisis brings new challenges. Statutory services face heightened pressure as delayed medical procedures and appointments resume, and a huge range of concerns that have spiked during the crisis – ranging from mental ill health to loneliness, financial struggles and bereavement – are projected to weigh heavily on services still reeling from the impact of the pandemic.

Meanwhile, community organisations – that often bear the responsibility for addressing wellbeing concerns within the localities in which they operate – also face unprecedented pressures. The narrowing or closing of funding streams, the challenge of retaining staff, and the closure of community spaces and facilities, have all hindered the third sector from managing the increased demand experienced during the pandemic. Some organisations have faced closure or downsizing, and many of those remaining are facing huge challenges in meeting the need for support in their communities.

Against this backdrop, the role of social prescribing – a name given to a range of person-centred, social approaches to wellbeing that link individuals to support in their communities – is still being explored. Whilst making connections between statutory services and community organisations to provide local-level, non-clinical support has never seemed more necessary, both NHS services and community organisations are facing unprecedented challenges that make forming these connections all the harder.

This report, commissioned by the Royal Society of Edinburgh's Post Covid-19 Futures Commission, explores the potential for social prescribing to contribute to the recovery of Scotland's public service in the wake of the COVID-19 crisis. Drawing on the literature on social prescribing and on the views of those currently delivering and participating in it, the report:

1. identifies the origins, definitions and current practice of social prescribing in Scotland
2. explores the barriers faced in improving and expanding social prescribing
3. highlights examples of excellent practice in citizen-centred social prescribing, within and beyond Scotland
4. proposes recommendations for supporting both statutory and community services in making citizen-centred social prescribing part of Scotland's recovery from COVID-19.

1.2. Research approach

The main focus of this project comprises desk research, to review the current available literature on social prescribing and community-led approaches to wellbeing. Given the timeframe and scope of the project, the research was intended to provide a broad rather than comprehensive overview of the reality and potential of social prescribing in Scotland. Resources consulted include the following:

- Medical journals and NHS reviews
- Policy papers and proposals at local, Scottish and UK levels
- Coverage of social prescribing in relevant online media
- Online journals covering social prescribing and community wellbeing approaches
- Case studies of existing social prescribing arrangements, both within and outwith Scotland

This approach was supported by two subsidiary elements of research that were intended to complement the main desk research. Firstly, an **online survey** was developed to provide a source of primary *qualitative evidence* from those with direct experience of social prescribing. The survey was targeted at three principal groups:

- Primary healthcare workers (such as GPs) who socially prescribe
- Those who offer support via social prescribing, including link workers and community organisations
- Individuals with lived experience of accessing support via social prescribing

The survey was circulated through Support in Mind Scotland's networks, as well as the Scottish Social Prescribing Network and 32 Scottish Local Authorities. The survey was designed to provide rich qualitative information via open-ended questions to those with experience of delivering, facilitating and accessing social prescribing.

Secondly, **online interviews** were conducted with key figures in social prescribing in Scotland and wider UK. These included link workers, managers of social prescribing programmes (both local and national), representatives of community organisations, social entrepreneurs, and individuals with lived experience.

The findings of these three strands of research were then brought together into a series of interim findings, which were circulated to interviewees and other social prescribing stakeholders in order to sense-check the findings, giving opportunity for feedback and comments. The response was very positive, and shaped the final recommendations included in this report.

2. The origins of social prescribing in Scotland

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2.1. Why has social prescribing emerged in Scotland?

Social prescribing – also known by a range of similar names, such as community referral – refers to the practice of individuals accessing, or being supported to access, non-medical support in their community. Whilst the precise definitions of social prescribing vary considerably and a large variety of models have proliferated (as the next section will detail), the core principles of these practices include a shift towards **person-centred care** and **shared decision-making**, and encouraging a **non-clinical approach** to addressing health and wellbeing concerns. Whilst the main players in each system will vary considerably to achieve this, social prescribing arrangements generally promote **inter-organisational connections** between and within **primary health services and community organisations**, often employing a **designated link worker** to make connections between individuals, statutory services and community organisations.

These approaches have been gaining increased interest and scrutiny in previous decades. The practice of connecting individuals to support in their communities has come under consideration by health systems, academics and community practitioners as a potential strategy for tackling many of the health and wellbeing challenges faced in modern society by individuals, communities and health services. In particular, social prescribing's focus on preventative care by 'understanding need' has been regarded both as a means of encouraging co-production and person-centred care, and reducing the volume of repeat or returning appointments for long-running concerns (Malby *et al*., 2019:8). Social prescribing approaches are, therefore, at the heart of discussions around developing and expanding 'citizen-centred' models of healthcare.

Whilst the UK has been seen as fertile ground for community-led approaches, their development has been gradual and uneven. Community-led social prescribing arrangements began to emerge from the 1980s, but were 'practised in pockets and largely unnoticed' until the more recent 'formalisation' of these approaches (Buck & Ewbank, 2020; Islam, 2020). Because of this, it is difficult to pinpoint the precise origins of social prescribing, either in Scotland or in the UK more broadly. Early social prescribing approaches often emerged from highly local partnerships between statutory services – sometimes individual GP surgeries – and community initiatives, or as collaborative efforts between voluntary sector organisations. The **Bromley-by-Bow Centre**, a community-developed social prescribing centre established in East London in 1984 (Box 1), is a prominent early example, but many other local-scale non-clinical initiatives emerged during the 1980s and 1990s (Wolff, n.d.). The recognition within the health policy landscape of the need for these social-level approaches to health and wellbeing to be scaled up or extended has been more recent.

After the 2000s, evidence and interest mounted in the potential role of social prescribing, such as in a Scottish Government-commissioned 2007 report by the Scottish Development Centre for Mental Health, which identified social prescribing's 'potential to become fully integrated as a patient pathway for primary care practices in Scotland'. This growing body of literature helped fuel interest in community approaches at a broad NHS level from the 2010s. In England, the NHS 2014 Five Year Forward Plan identified the challenges facing contemporary health services, particularly the need for mental and physical health support to be 'integrated around the patient' in a holistic manner. They examined a range of existing, local-level support models, including social prescribing, to evaluate their potential for addressing these challenges (Five Year Forward View, 2014:17). The following plan, initially released in 2017, commits to expanding access to social prescribing to 2.5 million people across England by 2024 (NHS Long Term Plan, 2019).

The Bromley-by-Bow Centre

Often cited as one of the earliest examples of community-led social prescribing in the UK, the Bromley-by-Bow Centre was established in east London in 1984, in an area experiencing high levels of socio-economic deprivation. The Centre was established as a charitable organisation, providing support on a wide range of issues including social isolation, living healthy lifestyles, and support with employment and education.

The Centre developed from these community origins to open their own GP centre - the first health centre in the UK to be owned by its own patients - in order to facilitate the referral process and provide holistic support to those who access its services. It has since developed its network to include multiple other GPs surgeries in the community, illustrating that social prescribing models can shift and evolve significantly over time to best respond to local need and changing contexts.

The Centre remains an active hub of social prescribing in the UK, offering a Certificate in Social Prescribing - co-designed with the University of East London and Conexus - and consulting with other communities around the UK seeking to develop their own community hub social prescribing approaches.

Box 1: Case Study 1 – Bromley-by-Bow Centre (England) established in 1984.

Similarly, NHS Health Scotland's 2016 guidance paper on Social Prescribing in Mental Health identified the potential for social referrals to support statutory services in addressing the large range of social factors that contribute to poor mental health. In examining 'current tests of change' with emerging social prescribing projects in local areas across Scotland (e.g. Links Worker Programme and ALISS), it recommends investment in social prescribing more broadly in order to support individuals to 'stay well' through self-directed care (NHS Health Scotland, 2016). This was followed by Public Health Scotland's 2018 release of social prescribing resources for primary health services, including case studies of good practice and guidelines for implementation. This illustrated a shift towards recognising and expanding social prescribing beyond its highly localised origins.

This interest in social prescribing within NHS bodies has also been reflected in policymaking circles.

A 2019 Inquiry into the impact of social prescribing by the Scottish Parliament's Health and Sport Committee received responses from public and third sector services as well as individuals. The Committee concluded that social prescribing held considerable potential for 'preventing long term conditions and dependence on pharmaceutical prescriptions'. The Committee then recommended that future considerations of social prescribing should be viewed as an 'investment, not a cost' (Scottish Parliament, 2019:18). The 'decisive shift towards prevention' in Scottish health policy, as highlighted in the 2021 Scottish Government's Independent Review of Adult Social Care, implies that social prescribing approaches dovetail well with overall Scottish health policy priorities and the 'ethos' of the Scottish public service environment (Scottish Government, 2021; Munoz *et al.*, 2019).

This perspective has been reflected in the increasing scope of, and Scottish Government support for, social prescribing initiatives. The **Links Worker Programme** represents an early example of this (Box 2). It was first piloted in Glasgow in 2011 by the Scottish Health and Social Care Alliance with Scottish Government support until December 2021.

The launch of **SPRING Social Prescribing**, a multi-regional social prescribing programme working in 30 communities across Scotland and Northern Ireland, demonstrates further momentum both to scale-up social prescribing within Scotland and to collaborate and share knowledge further afield (Box 2).

Most recently, the development of **ALISS** – a national database of community organisations developed by the Alliance and funded by Scottish Government – represents a Scotland-wide effort to connect people with community support, either autonomously or via health services (Box 3). Meanwhile, many other examples of local-level social prescribing initiatives continue to exist and develop, involving a wide range of local organisations and health services.

Despite this interest and momentum, and these examples, social prescribing has not been fully rolled out nationally via the NHS in any jurisdiction of the UK. Further, little data exists to measure the regional availability of social prescribing, either within Scotland or in the UK as a whole. Concerns over evaluation, in particular, have proved a barrier to the widespread adoption and acceptance of social prescribing. Specifically, a wide range of criteria has been used to evaluate social prescribing models in different contexts, making comparative evaluation more challenging. The majority of the evaluation evidence base in Scotland comes from a small number of (mostly urban) areas, principally Glasgow and Dundee (Munoz *et al.*, 2019). Another review found the evidence base to be highly mixed and inconsistent, calling for more robust comparative evidence (Pescheny *et al.*, 2019). However, despite this "mixed evidence" overall, individual evaluations from those accessing social prescribing has been positive (Loftus *et al.*, 2017). There are unresolved questions concerning 'what constitutes good evidence', particularly around whether positive patient outcomes are by themselves sufficient to justify increased investment in social prescribing. This debate indicates that social prescribing's rise in prominence might still be in its infancy and is not without controversy (Husk *et al.*, 2019).

Links Worker Programme

Initially piloted in Glasgow in 2011, the Links Worker Programme - developed by the Health and Social Care Alliance Scotland and funded by Scottish Government - was among the earlier large-scale social prescribing programmes in Scotland. Working with 'Deep End' GP surgeries - those in the most socio-economically deprived areas of Scotland - the project intends to provide partner GP practices with the skills, support and resources they need to deliver social prescribing.

The Links Worker Programme embeds link workers into GP surgeries, with the aim of making local healthcare services into hubs of local support capable of supporting the wide range of social concerns and needs that GPs and other primary health workers encounter.

Link workers connect individuals - often those experiencing complex circumstances - with community organisations and resources, whilst also working with both clinical and non-clinical primary healthcare staff to help embed the approach. As these link workers can support individuals on a longer-term basis, the Links Worker Programme represents a highly integrated model of social prescribing.

SPRING Social Prescribing

SPRING is a cross-regional social prescribing programme, active in 30 communities in Scotland and Northern Ireland. It formed as a partnership between three community organisations - Bogside & Brandywell Health Forum, the Healthy Living Centre Alliance, and Scottish Communities for Health and Wellbeing. The project is the largest scaling-up of local-organisation social prescribing in Scotland. It now serves an area covering up to 1.5 million patients across both Scotland and Northern Ireland.

Whilst referrals for the SPRING model are made by GPs and mental health professionals, the project's link workers - referred to as Social Prescribers - are based in the community organisations that comprise the project. SPRING therefore represents a 'hybrid' approach between GP-based and community-led social prescribing approaches. The project is also innovative in combining both rural and urban areas in Scotland. Receiving Big Lottery funding for an initial 3 year period between 2015-2018, project evaluation indicated that the savings to partner GP practices outweighed the cost of establishing the project. Feedback from those who'd accessed support reported increased confidence, lowered social isolation and reduced need for other services such as benefits (SCIE, 2019).

During the COVID-19 pandemic, SPRING has utilised online technologies to continue its social prescribing work, developing an online platform - Connect Well - to ensure continued contact between individuals and social prescribers, and continuing to liaise with partner GPs on issues arising during the crisis.

Box 2: Case Study 2 – Links Worker Programme (Scotland) established in 2011 and Case Study 3 – SPRING Social Prescribing (Scotland and Northern Ireland) established in 2015.

2.2. What is shaping the journey of social prescribing?

There are multiple factors that will shape social prescribing's journey from small-scale, highly localised initiatives to achieving national recognition. However, two factors are particularly prominent in Scotland: the **capacity** of primary healthcare services, and a **shift in ethos** towards person-centred care.

2.2.1 Primary healthcare capacity

Among the challenges faced by modern healthcare systems is the capacity to deal with the large range of widespread public health concerns, ranging from physical wellbeing (such as diet, exercise and sleep) to mental wellbeing (including isolation, stress and anxiety).

A large proportion of concerns around these issues are often considered 'social' rather than 'medical' in nature, as they derive (at least in part) from socio-economic sources rather than from a purely medical pathology (Public Health Scotland, 2015:6-7). Estimates of the proportion of GP appointments made to address these concerns range from 20% to 50%, suggesting that *socially-derived* health concerns are a major stress factor on the capacity of primary health services (Husk, 2019; Malby *et al.*, 2019:8-9). This is further compounded by the high proportion of individuals experiencing chronic poor physical or mental wellbeing who might access services continually over a prolonged period.

Similarly, many GPs feel have felt constricted in their ability to address these issues through medical or pharmaceutical means.

ALISS (A Local Information System for Scotland)

Administered by the Health and Social Care Alliance Scotland and funded by the Scottish Government, ALISS was developed to serve as a community mapping and signposting tool. It has been co-developed by the Alliance with a broad spectrum of community, healthcare and lived experience stakeholders. The tool seeks to address the challenges faced by many social prescribing and signposting arrangements of: (i) a lack of knowledge resources within communities; (ii) the high level of resource required for local services to maintain accurate databases; and (iii) the risks of duplication or obsolescence.

ALISS gathers and collates data about available community support in Scotland from services, community organisations, and members of the public, to develop a Scotland-wide resource of available local support assets. This resource is available both as an online tool for those seeking support to discover what's available in their area, and as a resource for use within health and social care scenarios to help professionals and support workers signpost individuals to relevant support. In this sense, ALISS is not intended as a fully holistic social prescribing platform but as a tool to enable light-touch support in medical, social care, community and self-led contexts.

The ALISS teams have also collaborated with local communities, such as Dundee, to help local health and social care partnerships develop resources appropriate to them in their local area. This is seen as an example of how national-level resources can help develop locally-appropriate support networks.

Box 3: Case Study 4 – ALISS (Scotland) with a new programme developed from 2013.

Compassionate Communities ('Frome/Mendip Model')

Located in Frome, in the Mendip region of Somerset in South-West England, the Compassionate Communities Project was established in 2013 as a partnership between Frome Medical Practice and Health Connections Mendip. Focussing on social connectedness as a determinant of health, the project worked to map local assets through the development of the 'Mendip Directory', an extensive mapping of local community support encompassing voluntary, community and professional support. This was used to help identify and fill gaps in available community support, with the partnership supporting the establishment of new groups where there was a clear need going unmet.

Resource and training was made available for Community Connectors to act as the link between health services and local community organisations. Access to the service was via GP referral, or self-referral in some cases. The project undertook extensive outreach, ranging from a monthly radio station slot to a drop-in 'Talking Cafe' where individuals could meet with each other and with Community Connectors to learn more about the project and the support available locally (Shift Design, 2019). Frome Medical Practice was proactive in informing its patients of the scheme, reaching out via mail to those whose GPs assessed they could benefit from the project.

An evaluation of the Compassionate Communities project associated it with a 14% drop in admissions to emergency inpatient services in the Frome area, compared with a 28.5% increase across the rest of Somerset (Abel et al., 2018). This model of 'Enhanced Primary Care', combining statutory services with thoroughly resourced, mapped and integrated community referral and a focus on developing social connections, has more recently been used and replicated as a blueprint for other social prescribing projects across Somerset, in Wales, and abroad.

Box 4: Case Study 5 – Compassionate Communities (England) established in 2013.

One study found that 78% of GPs reported prescribing antidepressants despite believing that an alternative treatment would be more appropriate, citing that other approaches were either not available or had long waiting lists (Mental Health Foundation, in Friedli *et al.*:4). Many recent regional-level social prescribing projects in the UK have explicitly focussed on alleviating both GP and emergency service admissions, such as the **Compassionate Communities** project, also known as the 'Frome Model' or the 'Mendip Model' (Box 4).

Capacity to address complex health concerns were also reflected in our online survey and interviews. Respondents emphasised that the benefit that social prescribing brings to primary healthcare services is both direct (e.g. by giving primary healthcare workers the means to refer into the community) and indirect (e.g. connected community organisations provide alternative avenues to GP consultation).

Further, primary healthcare survey respondents felt that: social prescribing arrangements could be *more effective* than pharmacological solutions for addressing many wellbeing problems; *and* social prescribing complements, not replaces, primary healthcare consultation as a means of addressing socially-derived wellbeing concerns. The issue of access to resource remains a key barrier to providing and participating in social prescribing, especially for the voluntary sector, as Section (4) discusses.

The issue of statutory service capacity is likely to intensify in the wake of the pandemic. Early indications are strong that long-running social contributors to poor mental health – such as economic deprivation, social isolation, insecure housing access and bereavement – have all worsened due to COVID-19. Primary health services are therefore anticipating increased pressure throughout the transition to the 'new normal' (Health Foundation, 2020). Therefore, the need for social prescribing is likely to increase due to the complexity of interconnected factors requiring equally complex solutions.

2.2.2. Person-centred community support

Pressures on frontline services have created the **material conditions** for interest in social prescribing due to practical capacity pressures. At the same time, the rise of person-centred support, informed by lived experience and characterised by shared decision-making, is the "ideational backbone". In other words, this gives social prescribing its **philosophical groundwork** for the shift in thinking.

The Christie Commission on the future of Scotland's public services, established in 2010 by the Scottish Government, is often credited with beginning the *systematic embedding* of person-centred principles into the Scottish healthcare system. The Commission's report proposed a shift in service delivery away from a 'top-down' towards 'with and for people and communities', and argued for individuals who access support to be empowered to take a leading role in shaping that support (Scottish Government, 2011:10). Crucially, the report acknowledged that non-clinical organisations 'have, over time, expanded to take on a more active role in delivering services directly', allowing for increased recognition of social prescribing and community support arrangements (2011:30).

This shift is reflected in Scottish public service acknowledgement of social prescribing. For example, the 2012-15 Scottish Mental Health Strategy committed to fostering a person-centred approach, characterised by 'mutually beneficial partnerships between patients, their families and those delivering healthcare services' (Scottish Government, 2012:13). This paved the way for formal recognition of **social prescribing**, both through Public Health Scotland's guidance on social prescribing in 2016 and the Scottish Government's 2017-2022 Mental Health Strategy explicitly promoting social prescribing as a means of providing individuals and communities with 'the tools to manage their own health' (2017:35).

However, this transition to user-centred care is still ongoing, and some evidence points to gaps between policy and practice. Research by SRUC and Support in Mind Scotland (2017) found demand for local-level, non-clinical support – especially in rural areas –is lacking, suggesting that some communities still face challenges in accessing and co-producing locally-appropriate systems of health support. Similarly, our survey responses emphasised the need for further progress. Whilst primary healthcare workers feel that inclusivity and co-production are at the heart of their social prescribing work; however, many lived experience and community workers state that much more is required to put the individual at the centre of social prescribing.

3. What does social prescribing currently look like?

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3.1. How is social prescribing defined in Scotland?

Despite the growing interest in social prescribing and other community-based support approaches, a single, widely-accepted definition of social prescribing has not yet emerged. Even within public services already offering social prescribing, definitions vary in their scope and in terms of which individuals and institutions are seen as being at the 'centre' of the process.

The first common definition of social prescribing focusses on the most well-known model of social prescribing; a system in which healthcare professionals, primarily GPs, refer individuals into the community for non-clinical support: *"a means of enabling GPs and other frontline healthcare professionals to refer patients into the community, specifically via a link worker"* (Social Prescribing Network, 2018). This definition is the most commonly understood in primary healthcare settings, and puts the GP's service (or other primary healthcare) at the centre of the arrangement. This definition portrays social prescribing as a means of enabling frontline healthcare staff to co-produce and support community-based solutions for those seeking support for 'non-medical' concerns (Friedli *et al*., n.d.:3).

However, other definitions of social prescribing are broader in their view of how individuals access support. NHS Health Scotland, for instance, view social prescribing as *"any means of connecting people to non-medical sources of support or resources in the community that help them address their own, self-defined health priorities"* (2016:4). This wide definition does not imply the necessary involvement of primary healthcare. Therefore, whilst GP practices may be one route to accessing support, this could also be facilitated through referrals by community organisations, friends and family, or – at the broadest end of this definition - self-referral. This allows for a far broader range of activity and local systems to fall under the social prescribing umbrella. However, these broader definitions have been criticised for being ambiguous, and other terms – such as 'community referral' - have been proposed for non-GP based social prescribing arrangements (Islam, 2020).

These two definitions (above) can be regarded as representing two ends of a spectrum of views on what social prescribing is and who it involves. Feedback from survey and interview respondents similarly reflect this spectrum of definitions. Nonetheless this spectrum remains useful as it allows us to define three points along its length, i.e. the two extremes and one mid-point, as illustrated in Figure 1 (below).

3.2. Who are the main players in social prescribing?

The above definitions of social prescribing largely focus on, and differentiate between, the roles played by different organisations and individuals in the process of supporting people to access non-clinical support in their communities. This sub-section explores these roles in a little more depth.

3.2.1. Primary and secondary healthcare

The most-recognised models of social prescribing integrate primary healthcare services to at least a certain degree. Most prominently, this includes GPs services with many of the most well-known and widespread models of social prescribing being focussed around GP referrals into the community. The 'narrow' understanding of social prescribing described above (on the right of Fig.1) is most commonly understood as a 'linear' path from which individuals go through their GP to access non-clinical support.

However, healthcare participants in social prescribing might also include other frontline professionals, involving health workers such as nurses (including community psychiatric nurses), physiotherapists, pharmacists and clinical psychologists. Whilst typically less involved across social prescribing programmes than GPs, some community-led social prescribing models actively reach out to other healthcare professionals, particularly those who are most relevant to the type of support they provide. Further, several interviewees and survey respondents to this study feel that broadening referral mechanisms to health workers beyond GPs could help make social prescribing easier to access.

3.2.2. Community and voluntary organisations

Although involved in practically all social prescribing arrangements, the role of community and voluntary organisations is highly asymmetrical across social prescribing arrangements. Such organisations also vary significantly in size, resources, mission statement and type of support offered. The perception of the function of community organisations within social prescribing can differ. Some see them as the 'service providers, not the prescribers', labelling them only as the destination of social prescribing

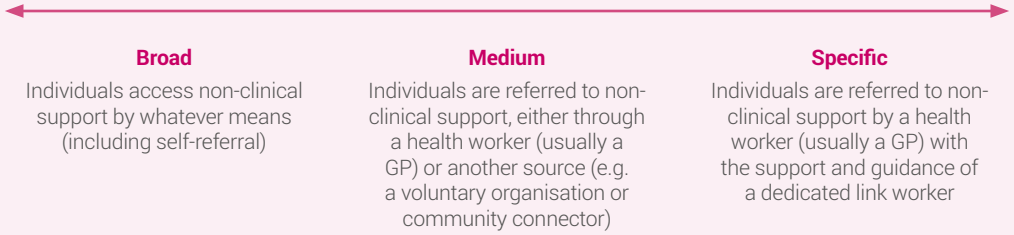

Figure 1: Spectrum of definitions of social prescribing

journeys that others – such as GPs – help facilitate (Islam, 2020). This rather limited perception of community organisations' roles and functions reflects the fact that they are rarely studied, despite their central role in facilitating and delivering support via social prescribing (Skivington et al., 2018), meaning also that their experiences and challenges remain poorly understood.

In contrast, other models of social prescribing see a greater role for community organisations to design, refer and shape social prescribing arrangements. This is reflected in early examples of local-level social prescribing, many of which represented 'bottom-up' initiatives by partnerships of organisations or led by a single 'anchor' organisation. This approach continues in many local areas in and beyond Scotland (Dayson, 2017:93). On a larger scale, community hubs represent a further model of community-led social prescribing, where one or more organisation(s) collaborate to provide in-community care, sometimes including their own referral system. Community networks could also include a broader range of community figures beyond the voluntary sector, such as social enterprises and local businesses, although this is less common.

All survey and interview participants for this study state that the community sector is an essential part of current social prescribing arrangements. However, community respondents describe differently how well-suited current social prescribing arrangements are to community organisations' own pressures and structures. Some respondents are enthusiastic about participating in primary healthcare-based social prescribing, and feel that the connection with health services is valuable. However, others find such models challenging, highlighting instead the potential of asset-based community approaches in enabling community organisations to build social prescribing models with little or no involvement from statutory health services.

3.2.3. Link workers

The connection between services and communities is essential to many social prescribing models. This connection is often (though not always) achieved via a dedicated member of staff, most often referred to as link workers (the term used in this report). Other names include community connectors, community navigators and social prescribing guides (National Link Workers Association, 2019). Many aspects of this role might change between models and situations, including the extent of their involvement with the individual seeking support, where the link worker is based, and who employs them. However, fundamentally the link worker role is knowledge-intensive, requiring a high degree of knowledge of local assets. The extent of the training and resourcing provided to link workers varies considerably between models.

Some social prescribing systems, such as signposting (below), do not employ a link worker at all. In these cases, the connection between the individual and the community is made either by primary health staff, a community organisation, or the individual themselves. The presence, role and setting of a link worker is therefore one of the key differentiating features of social prescribing models.

3.2.4. Individuals at the core, together with their friends and their family

The principle of co-production – where those who *access support* play a central role in making informed and meaningful choices about the type of care they receive – is central to the ethos of social prescribing and community-led health approaches more generally. However, the practice of this principle varies considerably across contexts and systems. Some primary healthcare-led models employ this principle through person-centred care frameworks. One such example is the House of Care model used in many Scottish public healthcare settings, designed to support health workers and individuals experiencing long-term health challenges to have meaningful conversations around self-management (Scottish Government, 2016). These approaches centre around integrating the individual within a medical care context.

However, some approaches – mostly community-led initiatives - aim to *de-medicalise* this relationship, putting the

individual (and sometimes their social circle) in the primary or sole decision-making role with little or no involvement from healthcare workers. Examples of this include online resources, intended to allow individuals to inform themselves of opportunities available in their area, as well as peer-support and social groups designed to provide individual-led support outwith medical spaces.

Some survey respondents to this study express reservations about this latter approach. They raise concerns that many individuals would not have the confidence (or be in well-enough health) to take on the responsibility of making decisions about support, and that healthcare workers still have a role in guiding individuals to appropriate support.

3.3. How can we make sense of social prescribing in Scotland?

We can see that social prescribing in Scotland encompasses a variety of players within different arrangements, with a diversity of definitions as to what can actually be delivered. By looking at specific **features**, primarily **structure and content**, we can identify the most prevalent forms of social prescribing. This then helps to create a **framework** of the social prescribing landscape and "plot" individual cases.

3.3.1. Structure

One way of viewing the differences between social prescribing models is in terms of what can be termed structure, that is, the '**who**' and '**where**' **of social prescribing**. This feature examines differences in which of the players identified above is most involved throughout an individual's journey of accessing support, and the setting in which this takes place. There are two types of models to be considered here: "**concentrated**" (GP-led referral in medical-only settings) and "dispersed" (multiple referral sources in community-based settings). These are now briefly outlined.

"Concentrated":

- This type of model comprises primary healthcare-focussed systems, in which the GP is the main point of referral into the community, often via a link worker also employed by and located within a GP surgery or other healthcare service. The decisions around the individual's social prescribing journey take place within *medical-only settings* – possibly the same single GP surgery – up until the point at which the individual accesses support in the community. These models broadly correspond to the narrower definition of social prescribing discussed earlier, in which social prescribing is identified as primarily or entirely a complement to GP consultations.

"Dispersed":

- In this type of model, link workers are based in (and may be employed by) a community organisation or a network of several organisations. Referrals into the community/network system might come from a diverse range of sources. For instance, community groups might proactively make connections with specific health services most relevant to them to facilitate individuals accessing specialist or mental health services, rather than GP surgeries.
- These also include community hub and community network models, in which multiple organisations refer individuals to one another to provide holistic, non-medical support for a range of concerns.
- At the furthest end, these might involve no healthcare input at all, being structured around community or self-referral processes and with all decisions about accessing support being made on a self-managed basis. These examples clearly push the limit of what is conventionally considered social prescribing, but fit within the broader definition of the practice highlighted earlier.

Survey responses and interviews for this study highlight that **structure is a broad spectrum**, and that many – if not most – systems **hybridise** various characteristics. For example, a system may refer individuals exclusively via primary healthcare, but host their link worker(s) within community organisations. The evidence also shows that **structure is not static**. The framework (Figure 2, below) features several examples of social prescribing models that have made considerable structural changes over time, or that are currently doing so.

Given these aspects, questions we can ask when examining the **structure of social prescribing models** might include:

- How does someone seeking support through this social prescribing system access it?
- In what setting is the connection between the individual and the community formed?
- Where are decisions about the design of the social prescribing system made?

3.3.2. Content

The content of social prescribing arrangements systems is concerned with the '**what**' and '**why**' **of social prescribing**, asking what **problems** social prescribing is intended to address, and what the role is for each of the participants in the system in addressing the identified problems.

Addressing this question of what/why, Kimberlee (2015) forms a model of social prescribing models in England ranging from "**light**" to "**holistic**". This report adapts the model for use in the Scottish context.

"**Light**" social prescribing models:

- individuals are informed of support or opportunities in their community which may be relevant to them and their needs, but their access to this support is otherwise entirely self-managed. This also includes 'signposting' approaches, in which individuals are informed of support relevant to their needs, but access it in an entirely self-managed manner.
- Evaluation of how successful this type of support has been is mostly or entirely in the hands of the individual themselves. Other forms of light social prescribing may involve some evaluation, possibly conducted by a link worker, the organisation receiving the referral, or a single follow-up GP appointment.
- Light approaches are often intended to fulfil a single purpose – for example, a particular aspect of wellbeing, such as exercise or isolation – and the outcomes of these approaches are sometimes measured by how well they have addressed this single individual need (Elston *et al*., 2019). Alternatively, light approaches might simply be interested in how individuals are feeling more broadly, rather than addressing particular aspects of wellbeing (for example, asking 'how are you feeling today?' rather than 'how would you rate your isolation and anxiety?').

"**Holistic**" social prescribing models:

- These are highly integrated with healthcare, taking account of multiple aspects of wellbeing, often including both physical and mental health. They are often characterised by long-term partnerships between organisations, with support specifically designed to meet needs identified by the organisations or services in the partnership.
- Evaluation or outcome monitoring in these systems is often routine and/or scheduled, with ongoing conversations between the individual and their GP, link worker, community organisations and/or other support staff involved to ensure that the social prescribing support is achieving positive and meaningful outcomes for the individual accessing it.
- We note from interview and survey feedback that whilst holistic social prescribing often centres around primary healthcare services (for reasons discussed later in this report), it does not necessitate their participation. Some models, such as community hubs, aim to provide holistic support with little or no formal involvement of statutory services. Some social prescribing models will also hybridise signposting and holistic approaches, depending on how best to address local or individual needs.

Given these aspects, the questions we can ask when examining the **content** of social prescribing models might include:

- What constitutes '**success**' in social prescribing, and according to whom?
- What '**problem**' is social prescribing trying to solve?
- Why seek support through **social prescribing** arrangements, rather than through 'conventional' services?
- How **integrated** is the support offered through social prescribing with other support the individual is accessing (e.g. medical, pastoral or specialist support)?

Analysis of **structure** (concentrated and dispersed) and **content** (light and holistic) allows us to build a **framework or matrix**, mapping the variety of social prescribing systems within and beyond Scotland (section 3.4 below).

3.4. Mapping social prescribing models

Each quadrant of the below framework or matrix represents a different model of social prescribing or community-based support. Examples on this matrix illustrate the characteristics of each model displayed, and also show that there can be variations within a quadrant as well as between quadrants. The examples on this matrix are neither exhaustive nor representative of the full variety of social prescribing across Scotland, but rather are designed to be **illustrative** of social prescribing's diversity in practice.

This framework shows the ways in which it is possible to "plot" examples of social prescribing according to their structure and content, and also to reflect on where examples could sit in order to deliver specific outcomes. The following sub-section now looks at each of these quadrants in a bit more detail, moving from calling models by their individual features (**structure** and **content**) into labels which tell us more about **how they work**.

Integrated Social Prescribing (Top Right Quadrant): This is the most commonly understood model of social prescribing and is the most prevalent in the recent literature. The GP and other primary health services integrate social referral into their practice through long-term partnerships with community organisations. Partnerships are often intended to address multiple, overlapping areas of wellbeing commonly encountered by primary healthcare, such as diet, exercise and mood. Link workers, usually based within one of the GP services participating in the arrangement, are highly integrated into GP practices, often lead on co-producing support pathways with individuals and their GPs, as well as taking an important role in measuring outcomes of social prescribing. Due to this, these models are well-represented in evaluations of the impact of social prescribing in the UK.

Signposting (Bottom Right Quadrant): Support is made available primarily within statutory services. There is a high degree of self-management and little formal evaluation or outcome measuring takes place.

These models might exist at local, regional or national scales. On the *larger scale*, these models resemble mapping tools, databases and resources of regional or national organisations that GPs and other frontline staff use to make informed, co-produced referral choices with individuals seeking support. These often require significant amounts of resource, time and local coordination to build. On a *smaller scale*, signposting approaches often consist of a single GP surgery – in some cases, individual GPs – guiding individuals to appropriate support, with or without a link worker. This is often an informal arrangement, with no follow-up appointment or formal evaluation conducted by the GP, in contrast to more holistic models. These signposting arrangements have been among the most common practised models of social prescribing across the UK (Kimberlee, 2015).

Community Hub/Network (Top Left Quadrant): These are community network or community hub approaches, where community or voluntary organisations provide support on one or more areas of wellbeing in a variety of ways. In some examples, multiple community and voluntary organisations and/or social enterprises

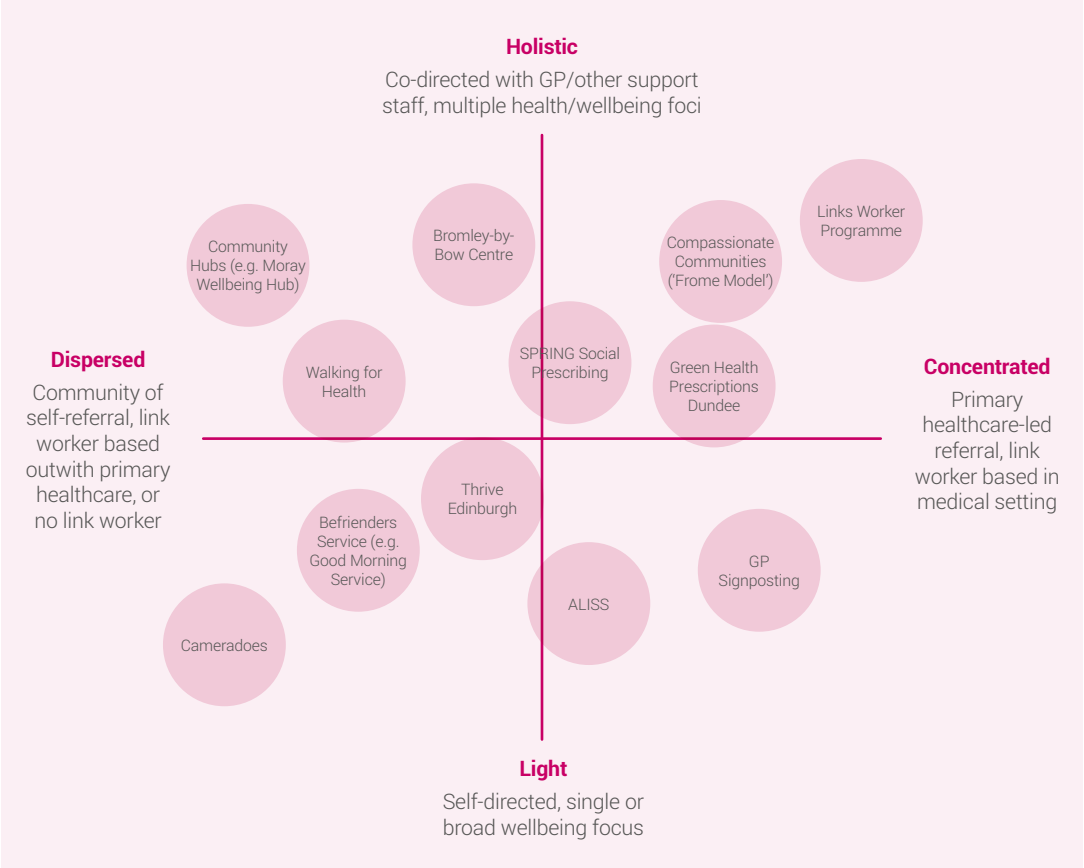

Figure 2: A framework or matrix of social prescribing models, using the axes of **structure** *(concentrated and dispersed) and* **content** *(light and holistic) to organise the examples from Scotland and wider UK.*

collaborate to provide support for a range of wellbeing concerns. This may include statutory services, but these models do not necessitate their involvement; in some cases, GP involvement may be replaced by other, more relevant health workers, such as in the **Walking for Health** programme (Box 5). Alternatively, a single organisation could build a multi-organisation partnership around their work, reaching out to others, including statutory services, to build a 'bottom-up' model of referrals into the services they offer. At its most integrated, these models fall in line with the *Asset-Based Community Development* approach, in which communities develop the support they need around the assets, organisations and knowledge already present. Due to a range of constraints, primarily resources, this is *the least populated quadrant* in this matrix. Recent approaches of 'community-enhanced social prescribing', seek to acknowledge and address this (Morris et al., 2020). They emphasise the potential for communities to become 'enabling environments' for individuals by developing integrated local-level social prescribing. Section 5 of this report discusses some of the challenges faced by community-led approaches in more detail.

Local Support (Bottom Left Quadrant): these represent largely or entirely 'social', local-level or even 'de-medicalised' approaches to providing support outwith GP surgeries. Most commonly, this refers to community organisations providing 'light-touch', local community support – including befrienders groups, activity sessions and other social opportunities. They receive referrals from the community, including (or sometimes exclusively) self-referral. They are often highly local in scale, although some Scotland and UK-wide organisations also provide this type of support. They provide opportunities to

Walking for Health

The Walking for Health Programme, established by Scotland-wide charity Paths for All, aims to provide support to promote health and wellbeing through walking. It features the Scottish Health Walk Network, made up of over 240 projects from across Scotland, each set up and coordinated by a range of local partners. The Network is designed to promote strong relationships between these partners, and support new projects in local areas.

The programme takes a highly localised, bottom-up approach, aiming to develop local walking projects that are sensitive to local needs and engaging with the most locally-relevant partners in each area. This includes their referral processes, which are driven by reaching out to appropriate local figures - including physiotherapists and community organisations - rather than access being made primarily through GP surgeries or link worker programmes. Paths for All also act as a funding organisation, providing grants for organisations or groups looking to start a walking project, giving them a 'hybrid' role as the coordinator of a community-focussed social prescribing network.

The pandemic has led the Walking for Health programme to utilise online technologies to deliver its work, and has developed an online discussion forum and online walker training to continue its work, whilst also providing paper resources to ensure inclusion. The non-clinical setting of the network illustrates the potential for community-led, network approaches to social prescribing to complement the more prominent healthcare-led models.

Box 5: Case Study 6 – Walking for Health (Scotland). Established in 2017

improve either overall wellbeing, or a single aspect of it, such as reducing isolation, building connections and increasing confidence, rather than offering a monitored or integrated 'intervention'. Usually lacking formal evaluation, there is a high level of self-management allowing individuals the opportunity to 'be their own link worker'. Interview and survey feedback for this study highlights that this kind of support exists in many communities, but often is not considered social prescribing due to its informal nature and lack of a link worker role. Although this quadrant aligns with the broadest definition of social prescribing (above) the medical connotations of the word 'prescribing' has, for some, caused doubts as to the term's suitability to describe this type of support (de Iongh, 2018).

The next section of this report examines the specific advantages of these diverse models of social prescribing, identifying what is working well including from the perspectives of those who provide, facilitate and access such services.

4. Exploring the impact of social prescribing

4. Exploring the impact of social prescribing

4.1. Introduction

The significant diversity of social prescribing and community support models in and beyond Scotland is accompanied by a varying, and at times contradictory, evidence base as to their impact, both for individuals seeking support and the organisations and services providing it. Whilst this is in part due to the difficulties in collecting data, it is also due to the very diversity of social prescribing models and systems, as this report has identified and described (above).

Given it is therefore not possible to evaluate all forms of social prescribing by the same metrics, we can take two approaches to exploring the impact of social prescribing. Firstly, by examining existing evidence of the impact on the two issues it was intended to address: alleviating healthcare burden and providing person-centred support. Secondly, by examining the merits of each of the four types of social prescribing this report has identified, in the words of those who provide, facilitate and access these services.

4.2. Does social prescribing achieve its goals?

4.2.1. Relieving pressure on statutory services

Evaluating the impact of social prescribing arrangements on GP burden has been among the most prominent features in the social prescribing evidence base. This is especially true of "integrated social prescribing" models, many of which are established with the explicit purpose of reducing pressure on GP services or other bottlenecks.

Much of the available evidence suggests that social prescribing arrangements are successful in alleviating the pressure on statutory services, especially GP appointments.

Similarly, NHS-wide reviews of social prescribing's systemic benefits for the NHS have highlighted the 'domino' effect of the preventative aspect of community-based support. Providing non-medical support wherever suitable can lower reliance on medical or pharmaceutical prescriptions, reduce hospital admissions, and help reduce outpatient appointments. One study found a 75% decrease in non-elective inpatient episodes among those who had accessed support through social prescribing (BMA, 2019:3).

Similarly, a 2018 University of Westminster study of GP-based (i.e. "integrated" or "signposting") social prescribing found that social prescribing reduced demand for GP appointments by an average of 28%, and A&E referrals by an average of 24% (Polley et al., 2018:5). The Westminster study's evaluations of social prescribing's impact on secondary care were also positive, with a reduced pressure on statutory services across the board. However, the reduction in demand for GP appointments varied enormously between the services, from 2% to 70%, suggesting that social prescribing is not a 'silver bullet' for relieving pressure on GP demand but requires particular factors to facilitate its success.

The first of these factors is **strong connections between health service(s) and community organisations**. In our study, primary healthcare and community sector survey and interview respondents stated that strong inter-organisation and inter-sector relationships were essential. They allow referrals to be facilitated, a good understanding of the role of the link worker, and meaningful outcomes for the individual seeking support. The second factor is **resourcing**: for the link worker; facilitating regular and meaningful communication between organisations and services; ensuring GPs are well-informed and supported to offer social prescribing; and promoting the social prescribing support offered. Such resourcing is not equally available between regions, sectors and organisations, with rural areas and the community sector often (but by no means always) at a disadvantage.

When considering the impact of community hubs and networks or local support on the statutory service burden, there is far less evidence available. Since such provision focuses around prevention by providing non-clinical support in the community, it is frequently omitted from many studies on efficacy of models situated in primary healthcare settings. Although the cost-saving impact of third-sector organisations and networks for statutory services is well-recognised, evaluation of community-led models of social prescribing support is less developed (Weaks, 2013).

4.2.2. Delivering person-centred support

Evidence points to positive delivery of social prescribing's aim of embedding a more person-centred approach into healthcare. Evaluations of this tend to be highly qualitative in nature, relying on personal testimony from those who have either delivered or accessed social prescribing arrangements. Whilst compelling evidence of person-led approaches does exist, some feedback nonetheless indicates that there is more to be done.

The continued growth of social prescribing has been attributed to the system being 'very well liked by GPs and patients alike', despite its conflicted and incomplete evidence base (Polley et al., 2018:7). For GPs and other health workers, social prescribing can provide a resource to support concerns that many health workers report feeling under-confident in addressing, such as (but by no means limited to) employment, education, benefits and finances. This is particularly the case when GPs and other health workers feel that it is properly resourced and with the right support. Survey respondents from primary healthcare backgrounds praise social prescribing for addressing the 'root cause' of many concerns they face. Some feel that the consultative, 'patient empowerment' approach helps to ensure that time spent during appointments is more likely to result in a relevant and sustainable outcome for individuals.

This point is echoed in lived experience studies which highlight the importance of 'accessible and meaningful' support, suggesting that social prescribing gives more avenues for person-centred care

and/or discussions (Hassan et al., 2020). Activities included in social prescribing are hugely varied and encompass a wide range of intended outcomes, as do the benefits reported by those who access support, including improved social connectedness, confidence and general wellbeing.

Some view this approach as a 'welcome path away from the medicalisation of society' and a shift towards **the recognition of individuals as experts by experience**, signalling a systemic shift towards citizen-centred support models (Brandling & House, 2009). At a smaller level, much of the positive feedback from those who have accessed social prescribing valued the ability to have a conversation with their GP, link worker or other health professional about what matters to them.

Despite this shift, our research indicates mixed feelings on the realities of the person-centred nature of social prescribing. Whilst all three respondent groups (providers, facilitators and those accessing services) feel that social prescribing can help people access the support that is most meaningful and impactful to them, there is a noticeable disparity amongst respondents in terms of how much of a role social prescribing actually allows for individuals to shape their own care. Whilst primary healthcare respondents state that the social prescribing arrangements are inclusive and encourage individual involvement, the lived experience respondents all feel that there is more required to improve social prescribing, as Section 5 will discuss.

4.3. For those accessing or delivering social prescribing, what are the benefits?

4.3.1. Non-clinical support

The highly personal aspect of 'not being looked at as a "patient"' is often overlooked by formal evaluations of social prescribing, but emerged as a significant theme both in the feedback given to current social prescribing services in Scotland (Health in Mind, 2021) and in our own survey. Reasons given for this were varied, including:

- Removing the hierarchy of medical relationships
- Building social connections and forming mutual peer-support relationships
- Reducing the number of 'steps' it takes to get relevant support
- Not having to go to the GP for something not requiring medical attention ('pre-crisis' support)

Lived experience responses in particular highlight that the non-clinical aspects of social prescribing (in particular, peer support and self-management) were the most valuable aspects of their social prescribing experience. Further, that more knowledge of options outwith medical services would be valuable. Similarly, some local support initiatives felt that being able to offer support outwith medical relationships allowed their organisation to work more independently, designing support and referral paths that more closely reflected the needs of their organisation and/or community, rather than those of statutory services. For organisations that offer social opportunities in an intentionally non-clinical environment, such as **Camerados** (Box 6), the inclusion into a community hub or integrated social prescribing arrangement would require these needs to be recognised.

4.3.2. Adaptability and context sensitivity

Due to the wide range of contexts in which social prescribing is practised, different social prescribing systems can be accessed in a variety of different ways. Whilst evidence points to this making social prescribing difficult to assess for some, the multiple ways in which social prescribing and community support models can be accessed emerges as a positive factor in our survey. This is because the variety of social prescribing gives appropriate, context-sensitive support and "covers each others' weaknesses". This may also explain the simultaneous evolution and persistence of multiple approaches.

For instance, integrated social prescribing arrangements and signposting (in which medical services are the primary 'space') are able to utilise their resources and centrality available to medical services. Since GP offices are 'where people already go' for support, then GP services acting as hubs of social prescribing allows individuals to access support in a location they are familiar with and trust (Sanderson, 2019). Conversely, recognising the view that 'social prescribing doesn't suit everyone', local support and community hub & network models are able to provide community-level support for those who are more confident in self-management, or who prefer to access support without going to their GP or other medical setting (Brandling & House, 2009).

In a similar vein, growing support for holistic social prescribing arrangements permits more space for co-produced discussions between individuals and those who support them, addressing multiple areas of health and wellbeing (Kimberlee, 2015). Further, given the prominent role of self-management as an advantage of social prescribing, local support and signposting arrangements can also guide those who feel confident in managing their own support, and/or who do not feel that they would benefit from 'hands-on' support and evaluation from a medical professional or community support worker.

In this sense, **the variety of social prescribing models currently in practice is not a symptom of the failing of any one model, but rather a demonstration of the different contexts in which each is appropriate**. This is a social prescribing landscape in which social prescribing is practised broadly and diversely, with room for a variety of local organisations and spaces based on appropriate local need. This diversity gives the breadth of support that can respond to the diverse needs that social prescribing approaches aim to recognise and address.

Similarly, feedback highlighted that multiple trends are improving social prescribing's adaptability and flexibility. The development of online social prescribing platforms and resources (such as **Elemental Software**, Box 7) were already in use before the COVID-19 crisis. However, the challenges faced by organisations and services in reaching people during the pandemic have further spurred the use of digital platforms, widening

The Camerados movement

Representing an entirely non-clinical approach to community wellbeing, Camerados - prototyped between 2015-2017 - is a movement aiming to create 'public living rooms' in which individuals can build connections with others, with a strong emphasis on providing peer support, or helping oneself by helping others. Led by a small team which helps support the establishment of new locations - but not running them, which is managed locally - Camerados is now a UK-wide network based in a large variety of settings across the country, including hospitals, prisons, art galleries, and universities, as well as supporting other similar spaces by providing 'public living rooms in a box'. Access to Camerados spaces and events is open, and managed online and via word of mouth, rather than by referral; Camerados therefore exemplifies the broadest definition of dispersed, local support identified by this report.

The movement aims to encourage individuals to support each other in an open, inclusive environment, without the pressure of staff, formal outcome measures, or any clinical goals. Feedback from those who have accessed public living rooms has been positive, reported lowered isolation and stress; whilst Camerados are open to operating in a wide variety of places, they credit their success with remaining 'locally owned and led' as well as free from formal evaluation (Batty *et al*., 2020).

Box 6: Case Study 7 – Camerados (UK-wide). Established in 2015.

Elemental Software

Launched in 2015, Elemental is an online social prescribing platform designed to integrate digital technology into providing and designing social prescribing. The Elemental platform integrates a range of social prescribing services, designed to aid communities and services already interested in delivering social prescribing. The online platform also includes a self-referral system, for those looking to access support outwith a GP or other primary healthcare appointment.

The platform has won multiple awards, including a Digital DNA Award as Best Tech Innovation in the Third Sector. It is currently used by over 200 social prescribing systems across the UK and the Republic of Ireland, in a wide variety of settings and models from GP-led arrangements to small-scale, community-led organisations.

The use of digital technologies in connecting organisations, reaching individuals and facilitating referrals looks set to be an essential part of expanding social prescribing in the wake of COVID-19. Elemental aims to provide a means of sharing best practice and knowledge between the services and organisations who use it. Most recently, Elemental are offering guidance on how services can best deliver social prescribing support during and after the COVID-19 pandemic.

Box 7: Case Study 8 – Elemental Software (UK and Republic of Ireland). Established in 2015

the potential reach of social prescribing as a support option. Similarly, some primary health and community support staff reported progress in broadening referrals beyond their current system (primarily GPs), providing additional means via which to access support via social prescribing.

4.3.3. Building community connections

Creating connections between organisations delivers goals of social prescribing, as well as being a benefit in its own right. The infrastructure of social prescribing systems (such as the existence of a dedicated link worker) has facilitated better communication between organisations and sectors. This is particularly the case in integrated social prescribing and community hub/network arrangements, which offer 'repeated opportunities for multi-directional collaborations'. In some signposting and local support models these links also allow services to be more aware and knowledgeable about one another's work (Morris *et al.*, 2020). In communities with diverse support and a thriving third sector, social prescribing can help to strengthen ties between existing support, and/or contribute towards a 'no wrong door' approach in which individuals are able to access the support they need regardless of where they initially seek support (Hartley, 2016). Conversely, establishing social prescribing arrangements can help identify and highlight the gaps in support.

In summary, social prescribing arrangements can provide the infrastructure for organisations to collaborate more closely, be aware of areas of potential cooperation, help communities understand what assets they have, and highlight gaps in support. However, it is important to note that communities' ability to act on this increased collaboration and knowledge will be resource-dependent. Some respondents from rural areas particularly highlight that increased knowledge and expectation can run the risk of overburdening the existing organisations available.

This section has highlighted many of the main advantages of social prescribing. However, all of these advantages are contingent on other factors, as well as the barriers that services face in delivering, expanding and improving their provision. The following section now explores these barriers.

5. What are the barriers to improving and expanding social prescribing?

5. What are the barriers to improving and expanding social prescribing?

Each of the models of social prescribing identified in this study has advantages, and each could benefit with support to enable it to contribute further to the Scottish public service environment. The barriers facing social prescribing's current practice and expansion are similarly varied, reflecting local areas and multiple models. Despite the complex landscape of social prescribing, it has been possible to identify three broad barriers that represent the most common and pervasive challenges to delivering, and being involved with, social prescribing. These are **resources**, **awareness**, and **knowledge**. Each of these barriers is now explored.

5.1. Resources

The ability of social prescribing to divert pressure away from statutory services is among its most commonly-cited advantages. However, resource remains a barrier to providing and expanding all models of social prescribing, with this research highlighting distinct resource challenges for statutory and community organisations.

For statutory services and link workers, access to resources can be highly uneven. Some integrated social prescribing programmes, particularly those on a larger scale, are able to provide participating primary healthcare workers with considerable resource, including both funding and staffing. However, there are concerns amongst smaller-scale social prescribing models operating on a highly local basis. These report that GPs and other primary healthcare staff feel that (i) social prescribing could be a further pressure on top of their existing caseload, and (ii) raising awareness of social prescribing could further pressure their capacity. Link workers based in healthcare settings report facing a similar situation, with available training, resource and information varying considerably in different contexts.

A Scotland-wide rollout of social prescribing is seen as an enabler of a more evenly distributed resource pool amongst statutory services participating in social prescribing in Scotland. A national approach would address the disparity of funding and inconsistent access to resources.

The challenge of resources is also pressing at the community level. Voluntary organisations – especially those participating in integrated social prescribing and signposting arrangements - express a strong concern that resource is limited, with a fear that the pressure taken off statutory services by social prescribing is being directed to community organisations who do not necessarily receive additional resource to provide support. There are concerns that funding in some social prescribing arrangements is 'frontloaded' towards employing link workers based in primary healthcare settings, and not supporting community organisations to increase their capacity. Some integrated social prescribing models, and a few community hubs and networks, are able to offer community grants and other resourcing support to participating organisations. However, these resources are often only available to the larger social prescribing projects in Scotland and are much harder to access for local-scale or community-driven projects.

The widespread concern encountered by our third-sector interviewees and respondents of having extra pressure 'dumped' onto voluntary and community organisations also acts as a barrier for organisations *not yet involved* in social prescribing. COVID-19 has placed significant pressure on community organisations in Scotland; the support available for businesses throughout the crisis has not been matched by support for the voluntary sector, where many organisations have seen their funding avenues become more competitive and less accessible (Martin, 2020). This has been accompanied by other resourcing challenges, including the closure of physical spaces and buildings to host activities, the interrupting of routine communications with other organisations, and increased difficulty in maintaining staffing levels. Within this wider context, respondents are concerned that looking to the third sector to participate in social prescribing models as part of the rebuilding efforts from the pandemic requires a great deal more resource than is currently available to most community organisations in Scotland. Therefore, when assessing the impact of social prescribing on relieving the capacity of the "system", it is critical to look *beyond* statutory services, to examine how current and potential resilience can be improved.

Finally, this inconsistent access to resource is a key explaining factor for the relative lack of community hub and network social prescribing models (see Figure 2, above), and is cited as a major barrier by interviewees. The lack of resource (funding, staffing and community mapping) hinders the forming of cross-organisation networks or community hubs outwith statutory services. It also results in community-led initiatives often competing for funds rather than coordinating to provide a holistic, inter-linked model of social referral within their communities. This competition for funds is exacerbated in those instances where there is a concentration of resources in social prescribing programmes involving statutory services.

Sustainable, long-term funding would address this barrier and fill a gap in the current Scottish social prescribing environment, giving better-resourced, community-led social prescribing that delivers locally-led, holistic support.

5.2. Awareness

Although social prescribing has gained considerable recognition within policy, academia and health experts, a lack of awareness of what social prescribing is remains a fundamental but significant barrier, both to those looking to deliver support and to those who might access it.

UK or Scotland-wide studies on awareness of social prescribing have not been undertaken. Local-level reviews of barriers to social prescribing have indicated that a lack of individual awareness of social prescribing remains a key barrier to usage, even in areas with long-running social prescribing programmes (Healthwatch Shropshire, 2019). Our survey and interview responses reflect this. Primary healthcare and community workers feel that lack of public awareness of social prescribing, and understanding of its benefits, constitute a major roadblock to social prescribing taking a more significant role in the public service landscape. In particular, lived experience respondents

have limited awareness of how to access social prescribing arrangements, with some stating that there are too many steps involved in learning about and accessing it. This echoes wider calls for a 'streamlined' referral process, giving individuals the ability to access support for example, via an online portal rather than requiring a GP appointment – and increasing the visibility of social prescribing options (Elemental, 2020).

Lack of public awareness of social prescribing is mirrored within (and possibly related to) an uneven awareness of social prescribing among primary healthcare workers. A 2019 study indicated that only 7% of UK medical students and junior doctors were aware of the concept of social prescribing, although 98% of those who *had* heard of it regarded it as useful (Santoni *et al*., 2019). Efforts to ameliorate this are underway, such as the NHS National Social Prescribing Student Champion Scheme, which links health workers and medical students with existing social prescribing networks. However, our survey responses and interviews strongly indicate that improved awareness and 'buy-in' from GPs needs reinforcing to address the regional disparities in the accessibility of social prescribing.

Community organisations also feel that their awareness of social prescribing, what it is and what is on offer, is highly uneven. Even those respondents already involved in social prescribing identify insufficient public or medical awareness of what already exists, as well as highly uneven awareness between and within voluntary sector organisations. Other respondents indicate an interest in becoming involved with providing support through social prescribing, but are unaware of local schemes through which they could contribute.

Awareness-raising, both within services and communities, will therefore form a cornerstone in improving the accessibility and reach of social prescribing.

5.3. Knowledge

Material resources, including funding, physical space and staff, are essential to sustainable social prescribing models. However, the need for **improved knowledge**, **connections** and **understanding** are also additional barriers to improving and expanding social prescribing.

Firstly, our evidence shows that an essential part of successful social prescribing arrangements is a **sound and shared knowledge of local assets, organisations and connections**. Respondents identify the need for social prescribing systems to be built *with* the community 'as the first port of call'. This allows those in primary healthcare to feel confident in knowing where to refer individuals due to knowing the local organisations, and for community organisations to feel better aware of opportunities to network and form meaningful partnerships. More needs to be done at local level to ensure that those looking to build or expand social prescribing networks have access to information on what exists, and what is missing, within their communities. This could complement the considerable community mapping work that has already been undertaken at national level, such as the Scotland-wide ALISS service (see Box 4).

Secondly, **lack of skills** also presents a barrier to social prescribing. Even within social prescribing systems with thorough community mapping, research has suggested that some GPs and primary health workers feel that the 'inter-personal skills' required to make referrals confidently into the community require further training. Without those necessary skills, social prescribing could be perceived by frontline health staff as being burdened with 'wellbeing' as well as 'health' (Aughterson *et al*., 2020; Husk et al. 2019). This is mirrored by a related concern among some community workers: that social prescribing might result in third sector organisations being expected to take responsibility for serious social- or health-related problems that their staff lack the skills or knowledge to manage confidently.

Finally, the challenge of reaching **a shared understanding of social prescribing**, among and between community and statutory services, remains an obstacle in many areas. A wide range of definitions of social prescribing exists (Section 2). This is largely as a consequence of different social prescribing models evolving to address differing, often locally-driven concerns.

Respondents working in primary healthcare, particularly those in integrated social prescribing models, feel that a national rollout of social prescribing would allow all healthcare staff, link workers and community organisations to access the information necessary to deliver social prescribing. This would also level out the large local variance in the availability of social prescribing in Scotland. However, this proposal raises concerns from surveyed community organisations and initiatives. There is a fear that a national rollout would 'impose' a particular model of social prescribing across hugely varying local contexts and landscapes, and that the purposes of their organisations would be 'subsumed' into a medical-led social prescribing system in which they would become 'an NHS initiative' rather than a community-driven organisation. Questions also emerge over who could be included and excluded in a national-scale social prescribing rollout. Some respondents from sectors currently little-represented within social prescribing arrangements – such as social enterprises – feel excluded from current understandings of the practice, despite feeling that they could contribute to them. Future considerations of how social prescribing is considered could evaluate who is 'around the table' in developing a shared understanding of social prescribing.

6. How can social prescribing change?

6. How can social prescribing change?

Introduction

This report sheds light on the reasons for social prescribing's origins in Scotland, its highly diverse forms and its successes. Social prescribing is currently playing a growing role in the Scottish public service landscape, and appears - from the evidence available to us - to be contributing a greater role for citizens and communities within health and wellbeing.

However, the evidence in this report also highlights caveats and barriers faced by those offering, participating in or considering social prescribing. Despite the current array of excellent social prescribing in Scotland and wider UK, and its promising prospects for the future, our research indicates that social prescribing is not a 'quick fix' for the issues facing the Scottish public service environment after the pandemic. It will require widespread and meaningful change and investment if it is to become embedded within statutory services on a Scotland-wide scale.

We also describe the barriers to community organisations who might be future partners in social prescribing arrangements. These must be acknowledged if social prescribing is to become widespread practice throughout Scotland in the future.

Finally, feedback from those with lived experience of accessing support via social prescribing indicates that changes to social prescribing should be made to improve its accessibility and inclusion.

With this in mind, this report makes the following recommendations to change and improve social prescribing in Scotland in the post-COVID environment.

Recommendation 1: Improve awareness of social prescribing

The low level of awareness of social prescribing remains a primary barrier to its development at every level. Many GPs and primary healthcare workers remain either unaware of what social prescribing is, or feel that it is not something they can deliver, whilst some community organisations feel that it is not relevant to them if they do not already work with GP surgeries.

Whilst a public-level survey on social prescribing awareness has not yet been undertaken, our initial survey indicates that public awareness of social prescribing, even in areas where social prescribing is already being delivered, remains low.

More needs to be done to raise awareness of social prescribing and community-based support systems more broadly. For areas *already delivering social prescribing*, this could include more public awareness campaigns within health services and reaching out to community organisations beyond their current networks. In areas *without existing arrangements*, the challenge is harder. It will require concerted efforts from local government and local services (both statutory and voluntary) to build an improved understanding of the existence and benefits of social prescribing. In both cases, the remit and purpose of social prescribing in its many forms must be better communicated within services and to the wider public to improve awareness and reduce confusion.

Recommendation 2: Recognise the diversity of social prescribing

A commonly-cited reason for the apparent low public awareness of social prescribing is the lack of a single, commonly understood definition of the practice. This report has recognised this concern and provided a 'spectrum' of definitions and typology to make sense of the large variety of social prescribing activities existing in Scotland. However, it is also apparent that this diversity of arrangements and community health approaches is not a failure but in fact reflects the large range of local needs within communities of place and interest. Different models of social prescribing aim to achieve different outcomes in different contexts for different people. They often complement, not detract from, one another.

This report therefore recognises that whilst a Scotland-wide rollout of social prescribing could hugely extend its reach and prominence, any such initiative must take into account the reasons for social prescribing's diversity. It must allow room for local communities and the organisations that work in them to maintain systems and structures that are best suited to the needs of their communities. It must also consider which organisations and services are currently excluded from social prescribing arrangements, and how these could be integrated into meaningful and beneficial partnerships. For social prescribing to continue to develop as a citizen-centred initiative, it must account for the needs of communities and the individuals who live in them.

Recommendation 3: Resource statutory and voluntary services

Resource remains a primary barrier for all organisations looking to expand or participate in social prescribing. Whilst the saving of primary health resource has been a key driver of social prescribing, it is clear that this comes with several major caveats.

Firstly, beneficial impacts are only seen when social prescribing is well-resourced to begin with, allowing it to have a preventative effect that lowers primary healthcare demand in the longer term. Secondly, it is clear that the resource limitations of the community sector have been under-researched in the social prescribing literature, and the concerns of

having statutory service demand 'offloaded' onto voluntary services with even scarcer resources is a significant barrier to the involvement of many local organisations in social prescribing arrangements. Thirdly, the capacity of community organisations to build bottom-up holistic approaches with other organisations (the Community Hub/ Network model in our matrix) remains limited, especially with the resource pressures in the post-COVID-19 environment.

Social prescribing therefore needs considerable resources, both at national and local level, to continue developing. Integrated social prescribing and community hub/ network models manifests a need for well-resourced link workers, plus resources for GPs and other health staff to feel confident and well-trained in offering social prescribing. More broadly, almost all forms of social prescribing require adequate resources to build, embed and expand local networks, whether statutory-voluntary or between community organisations. The development of online social prescribing platforms, and the development of large-scale asset mapping tools, are a promising development in this regard. The increasing availability of training for healthcare staff, such as the Bromley by Bow Centre's certificate for social prescribing, could also be a focal point of future investment (Bromley by Bow Centre, n.d.).

In all systems, community organisations must feel confident in the resource available to them if they are to be long-term partners in social prescribing arrangements. Social prescribing is not a sustainable development if it removes pressures from statutory services but worsens it for community organisations. Especially for voluntary organisations working with statutory services in integrated social prescribing or signposting systems, concerns around managing the 'diverted' capacity from health services must be accompanied by appropriate resource for these organisations. Our evidence shows that resource should 'follow' an individual throughout their journey of accessing social prescribing support, beyond the initial point of contact or conversations with a link worker. Within local support and community hub/network systems, more local authority resource allocated to financial, staffing and physical space for community organisations to form partnerships and hubs could help bottom-up, community-led social prescribing models to develop. This in turn would further depressurise local statutory services and provide local, non-medical support that complements more concentrated, healthcare-based approaches.

Funding opportunities for social prescribing arrangements therefore need to be scaled-up and longer-term, both at national and local level. They must account for the multiple pressures of all participating organisations. This would allow for a social prescribing environment that both takes long-term pressure off statutory services and ensures a community-appropriate, person-centred model of care.

Recommendation 4: Improve accessibility and inclusion

Feedback from those who have accessed social prescribing is positive, indicating that social prescribing is helping to embed community-level, non-clinical and person-centred care. However, our additional evidence provides a further indication that there is still more to do to embed these principles into Scotland's health and wellbeing support systems.

Firstly, concerns and criticisms about the '**prescribing**' aspect of social prescribing persist. The non-clinical nature of social prescribing is a singular benefit cited by lived experience and community organisation respondents, but is omitted in most formal reviews of social prescribing. Whilst this report has highlighted the many benefits of primary healthcare-based models – integrated social prescribing and signposting - our evidence shows an ongoing need to shift away from the "prescription" mindset to person-centred practice. More must be done to support healthcare staff to have meaningful, genuinely collaborative discussions with individuals seeking support, within the time and resource restraints under which they operate. This allows recognition that 'the doctor cannot do everything', supporting local support

and community hub & network models in parallel with (not instead of) "concentrated" ones. This will diversify the opportunities that individuals can seek support, in a place and context that feels appropriate and meaningful to them (Russell, 2017).

Secondly, **access** to social prescribing systems remains a barrier for individuals. The rationale for many social prescribing systems to focus on GP surgeries is strong. However, many individuals who emphasise the non-clinical nature of social prescribing feel that this is a barrier that could be overcome with more avenues provided for accessing social prescribing. This is being recognised in several of Scotland's social prescribing models, some of which are broadening their referral system, including via secondary health professionals, community organisations, mental health professionals, schools and colleges. Similarly, the potential for *self-referral* into social prescribing systems of all kinds is being facilitated by the growing use of online platforms. All current and potential social prescribing and community support models should consider the accessibility of their referral process, including the potential for others, such as individuals and their families, to play a greater role.

In conclusion, social prescribing has significant potential to contribute to the post-COVID-19 recovery of Scotland's public services in a meaningful, citizen-centred and community-driven way. Many examples of excellence in social prescribing are already well-established in transforming the role of the individual in Scotland's public services. This report has shown that, with appropriate investment of resources in public and voluntary services, appreciation of the diversity of local needs and contexts, and a reaffirming of the principle of citizen-centred support, social prescribing can be a vibrant, dynamic and empowering force within Scotland's recovery from COVID-19.

Appendix 1:
Summary of Research Methods

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1.1. Desk Study

The main focus of this project comprised desk research, to review the current available literature on social prescribing and community-led approaches to wellbeing. Given the timeframe and scope of the project, this was intended to provide a broad, rather than comprehensive, overview of the reality and potential of social prescribing in Scotland. Resources consulted include the following:

- Medical journals and NHS reviews
- Policy papers and proposals at local, Scottish and UK levels
- Coverage of social prescribing in relevant online media
- Online journals covering social prescribing and community wellbeing approaches
- Case studies of existing social prescribing arrangements, both within and outwith Scotland

This approach was supported by two subsidiary elements of research that were intended to complement the main desk research. Firstly, an **online survey** and secondly, **online interviews**. Further detail is provided below. The findings of these **three strands of research** were then brought together into a series of interim findings, which were circulated to interviewees and other social prescribing stakeholders in order to sense-check the findings, giving opportunity for feedback and comments.

1.2. Online survey

A short **online survey** was developed specifically to provide a key source of primary *qualitative evidence* from those with direct experience of social prescribing. The "niche" survey was directed at three principal groups:

- Primary healthcare workers (such as GPs) who socially prescribe
- Those who offer support via social prescribing, including link workers and community organisations
- Individuals with lived experience of accessing support via social prescribing

The survey was circulated through Support in Mind Scotland's networks, as well as the Scottish Social Prescribing Network and 32 Scottish Local Authorities. The survey was designed to provide rich qualitative information via open-ended questions to those with experience of delivering, facilitating and accessing social prescribing. Table A1 (below) shows the open-ended questions presented to each of the three target respondent groups.

A total of 24 text-based responses were received giving a rich evidence-base. The responses can be subdivided as follows: primary healthcare (6); community organisations or link workers (15); lived experience (3). Given the intention had not been to create a representative sample but to focus on textual responses from a "niche", targeted group, clearly no statistical analyses were carried out as these would have been inappropriate. Rather, thematic analysis of responses occurring across all 24 responses was firstly carried out, followed by an exploration of any themes that emerged within singular groups.

1.3. Stakeholder interviews

Thirdly, a purposive sample of 12 **online interviews** were conducted with key figures in social prescribing in Scotland and wider UK. These included link workers, managers of social prescribing programmes (both local and national), representatives of community organisations, and individuals with lived experience. Those organisations from which representatives participated in the semi-structured interviews are as follows:

- SPRING Social Prescribing
- Health and Social Care ALLIANCE Scotland
- Meigle and Ardler Community Development Trust
- Voluntary Centre Services
- Camerados
- Wee Red Upcycles
- Making Sport Fit
- Darach Social Croft
- Paths for All
- One individual with lived experience

The interviews were conducted online via Zoom and Teams between February and April 2020. Interviewees were provided with an information sheet about the research and were asked for their permission for their interview to be recorded for confidential project use only. Each interview lasted between 20 minutes and 1 hour, depending on the depth of interviewee experience and openness. The core interview script is summarised in Table A2 and was tailored where necessary for each interviewee. The open-ended questions were designed to echo some of those in the online survey.

Open-ended Questions asked of each sub-group of targeted respondents			
	Primary healthcare provider who has referred to social prescribing	**Provide services or support under social prescribing**	**Personal experience of using or accessing social prescribing**
1	What is your understanding of "social prescribing"?		
2	What led you to become involved in social prescribing? What appeals to you about social prescribing?		What led you to become involved in social prescribing?
3	What social prescribing options do you offer (give examples)?	What do you deliver through social prescribing that can't be delivered through statutory services?	What benefits do you gain from social prescribing that you don't get from statutory (e.g. NHS) services?
4	How do people access the social prescribing options? (e.g. GP referral/community referral/other healthcare referral/self-referral/other (please expand)	What social prescribing options do you offer (give examples)?	What social prescribing option(s) have you used (please specify)?
5	What are the main benefits to your service/organisation from offering social prescribing?	How do people access your social prescribing options? (e.g. GP referral/community referral/other healthcare referral/self-referral/other (please expand)	How have you accessed the social prescribing options you have used? (e.g. GP referral/community referral/ other healthcare referral/self-referral/other (please expand)
6	What is working really well in your experience of social prescribing?	How are those who use your social prescribing support or services involved in their design [Scale of 1-5 where 1 is not at all and 5 is all time time]?	What is working really well in your experience of social prescribing?
7	What is the single most important barrier that needs to be removed to make your social prescribing work better?	What are the main benefits to your service/organisation from offering social prescribing?	How involved are you in shaping your own social prescribing support or service?
8	How could/should social prescribing evolve, e.g. new approaches, new services?	What is working really well in your experience of social prescribing?	What is the single most important barrier that needs to be removed to make your experience of social prescribing work better?
9	What is the best example you have seen of social prescribing in Scotland (or wider UK?)	What is the single most important barrier that needs to be removed to make your social prescribing work better?	How could/should social prescribing evolve, e.g. new approaches, new services?
10	Please tell us any other comments about your experiences with social prescribing that will improve social prescribing for others in Scotland	How could/should social prescribing evolve, e.g. new approaches, new services?	What is the best example you have seen of social prescribing in Scotland (or wider UK?)
11		What is the best example you have seen of social prescribing in Scotland (or wider UK?)	Please tell us any other comments about your experiences with social prescribing that will improve social prescribing for others in Scotland
12		Please tell us any other comments about your experiences with social prescribing that will improve social prescribing for others in Scotland	

Table A1: Online survey open-ended questions to generate qualitative data for the three target sub-groups.
Note: for this research, the focus was deliberately on benefits and barriers, hence the focus of these questions.

1	What is your understanding of social prescribing?
2	Have you been involved in social prescribing, and if so, what led you to offer/participate in social prescribing?
3	What issues did you or your service/organisation experience (if any) that could not be solved through statutory services?
4	Who are the main players in your experience of involvement in social prescribing?
5	Are there others that you think may be able to offer social prescribing in your organisation/service/network?
6	What have the benefits been to you or your service/organisation from offering social prescribing?
7	In your view, what have been the benefits to those who have been offered social prescribing?
8	What role do those who have been offered social prescribing have in directing/shaping their experience of social prescribing?
9	Have you experienced any barriers to delivering social prescribing? If so, what are they?
10	What would make social prescribing easier for you/your service to deliver?
11	Any other comments about your experiences with social prescribing?

Table A2: Core interview script for online stakeholder interviews.
Note: for this research, the focus was deliberately on benefits and barriers, hence the focus of these questions.

References and Resources

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