World Health Organization
Western Pacific Region

A TOOLKIT ON HOW TO IMPLEMENT SOCIAL PRESCRIBING

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Overview

What is this toolkit?

This toolkit was created to help introduce social prescribing at the community level. It outlines the steps required to introduce a social prescribing scheme and includes sample materials, which can be adapted to the local context.

Who is this toolkit for?

This toolkit can be used by implementing organizations and individuals, such as community health-care facilities, long-term care facilities, mental health clinicians and health-care workers. Policy-makers and health and social welfare authorities may also find this useful for scaling up social prescribing.

How to use this toolkit?

This toolkit aims to provides simple steps to implementing social prescribing to ensure managers and staff at community health-care facilities feel confident and empowered to utilize social prescribing as a pathway to improve health and well-being. It should be noted that social prescribing can be implemented in different ways and there is no one-size-fits-all approach. This toolkit builds on the examples of social prescribing implementation from several different countries.

When implementing this toolkit,
it is recommended that you engage with all potential stakeholders throughout the process and adapt the toolkit to your local context.

What is social prescribing?

Social prescribing is a means for health-care workers to connect patients to a range of non-clinical services in the community to improve health and well-being. Social prescribing can help to address the underlying causes of patients' health and well-being issues, as opposed to simply treating symptoms. Thus, social prescribing is a more holistic approach to health care, which promotes community-based integrated care and helps to demedicalize health service provision. Research evidence behind the impact of social prescribing on health and well-being is summarized further below in this section.

Social prescribing can be used to refer patients to a variety of activities and services. The exact "social prescriptions" are specific to each community and care setting, but typically they include services providing support in mental health, social inclusion, and financial and housing advice, as well activities promoting physical activity and creative self-expression.

Social prescribing can take various forms and can be adapted in different communities and care settings. In the most common model, primary health-care providers can refer patients to specialized "link workers" who work with patients to identify their social needs. These link workers typically work with patients to co-design personalized plans to improve well-being, routinely follow up with patients to monitor their progress, and make use of behaviour change techniques (Fig. 1).

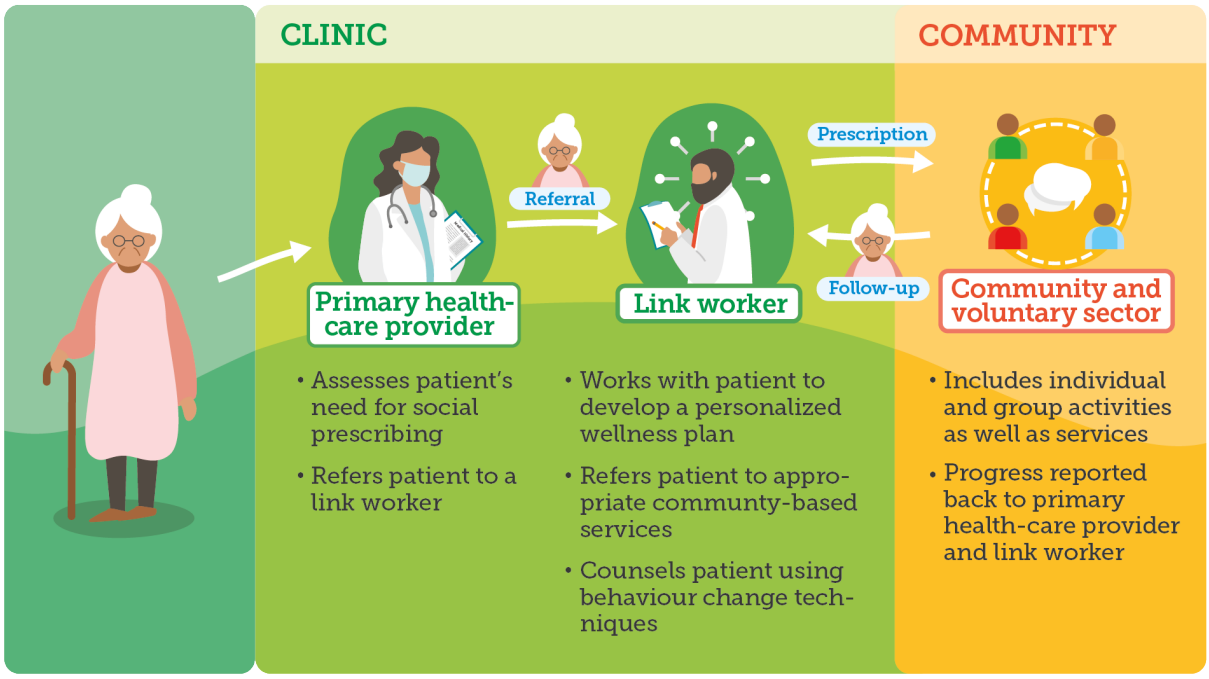
Social prescribing is not an intervention by itself, but rather a pathway that helps to address the patient's needs.

While the model with a dedicated link worker is the most prevalent, variations exist. For example, the consultation and assessment of the patient's social determinants of health can be done upon registration at a health-care facility, rather than following a referral from the clinician. The health-care provider, such as a clinician or health assistant, could also fulfil the role of the link worker, although it is preferable to have a dedicated person able to provide sufficient time for the patient. It may also be possible for an organization, such as a nongovernmental organization (NGO), to fulfil the role of the link worker. The responsibilities of the link worker could therefore span a team, rather than rely on an individual.

The link worker model can be adapted for each unique context. For example, the link worker responsibilities could be fulfilled by existing staff such as social care workers, community workers and nurses, by an organization (for example, a community-based NGO), or a newly created position.

Fig. 1.

Example of a social prescribing patient pathway built on the "holistic" model outlined by Husk and colleagues



Source: Husk et al. *(1)*

Why social prescribing?

Social prescribing builds on the evidence that addressing social determinants of health, such as socioeconomic status, social connectivity, housing and education, is key to improving health outcomes (Fig. 2) *(2,3)*. Social prescribing allows provision of more holistic, person-centred care. It also empowers the patients to take care of their own health and well-being and ultimately reduces stress on health systems.

Studies indicate that social prescribing may be effective in improving health and well-being, as well as being cost-effective by reducing demand on the health sector.

Social prescribing has been implemented in several countries, including Australia, Canada, Ireland, Japan, New Zealand, Portugal, Singapore, and the United Kingdom of Great Britain and Northern Ireland, with early pilots taking place in different parts of the Western Pacific Region, such as in China. Social prescribing is a relatively new concept in health care, as it requires inclusion of community partners from outside the health sector.

Fig. 2.

Dahlgren-Whitehead model of the social determinants of health

Source: Dahlgren and Whitehead *(3)*

One of the strengths of social prescribing lies in providing a link to services that in most cases are already available in communities, thus having a potential for providing significant impact at a relatively low cost. There are several studies that have evaluated cost-effectiveness of social prescribing and show evidence of long-term savings *(1,4)*. However, it is important to remember that these evaluations are very context specific.

Several studies have evaluated the impact of social prescribing on health outcomes of patients, as well as its impact on cost reduction within the health sector. Studies have shown that social prescribing may reduce primary care doctor and emergency department service demand *(4)*, reduce secondary care referrals, improve psychological well-being, reduce anxiety and increase the perceived quality of life *(5)*. Patients have also reported reduced feelings of loneliness and social isolation and improved mental and physical health *(6)*.

Currently, quantitative findings around the effectiveness and cost-effectiveness of social prescribing are mixed, largely due to an absence of rigorous evaluation *(7)*. However, it is important to remember that social prescribing is not the intervention itself – its success depends on the success of the services to which the patient is referred.

In any social prescribing programme, it is encouraged to implement a strong monitoring and evaluation system. This allows evaluators to assess the impact of the programme, as well as to contribute to the global pool of knowledge, thereby strengthening the evidence pool.

Evidence behind non-pharmacological interventions for older adults

There is a large body of evidence behind the impact of various non-pharmacological interventions (NPIs) for different conditions in older adults. NPIs include interventions such as standard therapies, including behavioural therapy, reminiscence therapy and psychotherapy, as well as physical exercise, art and crafts, musical activities or pet therapy, among others.

Some of these therapies have been shown to be effective in addressing depression, fatigue, incontinence, sleep disturbances, apathy, mobility, cognitive performances and improving the perceived quality of life.

It is worth remembering that the effectiveness of an intervention has multiple variables. Services prescribed to a patient must be carefully considered to maximize their effectiveness in addressing the issues experienced by the patient.

Who is social prescribing for?

Although social prescribing can benefit anyone, people with certain social determinants of health could benefit the most. These include people who live in poverty, have stresses in early life, experience unemployment or social exclusion and are more likely to have negative health outcomes, such as poorer mental health and chronic conditions. They experience the greatest inequity and vulnerability to poorer health outcomes.

Evidence shows that those populations that are the most disadvantaged to begin with, or who have social determinants of health that result in comparatively worse health outcomes, are likely to benefit the most from social prescribing *(8)*. Social prescribing is therefore a tool that may help increase health equity to reduce health inequalities within a community. Populations that are most likely to benefit include:

- **people with chronic conditions**
- **people who are lonely or socially isolated**
- **people at a high risk of mental health illness**
- **people who are vulnerable, for example because of their age or their financial situation.**

Thus, older people who have chronic conditions, experience loneliness or are at risk of social isolation may benefit substantially from social prescribing. Additionally, COVID-19 has exacerbated existing vulnerabilities, leaving people, in particular older people, feeling further isolated due to lockdowns.

Implementation steps

Implementation of social prescribing involves several steps, but the order in which they are implemented may vary depending on the specific context and circumstances. It is a non-linear process and may involve several iterations to improve the model based on feedback. As you begin the implementation, it may be necessary to return to a previous step and make changes.

Key steps in implementing social prescribing

1
Conduct a situation analysis

2
Assemble a core implementation team

3
Develop an implementation plan

4
Map out community resources

5
Get everyone on board
(health, social and voluntary sectors, link workers)

6
Link worker training

7
Monitoring and evaluation

Case study: Using the PDSA framework

To manage project implementation as an iterative process, a specific framework may be adopted, such as the Plan-Do-Study-Act (PDSA) cycle *(9)*. The PDSA cycle allows for iterative improvements over time, with each phase being distinct but not completely unidirectional.

An example of application:

Cycle 1: Proof of concept
Cycle 2: Prototyping of the programme
Cycle 3: Installation of the full programme
Cycle 4: Continuous improvements to the programme

A case study on how this framework has been applied to social prescribing in Singapore has been included in the Annex (page 41).

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Step 1. Conduct a situation analysis

It is important to conduct a situation analysis in order to understand the context in which social prescribing is to be implemented. A situation analysis will facilitate understanding of the local sociocultural context and help to examine the gaps between the needs of the target population and service provision. It will help to specify the target population, assess the feasibility of implementing the programme and define the expected project outcomes. It is recommended to conduct a brief situation analysis at the beginning of the project, together with a smaller project team. Once the implementation team has been identified and assembled, an in-depth analysis may be conducted to help scale up the programme.

A situation analysis should consist primarily of a consultation with the key stakeholders: clinicians, patients, caregivers and community partners, including representatives from the health, social and volunteer sectors. Such a consultation can consist of a series of interviews. In some cases, it may be useful to conduct a patient needs survey or focus group discussions, which may help better define the needs of the population, as well as assess the feasibility of social prescribing in the local context. Table1 provides a checklist that can help guide the situation analysis for social prescribing.

Table 1. Considerations for situation analysis

Population

- ☑ Identify the population segment that could benefit from social prescribing.
- ☑ Identify the inclusion and exclusion criteria to narrow down the target group, such as demographic and socioeconomic factors and health status.
- ☑ Assess the needs of the target population, including mental health services, social support, healthy living advice, pain management advice and living conditions.
- ☑ Identify the challenges and opportunities within the population and their communities, for example, cultural attitudes and local behavioural trends.
- ☑ Consider digital technology literacy (if mobile technology is to be integrated).

Feasibility

- ☑ Identify cultural and social factors that may affect implementation.
- ☑ Consider community dynamics, such as the state of collaboration between different sectors.
- ☑ Examine the utility and convenience for the population.
- ☑ Estimate participant cost and available funding.
- ☑ Secure leadership support.
- ☑ Find out the availability of local services and their capacity.
- ☑ Check if similar programmes have been implemented, either in this community or elsewhere in the Region.

Network and stakeholders

- ☑ Identify suitable members for the core implementation team.
- ☑ Map out the points of contact between the target population and health-care providers, such as hospitals, primary health-care centres, community centres, mental health centres, long-term care facilities, rehabilitation centres, social security offices, NGOs, community groups and the private sector.
- ☑ Map out existing collaborations and referral systems, including existing relationships with community organizations.
- ☑ Establish the existing roles of the governmental, nongovernmental, community and patient organizations and the private sector.
- ☑ Find out the local availability of relevant technical experts, such as in mental health and geriatrics.
- ☑ Consider who could fulfil the role of the link workers and how they could be integrated into the existing system.

Please see Step 3 for more detailed considerations regarding the intervention itself.

Case study: patient survey in Australia

To learn about the feasibility of social prescribing from the patients' perspective, the Consumers Health Forum of Australia and the Royal Australian College of General Practitioners have conducted a survey on a sample of primary health-care patients *(10)*. Some of the questions posed to the patients included:

- **Where do you get information about local programmes and services from?**
- **Do you feel knowledgeable about what services are on offer?**
- **Do you participate in any services? Which ones? Why not?**
- **Would you be interested in participating in community programmes?**
- **Would you be likely to attend an appointment with a community support worker to discuss what programmes are on offer?**

The survey revealed that most people did not feel knowledgeable about available community services; however, they would be interested in participating. The main barriers to participation in activities included the cost, schedule timing, transport difficulties and other conflicting responsibilities.

Step 2.
Assemble a core implementation team

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The core implementation team will plan and oversee programme implementation. Team composition can be variable, depending on the local context. Typically, the team is led by the local community health centre; however, this role may also be adopted by another institution that has the required technical expertise and is well-positioned in the community. The implementation team may consist of an expert supervisor, implementation lead, community-based lead and volunteers.

In some settings, a three-level leadership structure may be considered:

- **expert supervisor (based at the regional or national level), such as a specialist in NCDs, mental health or geriatrics, who can share their expertise in the health-care needs of the target population;**
- **implementation lead (from a health centre or a hospital hosting community outreach programmes), who can oversee project implementation; and**
- **community-based lead (based in the community administrative centre), who can coordinate the space and administrative resources.**

A strong implementation team should be multidisciplinary and have expertise in engaging with different stakeholders. The team should have experience in carrying out public health programmes, as well as conducting research and evaluation. Ensuring diversity among the staff is strongly encouraged, both in terms of the groups they represent, but also their age, ethnicity, gender, religious affiliation, physical and mental ability, and expertise, and so on. It is particularly recommended to include older volunteers in the core implementation team.

It may also be helpful to include at least one member who has first-hand experience working with patients, such as primary health-care providers, social workers, physiotherapists and occupational therapists.

It is important to identify a suitable project lead. The project lead (or leads) should be passionate and innovative and have good knowledge of local organizational processes and team dynamics. Expertise in project management and a background in public health or health promotion is preferable. The project lead may be supported by two to four additional staff or volunteers.

Support from high-level leadership

Depending on the context, it may be advisable to secure support from high-level leadership, such as the municipal, provincial, or national level health governance bodies, administration or policy-makers. Coordination support from governmental policy-makers can strengthen multisectoral coordination and facilitate collaboration among different sectors. The core implementation team may engage local policy-makers by asking them to join a steering committee.

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Step 3. Develop an implementation workplan

Once the team members have been identified and assembled, the team will need to meet in order to agree on the objectives and formulate a workplan. The areas to cover when planning programme implementation are outlined in Table 2. Please note that these areas do not need to be covered all at once, and some areas might continue to be revised throughout the implementation phase. When developing the workplan, it may also be worth considering some of the points mentioned in the situation analysis section.

Background	Operational management	Referral pathway	Community services	Monitoring and evaluation

Table 2. Considerations for workplan development

Background

- ☑ Develop a shared understanding of the social prescribing concept.
- ☑ Agree on the target population (demographics and geography).
- ☑ Develop a shared understanding of the anticipated needs of the target population.
- ☑ Agree how social prescribing can bring value to patients and the community.

Operational management

- ☑ Define programme objectives.
- ☑ Establish how the programme relates to local and regional strategies on healthy ageing.
- ☑ Define the roles and responsibilities of the core implementation team, including an overview of the management structure and accountability.
- ☑ Define roles and responsibilities of the other stakeholders (clinicians, link workers, community-based organizations).
- ☑ Discuss the options for engagement of the senior leadership, such as senior management within the organization and local government representatives.
- ☑ Agree how to keep all stakeholders informed, especially the service providers.
- ☑ Analyse the available financial resources or staff time (it is possible to introduce social prescribing without a dedicated budget).
- ☑ Develop a plan for long-term sustainability.

Referral pathway

- ☑ How will the patient be connected to social prescriptions?
- ☑ Who could take the role of the link worker? Are there existing positions that would be suitable for this role?
- ☑ How will the patient be connected to the link worker?
- ☑ How will service providers remain connected with the patient and follow up with them?
- ☑ Will the community services be informed about patients being referred to them (continuity of care)?

Community services

- ☑ Agree how community services are going to be mapped.
- ☑ Agree how the community services are going to be assessed for quality.
- ☑ Agree on the most suitable approach to engage with the community-based organizations (political and practical considerations).
- ☑ Find out if community services have the capacity to receive additional clients.

Monitoring and evaluation

- ☑ What are the criteria for success? What would be considered a “success” once social prescribing has been introduced?
- ☑ Agree on the monitoring indicators (progress, output, outcome, impact; short and long term).
- ☑ Consider feasibility of conducting an evaluation study (health impact and cost-effectiveness).
- ☑ Establish timelines for implementation and evaluation.
- ☑ Determine how progress and outcomes will be measured.

A logic model or the theory of change

A logic model, also known as the theory of change, is a description of the shared relationships between the inputs (resources), activities, outputs, outcomes and impact for the programme. It allows the team to visualize the relationships between the programme's activities and its intended effects.

During the course of the workplan development, it is advisable to create a logic model, as it will help with planning and subsequent monitoring and evaluation.

A logic model will be unique for each social prescribing programme; however, the following template may be used as a guide.

Inputs
What do I need?

This may include resources that will be committed, such as funding, human resources and assets available in the community.

Activities
What do I do?

This may include processes such as patient screening, referral and follow up, interactions between stakeholders, data and feedback collection, and analysis.

Outcomes
What are the results?

These may include process outcomes, such as the number of patients in the scheme and change in the utilization of community services, care outcomes (for example, reduced hospitalizations), and data (such as the mental health of the population).

Impact
Why does it matter?

These may include improved patient health and well-being, reduced rates of mental illness and increased savings by the health-care system. More suggested indicators can be found in Step 7 on page 32.

Identify available financial resources

While social prescribing can be implemented without additional financial resources (for example, by dedicating staff time), it is important to map out the financial resources available to support implementation. If financial resources are available, these could be used to fund link worker salaries, support community programmes, organize stakeholder engagement meetings and conduct comprehensive evaluations. However, social prescribing models can be built that do not require additional funding and that sustainably leverage available resources. They may rely on incorporating social prescribing into already existing positions within the health-care system or on recruiting and supporting volunteers.

Examples of funding models

United Kingdom of Great Britain and Northern Ireland

In the United Kingdom, there is currently no unified funding scheme for social prescribing. Most funding schemes, called "social prescribing connector schemes", are commissioned by local authorities or clinical commissioning groups. These schemes, which fund the link workers, vary locally. More rarely, link workers are funded by housing associations, general practitioner federations and National Health Service (NHS) trusts. As for the services offered to referred patients, they are often delivered by existing voluntary community associations and social enterprises. A unified social prescribing funding model may appear in the future as the NHS integrated social prescribing in its long-term plan. This transformation may change funding attribution, involving partnerships between the voluntary sector, community groups and various statutory agencies *(11)*.

China, Shangrao

In China, social prescribing initiatives are often based on discrete funding sources and small-scale localized programmes. As there are currently no dedicated link worker teams, these programmes typically rely on the existing community health workers and volunteers. For instance, in Shangrao the role of the link worker is fulfilled by a team of mental health community workers and a group of younger/older volunteers. While the community workers do not receive additional compensation, they perceive the social prescribing activities as supporting their routine work. Despite the challenges, social prescribing is growing in interest among local governments and communities, which encourages further development of social prescribing initiatives in China.

Singapore, SingHealth Community Hospitals

SingHealth Community Hospitals (SCH) is a member of SingHealth, Singapore's largest cluster of public hospitals. Social prescribing is funded through a grant given by SingHealth Office of Regional Health (SORH). SORH supports the development of innovative new models of care and services that improves population health. These programmes are closely monitored and evaluated for their impact, scalability and potential for streamlining into national programmes.

Taking a systems perspective

It is important to consider the potential effects of introducing a social prescribing practice on the wider medical care system. In particular, certain funding mechanisms might have a systemic impact. For example, financial incentives, which encourage more social prescribing practice in medical institutions, might pull human resources, such as link workers, from their original tasks at the community level. Since social prescribing aims to demedicalize health service provision, such a side-effect would be contrary to the desired outcome. It is therefore important to carefully consider the design, especially any payment or financial incentive schemes.

Step 4.
Map out community resources

List the available community services

The community-based resources to which patients could be referred can be diverse. Typically, these are services that already exist in the community and might include:

- welfare, legal, financial, housing support and food security;
- social care services, including mental health, addiction, and disability support;
- support for survivors of domestic violence, abuse or neglect, including gender-based violence;
- social activities (indoor and outdoor gatherings);
- employment services, vocational learning and social entrepreneurship support; lifelong learning and education;
- health-care and health promotion services, including physical activity and nutrition;
- in urban areas, opportunities for spending time in nature, such as local parks and outdoor activities;
- music, arts and culture-related activities; and
- volunteering opportunities.

Throughout the implementation of social prescribing, certain services might be identified as being in high demand but currently not locally available. In some cases, it might be possible to engage local volunteering organizations and community associations to fulfil this role. A strong programme monitoring system must be in place from the beginning in order to capture such information.

Assess the services

Once available services have been identified, it is important to assess their quality. This is firstly because the success of social prescribing depends on the success of the organizations to which patients are being referred. Secondly, patients referred to those services are likely to be vulnerable and therefore may require a more sensitive approach and protection.

Assessment of the services will ensure that they meet minimum standards. The standards should be defined by the core implementation team. The areas of consideration may include: organizational health and safety policies, food safety, confidentiality, inclusivity and effectiveness, among others. Already existing frameworks may be used as a reference guide *(12)*.

Step 5. Get everyone on board

© The Third People's Hospital of Shangrao

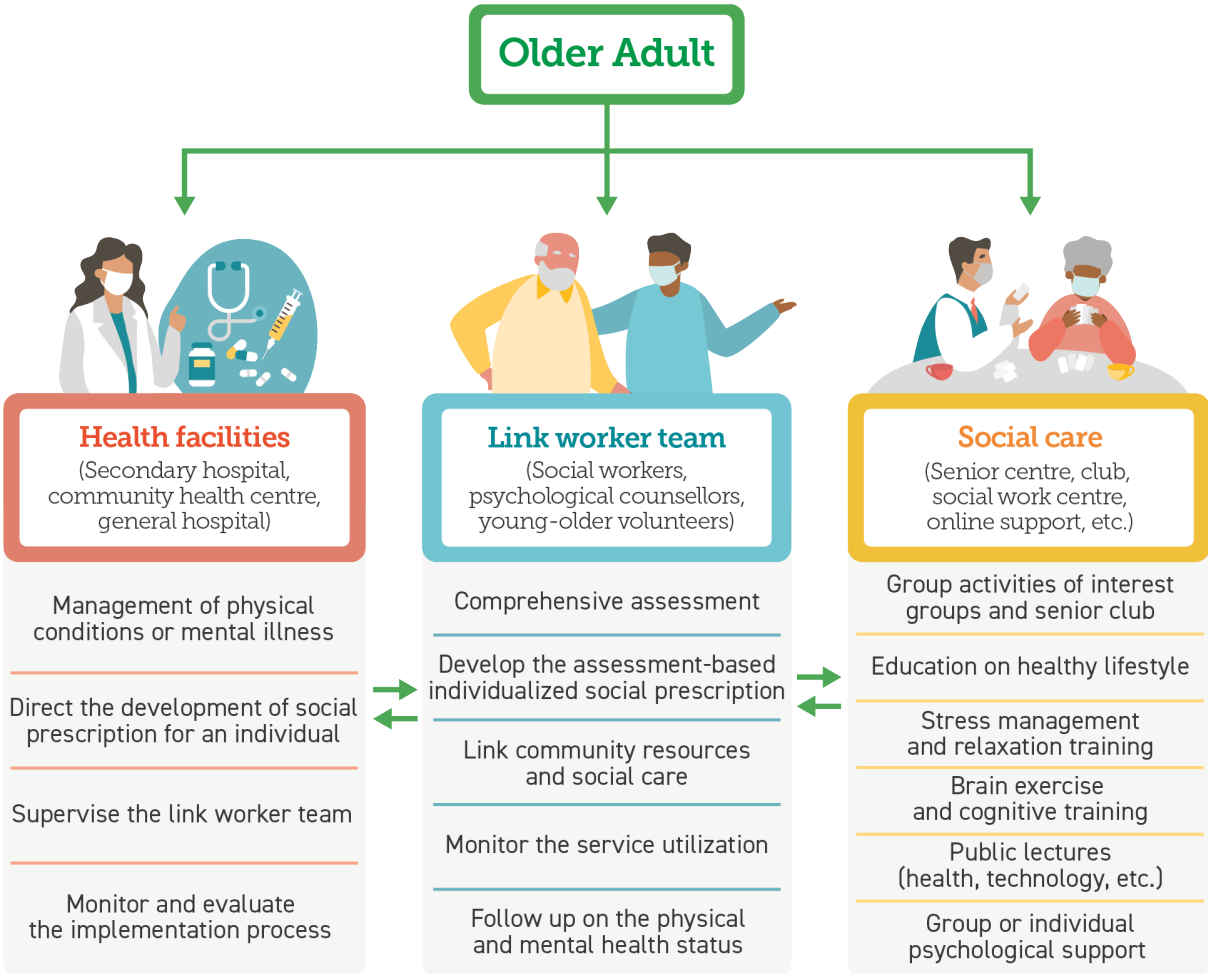
Once the plan has been formulated, the next step involves mobilizing the key players. Typically, patients are referred to the link worker team by health-care providers. Depending on the health-care system, there might exist multiple routes for the patient to access the service, in which case other stakeholders may also need to be included.

Most commonly, the following three key groups need to be engaged and trained:

1. health-care providers
2. social and voluntary sector organizations
3. link workers.

Fig. 3 shows an example of a potential relationship between these key stakeholders. These relations are context specific and should be defined when formulating the workplan.

Fig. 3.
A sample role delineation diagram



Source: Adapted from the Social Prescribing Programme for older adults in Shangrao, China.

1. Health-care providers

In social prescribing, the role of health-care providers is to identify patients who are suitable for social prescribing and to refer them to the link workers. This is typically a clinician or a community health assistant; however, this role may also be fulfilled by other service providers, such as a dispensary assistant. In theory, any institution that serves patients and is trusted within the community could take this role. Those service providers must be identified, recruited and trained.

Key responsibilities include:

A. assess whether the patient could benefit from social prescribing
B. refer the patient to the link worker
C. collect and report data.

The service providers must be familiar with the social prescribing context and knowledgeable about the different social determinants of health. They must be informed of the target population for social prescribing and be able to identify those who may benefit from the service. They must be trained on the practical aspects of the referral to the link worker, in particular any required data collection. They should explain to the patient what they might expect from the link worker, to set their expectations correctly. It is important to clarify that the link worker is not a counsellor, but someone who will design a referral plan together with the patient. For the purpose of monitoring, it might also be required to collect data on patients referred to a link worker.

2. Social and voluntary sector organizations

It is crucial to appropriately engage community programmes, services and organizations in the social and voluntary sectors. The organizations must have a shared understanding of social prescribing and be familiar with the referral process. Patient referral should not be passive and one-way. Good coordination among different organizations is essential to ensure that the patient has a streamlined experience.

For the safety and well-being of the patients receiving their services, it is encouraged to have a mechanism in place to ensure accountability of partners from the social and voluntary sectors. Monitoring and evaluation can help ensure the quality and success of the intervention.

Additionally, the organizations should feel supported and included as part of the whole patient journey, rather than just being the end point. They should be able to report back if they think that a patient may have been referred incorrectly and also able to report if they find themselves facing a situation where they cannot meet demand.

Service integration

It is necessary to consider how resources may be linked together. That includes securing active participation of the identified organizations, as well as ensuring that the referral process is streamlined for the patient. Often, available resources may be fragmented, especially regarding infrastructure, funding sources and human resources. It is essential to ensure good communication and coordination across all partners. Integration of mapped-out resources may be facilitated through a series of multisectoral meetings with the partners. Support from the high-level leadership greatly accelerates the process of resource integration.

Community initiatives

Communities are encouraged to leverage existing resources within their communities when implementing social prescribing. However, if gaps are identified during the implementation and additional services and support are needed, communities may wish to create/develop new programmes that can serve as social prescriptions. Communities are also encouraged to work with the target populations in co-creating new services and programmes that are intended to benefit them.

Case study: eSocial prescribing in Singapore

Ms K stays with her son and enjoys cooking for him. She was, however, admitted to the community hospital for rehabilitation following hip surgery. During her inpatient stay, the Wellbeing Coordinator (otherwise known as the link worker) connected with her and sounded out her interest in enrolling in the eSocial Prescribing programme on increasing digital literacy through smartphone use lessons.

Ms K agreed to participate in the programme on smartphone usage. She was initially very concerned that she might disrupt her son's routine if she tried contacting him. However, through the lessons, she found out that she could leave him voice recordings instead on the mobile phone messaging app, WhatsApp, which he can check at his convenience. She felt she was no longer a burden and much more empowered.

To motivate Ms K to continue with her smartphone usage after discharge, as well as to support her culinary interest, the Wellbeing Coordinator and a local government agency officer linked Ms K up with a community befriending service. A befriender was assigned to Ms K with whom she can now practise and improve on her newfound smartphone skills.

3. Link workers

Link workers play a critical role in any social prescribing scheme. Link workers have a good understanding of the community they serve and can effectively and compassionately connect their patients with community resources that will meet their needs (Fig. 4).

The role of the link worker is to empower people to take charge of their health and well-being.

Link workers should aim to build a trusting relationship with the patient, actively listening to their concerns to better understand what matters most for that person. They then work together with the patient to develop a personalized plan and connect them with the services available locally. Link workers should work as a team with health professionals and community organizations, and work to ensure patient follow-up.

Who can fulfil the link worker role?

Link workers must have a good understanding of their communities and ideally have experience supporting patients. Recruiting link workers may involve hiring new personnel or shifting/expanding the role of existing professionals, for example nurses, caregivers, occupational therapists, social workers, community outreach workers, health promoters or community volunteers.

An alternative approach to appointing individual link workers is putting together a link worker team that collectively supports each client, with each member of the team having a different area of expertise. It may also be beneficial to include an individual representing the target population as part of the link worker team. For example, if the goal of social prescribing is to improve the health of older people, including an older person as part of the link worker team is recommended.

Fig. 4.
Some of the services that a link worker can prescribe

Source: WHO

The key responsibilities of link workers include the following:

- **Meet the patients to identify their needs, goals and pathways to achieving their objectives.** Link workers should meet with the patients to understand their situation. In some cases, link workers may be able to meet with patients initially in their home, as this can provide unique insight into their daily life and the social determinants of health that may be affecting them. However, this may not be appropriate in all contexts.

- **Understand how the social determinants of health affect patients' well-being.** Link workers should enhance patients' knowledge, skills and confidence in managing their own health. Through this process, patients should feel empowered to take greater control and ownership over their health and well-being.

- **Connect patients with community services and provide ongoing support.** It is important to note that link workers are not therapists or counsellors. Their main role is to connect patients with resources in the community, which can include therapy/counselling services. When link workers connect patients to community programmes, patient support may be eventually transitioned to community programme leaders. It will be important for link workers to clearly identify sources of support for the patients within the community programme and maintain ongoing communication with these sources to ensure that the patients are always supported.

- **Continuously forge new relationships and strengthen existing ones with social and voluntary sectors.**

- **Work as a team and provide peer support to other link workers with the goal of collectively supporting the patients.**

An ideal link worker

- listens actively and empathizes with the patient
- communicates effectively
- can foster trusting relationships
- can build and grow community networks
- is knowledgeable and passionate about addressing the social determinants of health
- ideally has some experience of working with patients
- can speak local languages and is sensitive to the local culture.

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Step 6.
Link worker training

Link worker training may be offered online. However, it should also be complemented with a practicum that could be supervised by senior link workers, health professionals or community organizations.

In ensuring the sustainability of the social prescribing initiative across the health-care and social system, the curriculum of a competency-based training should fundamentally cover the following areas:

Overview of the social prescribing scheme

Link workers should possess knowledge about social prescribing, its purpose and importance, who can benefit from it, roles and responsibilities of different individuals and institutions, role of the link worker and practical arrangements.

Social determinants of health

Link workers should have a basic understanding of the social determinants of health (such as employment, housing, food, transport and access to green spaces), how they can impact an individual's health and well-being, and how social prescribing can help address these issues.

Communication skills

As link workers often interact with clients with complex health and social needs, who also may be vulnerable, they should understand concepts of ethics and professionalism. Link workers should be provided with training to strengthen their communication skills, covering areas such as developing rapport, building trust, active listening, and use of open and closed questions. Link workers should be respectful, non-judgemental and friendly. They should know how to create personal boundaries in order to prevent dependency and be aware of how to ensure privacy and confidentiality.

Using the social prescribing tools

Link workers should be able to use the available tools to develop personalized care and support plans, assess client needs and evaluate progress, and be trained on the process of referral and enrolment. They should also be provided with training on required data collection, including what data to collect and when and how. Collected data should be disaggregated by gender and age.

Patient interview and assessment

Link workers should be provided with an assessment form to help guide their discussions. However, the assessment should have a format of a conversation between a link worker and the patient, rather than a series of questions from a script. Link workers must build trust with the patients in order to identify the underlying causes and unmet non-clinical needs, some of which may be sensitive. Some information may need to be investigated through indirect questions *(13)*.

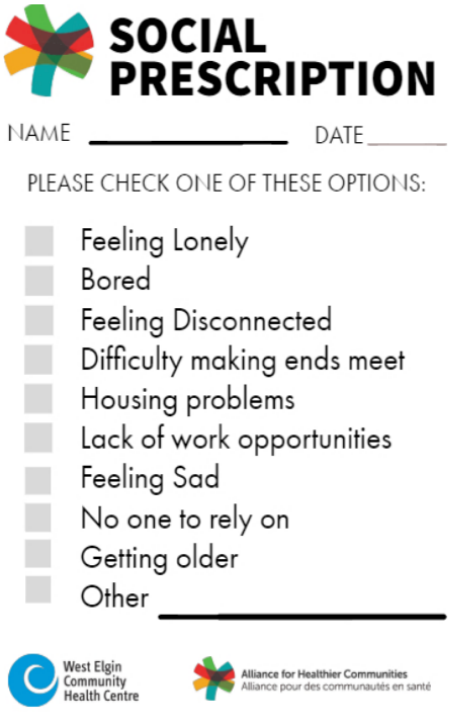
Patient assessment should cover the following areas:

- **Sociodemographic questions, such as age, support with daily living/accessibility requirements, cultural/ethnic background, gender identity, religion, sexual orientation, relationship status, educational attainment, employment and income.**
- **Questions about the social determinants of health that patients may want to address, such as social participation, physical activity, nutrition, education, employment and finances.**
- **Questions that assess patient's baseline health and well-being, such as physical health, mental health and quality of life.**
- **Questions about the types of social prescriptions the patient may be interested in, such as social gatherings, sports and fitness classes, and skill development courses, including technology, cooking, money management and social support.**

An assessment form may be used to help guide the discussion. Sample assessment forms can be found in Figs. 5 and 6. Questions used in the assessment form will depend on the more specific objectives of the social prescribing scheme, be it to reduce loneliness among older people or improve their well-being. Already published assessment tools may also be used, such as the Patient Activation Measure (PAM; commercial license), Office for National Statistics personal well-being scale (ONS4), or Measure Yourself Concerns and Wellbeing (MYCaW), among others. Tools that are locally used by mental health or general practitioners may also be adapted. Development of assessment tools should be facilitated by the core implementation team.

The initial patient assessment results may also be used to evaluate the effectiveness and efficiency of the intervention, together with results collected later in the programme. See Step 7 on Monitoring and evaluation for further information.

Fig. 5.
Sample patient assessment form

Examples of screening questions	
West Elgin CHC developed social prescription reminder card to help prompt providers during clinical appointments. These inform the "reasons for social prescribing referral" (below) that are entered into the Electronic Medical Record and passed to the Navigator.  SOCIAL PRESCRIPTION NAME _____ DATE _____ PLEASE CHECK ONE OF THESE OPTIONS: ☐ Feeling Lonely ☐ Bored ☐ Feeling Disconnected ☐ Difficulty making ends meet ☐ Housing problems ☐ Lack of work opportunities ☐ Feeling Sad ☐ No one to rely on ☐ Getting older ☐ Other _____ West Elgin Community Health Centre Alliance for Healthier Communities Alliance pour des communautés en santé	Carea CHC's Client Navigation & Support Program includes the following script to help guide providers (questions are to be chosen as appropriate, not that all will be asked within one encounter): A. Do you feel you are coping with the current COVID-19 situation? B. Are you feeling lonely or isolated? C. Are you struggling with your mental health? D. Are you struggling to access services? E. Do you need help with any of the following: • Accommodation / Housing • Food Security / Nutrition • Social Supports • Parenting Supports • Quitting Smoking • Employment Insecurity • Individual or Family Counseling Support • Parenting Supports • Maintaining Healthy Relationships F. Would you like me to connect you with a Health Promotion staff who can call you and see if we can provide some support?

Source: Alliance for Healthier Communities *(14)*

Fig. 6.
Sample fragment of a patient assessment form

4.6 Assessment

Name of Person:

Date:

We know that lots of things affect health and wellbeing so let's start by finding out what's going on in your life that affects your health and wellbeing. So I'm going to ask you some questions to begin with.

1. Lifestyle (see Appendix 1 for Lifestyle Health recommendations)

- [If person has long-term condition] What kind of lifestyle changes are recommended for your condition?
- Do you know who to contact if you were worried about your health?
- How is your diet, in terms of eating enough healthy food and avoiding any foods and drinks that may be harmful with the condition you have?
- What physical activity do you do? If person has LTC - what exercise is recommended for your condition? How often do you managed to do that and/or other ways to keep your body as strong and fit as possible?
- Do you smoke?
- Do you drink alcohol? If yes, how much? (See Appendix 2 -Alcohol Assessment for Alcohol Unit Information). If drinking more than 14 units of alcohol per week consider use of Alcohol Assessment – Appendix 2)
- Tell me about your sleeping habits (recommendation is 7-9 hours per night
- Do you feel that you would benefit from any lifestyle advice/support?

Notes:

Source: National Health Service *(15)*

Developing a personal well-being plan

Following the assessment, the link worker should work together with the patient to develop a well-being plan. A sample well-being plan, developed by NHS England, can be found in Fig. 7 *(16)*. It is recommended to provide link workers with a template or the plan, but there should be flexibility in how the plan is developed. Where possible, the plan should be filled in by the patient rather than by the link worker.

When developing the plan, link workers should consider a patient's privacy concerns and ensure full consent. They should ensure that the final choice of allocated social prescriptions remains with the patient. They should also consider potential barriers that the patient might encounter, such as cost, distance and waiting lists.

Fig. 7.
A sample personalized care and support plan - template

Name and contact details for person: _____

NHS number: _____

Part one - to be completed together at the start	
What matters to me:	
How best to support me: what people need to know about me and my life:	
Any health conditions that agencies need to know about:	
My goals:	
Summary of support that I am being connected to, including what I can expect from support:	
What I can do to support myself to meet my goals:	
Review – when shall we check how it's going?	
Part two - to be completed after 6 months	
What changes have taken place?	
I am happy to share my personal story?	
I am willing to complete a satisfaction survey?	
I am happy to participate in ongoing data collection and evaluation?	

Source: National Health Service *(16)*

Patient referral to community services

Typically, the core implementation team should provide link workers with a list of community services and programmes. They should also facilitate the connection between link workers and the social/voluntary sector, so that link workers can easily follow up patients. There should be a well-established referral system, to both support community services as well as to ensure continuity of care for the patient. In some cases, it might be beneficial for the link worker to go together with the patient to the activity prescribed, as that may facilitate patient engagement with the activity.

The implementation team and the link workers should co-create an asset map of the community that can support the patient (see Step 4). This is dynamic and evolves over time. Some programmes may wish to train link workers to seek and recruit community assets.

Improving service uptake

Patients are more likely to enroll when *(1,17)*:
- they believe the social prescription will be of benefit
- the referral is presented in an acceptable way that matches their needs and expectations
- any concerns are addressed appropriately by the referrer.

Patients are more likely to engage when:
- the activity is accessible
- transit to the first session is supported.

Patients are more likely to stay engaged when:
- the activity leader is skilled and knowledgeable
- their conditions or symptoms change.

Patient referral back to health-care services

Link workers should have access to health-care teams and learn how to work with local health-care providers. Where available, they should be part of a multidisciplinary team and learn about inter-professional care. In some situations, it might be necessary to refer the patient back to their health provider. This may include a suspicion of a mental health issue or physical illness that has not been attended to. It is important to specify in the training that the link worker should maintain confidentiality, unless in specified exceptional circumstances (for example, domestic abuse) – these should be in accordance with the local regulation.

Patient follow-up

Link workers should be trained in the follow-up process as well as the handing over of patients to community care providers and made aware of the need to avoid creating dependencies and build self-efficacy of the patient. The frequency of meetings with patients should be determined by the link worker and the patient. It is suggested that link workers connect with patients more frequently at the beginning to generate momentum but reduce contact with time as patients feel more empowered to take greater ownership over their health and well-being. This may also prevent patients from becoming too reliant on link workers. Sample questions to be included in the follow-up discussion are outlined in Fig. 8.

Fig. 8.
Sample patient follow-up form

4.11 Follow-up appointments (approx. 20 mins) - F2F or by phone

First follow-up to be scheduled around 2 weeks after the first appointment but dependent on availability, person issues, etc. Then aim to space appointments out at increasing lengths of time

Review:

- **How are things going?**
- **What has gone well?**
- **What has not gone so well?**
- **What else you need to ensure you meet your goal(s)?**
- **Provide further information and support as appropriate**
- Refer to PAM® for guidance on activation
- **Are there any changes to your action plan now?** Get person to write in Person Booklet any changes / additional plans

Date:

Notes:

Source: National Health Service *(15)*

Connecting with the core implementation team

Link workers should connect with their supervisory team on a regular basis (biweekly or monthly) to discuss how things are going and report on client assessment/follow-up information. Link workers should be provided with regular opportunities for debrief and with support in dealing with difficult patient cases. They should also be given an opportunity to provide feedback back to the primary health-care provider. Link workers should be able to work in teams and follow organizational governance and regulations.

Self-care

Link workers should be aware of self-care principles, as the nature of work is prone to burnout. They should be provided with an appropriate support system, as needed.

Training objectives

By the end of the training, the link worker should be able to do the following:

- identify and analyse patient needs in the context of social determinants of health
- locate and match community resources
- perform social prescribing tasks to improve the overall well-being of patients.

Step 7. Monitoring and evaluation

Monitoring and evaluation should be incorporated in the workplan of a social prescribing programme or pilot, particularly if social prescribing is new in the local context.

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

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

Monitoring can help to determine whether the intervention is on track to achieve its objectives and to identify factors that facilitate or create barriers to successful implementation. This can provide valuable information that allows refinement of the intervention to ultimately improve its impact. Monitoring includes collection of both quantitative and qualitative data and should be carried out throughout the implementation. Therefore, it is important to embed monitoring within the implementation design.

Monitoring objectives may include the following:

- **to understand how social prescribing is being used (including reasons for referral, types of social prescription referred to);**
- **to track uptake and adherence (including proportion of referrals that are taken up, proportion of people who adhere to social prescriptions, reasons for dropping out);**
- **to monitor the impact on the community organizations (for example, whether they are coping with the increased number of clients and whether clients are referred correctly);**
- **to determine areas for improvement, such as facilitators/barriers to participation, limitations of the social prescribing process and limitations of the existing community services/programmes; and**
- **to monitor changes in health outcomes of the target population.**

While the core implementation team should be responsible for leading and facilitating monitoring and evaluation, health-care providers and link workers play an important role in collecting the data. Information collected by health-care providers and link workers through the baseline assessment and follow-up questionnaires may also be used for monitoring and evaluation. It will be important to create a secure system for data storage and for health-care providers and link workers to share the data with the core implementation team. Depending on the organization and community's capacity, a digital or paper system may be used.

Health providers, link workers and community organizations

It is recommended to conduct regular informal check-ins between the health-care providers and link workers. A staff member of the core implementation team should connect with service providers regularly to see how things are going and make changes as needed. Depending on the capacity of the core implementation team, this could be done on a biweekly or monthly basis.

Additionally, formal interviews, focus group discussions or surveys with health-care providers, link workers and community organizations may be used:

- to assess progress;
- to determine challenges/barriers and how they can be addressed;
- to understand their level of satisfaction with participation;
- to understand changes in their knowledge, skill and capacity to support patients in addressing the social determinants of health; and
- to understand their perception of the impact of social prescribing on client health and well-being.

Interviewing health providers

The following questions may be used to assess the social prescribing programme from the perspective of health providers and link workers:

- How many patients did you refer to the social prescribing scheme last week/ month/year?
- How many of these patients were satisfied with the scheme?
- Do you think your patients benefit from the services you prescribe them?
- What are the main challenges you have encountered in referring your patients to the link worker/community services?
- What do you like about the social prescribing scheme?
- How is the social prescribing scheme beneficial for your practice?
- What could be improved in the social prescribing service?

Interviewing community organizations

The following questions may be used to assess the impact of the social prescribing programme on the community organization:

- How many people have been referred to your organization over the past X months?
- How well is your organization coping with receiving new people through the social prescribing scheme?
- Could your organization welcome additional referrals?
- How competent do you feel about supporting the needs and expectations of people being referred?
- Would you welcome additional external support in delivering the social prescribing activities?
- Have you identified any gaps in service provision through the social prescribing scheme?

Patients

Formal surveys, interviews or focus group discussions with patients may be used to monitor programme implementation. These should ideally be conducted at the beginning and at regular periods throughout the implementation. Success of the programme has multiple components, but it relies primarily on the success of patient enrolment, engagement and adherence *(1,17)*. It is therefore important to monitor these three and identify any barriers and how they may be addressed.

Examples of health and well-being assessment tools, which can be accessed freely online:

- Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)
- Measure Yourself Concerns and Wellbeing (MYCaW)
- Hospital Anxiety and Depression Scale (HADS)
- General Anxiety Disorder-7 (GAD-7)
- Patient Health Questionnaire-9 (PHQ-9)
- Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM)
- Work and Social Adjustment Scale (WSAS)
- General Health Questionnaire (GHQ-12)
- COOP - WONCA
- Brief Inventory of Thriving
- Medical Outcomes Study Social Support (MSS-OSS)
- The Quality of Life Scale (QOLS)

Interviewing patients

The following questions may be used to assess the perception of the social prescribing programme by the patients:

- How did you hear about the social prescribing scheme?
- What was your initial reaction when you learnt about it?
- What did you like/not like about social prescribing?
- How satisfied are you with the service?
- What benefits did you experience from social prescribing?
- Did you experience any changes in your life?
- Did you experience any difficulties in meeting with the link worker?
- Did you find the link worker to be helpful? Why/why not?
- How convenient was it for you to participate in the prescribed community services?
- How could your experience with social prescribing be improved?

Additionally, patient data collected by the link worker during patient assessment and follow-up may be used for the purpose of monitoring. These may include:

- sociodemographic information about the patient, such as age, gender, ethnicity and socioeconomic status;
- detailed information about reason for referral;
- social prescriptions the patient enrols in;
- level of satisfaction with social prescriptions and the social prescribing referral process; and
- perceived changes in health and well-being.

Evaluation

Evaluation can be used to assess the impact of the intervention, for example perceived changes to health and well-being, social networks and community engagement, among others. Evaluation can be used to assess the impact at the health system level, including measuring its cost-effectiveness. Evaluation should ideally be conducted in collaboration with a research institution with the capacity to support the study design.

Sample indicators for impact evaluation

Impact on the health system:

- Is there a change in the number of general practitioner consultations as a result of referral to social prescribing?
- Is there a change in Accident & Emergency Department attendance as a result of referral to social prescribing?
- Is there a change in the number of hospital bed days as a result of referral to social prescribing?
- Is there a change in the volume of medication prescribed as a result of referral to social prescribing?

Impact on the individual:

Patient-reported outcome measures (PROM) and patient-reported experience measures (PREM), for example:

- Is the person better able to manage practical issues, such as debt, housing and mobility?
- Is the person more connected to others and less isolated or less lonely?
- Is the person more physically active?

Information and knowledge sharing

Social prescribing is a new and growing field and evaluation findings can contribute to growing the body of knowledge about social prescribing both in the Region and globally. Information about social prescribing pilots can be shared and disseminated in different ways, depending on who the information can be shared with and for what purpose. The following are some examples of ways to share social prescribing experiences:

- for knowledge generation: academic journal articles, reports;
- for policy change: policy briefs; and
- for sharing best practices and public information: infographics/brochures, websites, webinars, social media.

Key factors for successful implementation

- A strong leadership team
- High levels of motivation, enthusiasm and creativity among the implementation staff
- Flexibility and ability to adapt
- Strong collaboration between the health-care and social care sectors, the government, NGOs and private sector organizations, including insurance companies
- Support from the high-level leadership.

References

1. Husk K, Blockley K, Lovell R, Bethel A, Lang I, Byng R, Garside R. What approaches to social prescribing work, for whom, and in what circumstances? A realist review. Health Soc Care Community. 2020 Mar;28(2):309–24. doi:10.1111/hsc.12839. Epub 2019 Sep 9. PMID: 31502314; PMCID: PMC7027770.

2. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep. 2014;129 Suppl 2(Suppl 2):19–31. doi:10.1177/00333549141291S206.

3. Dahlgren G, Whitehead M. 1991. Policies and strategies to promote social equity in health. Stockholm, Sweden: Institute for Futures Studies.

4. Polley M, Bertotti M, Kimberlee R, Pilkington K, Refsum C. A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. London: University of Westminster; 2017.

5. Grant C, Goodenough T, Harvey I, Hine C. A randomized controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. BMJ 2000;320:419–23.

6. Bickerdike L, Booth A, Wilson PM, Farley K, Wright K. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. BMJ Open. 2017 Apr 7;7(4):e013384. doi: 10.1136/bmjopen-2016-013384.

7. Pescheny JV, Randhawa G, Pappas Y. The impact of social prescribing services on service users: a systematic review of the evidence. Eur J Public Health. 2020 Aug 1;30(4):664-73. doi:10.1093/eurpub/ckz078. PMID: 31199436.

8. Evaluation of the Rotherham Mental Health Social Prescribing Service 2015/16-2016/17. Sheffield: Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University, on behalf of Voluntary Action Rotherham (VAR) and funded by NHS Rotherham Clinical Commissioning Group. https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/eval-rotherham-health-social-prescribing-2015-2017.pdf.

9. Taylor MJ, McNicholas C, Nicolay C, Darzi A, Bell D, Reed JE. Systematic review of the application of the plan–do–study–act method to improve quality in healthcare. BMJ Quality & Safety 2014;23:290-8.

10. Social Prescribing Roundtable, November 2019: Report. East Melbourne, Victoria: The Royal Australian College of General Practitioners and Consumers Health Forum of Australia; 2020.

11. Social prescribing – frequently asked questions. National Health Service. https://www.england.nhs.uk/personalisedcare/social-prescribing/faqs/#will-social-prescribing-link-workers-be-found-only-in-general-practice-and-primary-care-networks (accessed 19 August 2021).

12. Social prescribing link workers: Reference guide for primary care networks – technical annex. NHS England; 2020. https://www.england.nhs.uk/wp-content/uploads/2020/06/pcn-reference-guide-for-social-prescribing-technical-annex-june-20.pdf.

13. Andermann A; CLEAR Collaboration. Taking action on the social determinants of health in clinical practice: a framework for health professionals. CMAJ. 2016;188(17-18):E474–E483. doi:10.1503/cmaj.160177.

14. Social prescribing guidebook: for team-based primary care providers in Ontario. Toronto: Alliance for Healthier Communities; 2020. https://cdn.ymaws.com/aohc.site-ym.com/resource/group/e0802d2e-298a-4d86-8af5-21156f9c057f/social_prescribing_guidebook.pdf (accessed 30 November 2020).

15. Social prescribing toolkit. National Health Service; 2020. https://cptraininghub.nhs.uk/social-prescribing-link-workers/.

16. Welcome! An induction guide for social prescribing link workers in primary care networks. National Health Service; 2019. https://www.england.nhs.uk/publication/social-prescribing-link-worker-welcome-pack/.

17. Husk K, Blockley K, Lovell R, Bethel A, Bloomfield D, Warber S, Pearson M, Lang I, Byng R, Garside R. What approaches to social prescribing work, for whom, and in what circumstances? A protocol for a realist review. Syst Rev. 2016 Jun 3;5:93. doi:10.1186/s13643-016-0269-6.

Additional literature

- Social prescribing engagement [questionnaire]. Leeds: NHS Leeds Clinical Commissioning Group; 2018. https://71633548c5390f9d8a76-11ea5efadf29c8f7bdcc6a216b02560a.ssl.cf3.rackcdn.com/content/uploads/2018/05/Social-prescribing-questionnaire.pdf.

- Social prescribing [webpage]. Toronto: Alliance for Healthier Communities. https://www.allianceon.org/Social-Prescrib

- Evaluation in health and wellbeing: a guide to evaluation of health and wellbeing projects and programmes [online guidance]. London: Public Health England; 2018. https://www.gov.uk/government/collections/evaluation-in-health-and-wellbeing.

- Dayson C, Bashir N. The social and economic impact of the Rotherham Social Prescribing Pilot. Sheffield: Sheffield Hallam University; 2014. https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

- Douglas S, James IA, Ballard C. Non-pharmacological interventions in dementia. Adv Psychiatr Treat. 2004;10(3):171–7. doi:10.1192/apt.10.3.171

- Chen YJ, Li XX, Pan B, Wang B, Jing GZ, Liu QQ, Li YF, Bing ZT, Yang KH, Han XM, Ge L. Non-pharmacological interventions for older adults with depressive symptoms: a network meta-analysis of 35 randomized controlled trials. Aging Ment Health. 2019 Dec 27:1–14. doi:10.1080/13607863.2019.1704219. Epub ahead of print. PMID: 31880174.

- Kilpatrick KA, Paton P, Subbarayan S, Stewart C, Abraha I, Cruz-Jentoft AJ, O'Mahony D, Cherubini A, Soiza RL. Non-pharmacological, non-surgical interventions for urinary incontinence in older persons: A systematic review of systematic reviews. The SENATOR project ONTOP series. Maturitas. 2020 Mar;133:42–8. doi:10.1016/j.maturitas.2019.12.010.

Annex

Using implementation science in social prescribing: SingHealth Community Hospitals case study

The implementation of social prescribing is a complex and context-dependent process. Given the need for several iterations before arriving at a suitable social prescribing model, Deming's PDSA (Plan-Do-Study-Act) cycle may be used to guide this process:

Deming's PDSA cycle and its role in implementation science

Source: WHO

Deming's PDSA cycle (see figure above) is a systematic framework where the implementation science lens is adopted for the continuous improvement of a process or service. By using this framework, multiple iterations of a programme are expected. For example, cycle 1 as the proof of concept, cycle 2 as the programme prototyping, cycle 3 as the full programme installation, and cycle 4 onwards for continuous programme improvement. This case study uses the PDSA framework to explain the implementation of social prescribing at an inpatient setting in SingHealth Community Hospitals (SCH) in Singapore. It is important to keep in mind that the framework is not completely unidirectional in practice.

◷ Phase 1. PLAN

The first phase in the PDSA cycle is "Plan", where a newly formed project team crafts the project objectives and strategies. In SCH, a project team was formed consisting of: the SCH CEO as the Project Sponsor; a family physician with experience in care model implementation as the Project Leader; and allied health professionals, nurses and administrators as part of the Multidisciplinary Team. For the pre-pilot phase, this team recruited colleagues to set aside dedicated time to test initial ideas for social prescribing as Wellbeing Coordinators (the local term that SCH conceptualized for link workers). After gaining valuable insights on how social prescribing might be implemented in the local context, the team went on a study trip to the United Kingdom of Great Britain and Northern Ireland and visited various sites, including academia, policy-making bodies, professional bodies and service providers, to learn the best practices of social prescribing. Following this, the team reviewed the pre-pilot concept by adapting what they had learnt from the study trip to the cultural context of Singapore and the care setting of a step-down secondary care setting of a community hospital.

Key components of the pre-pilot were evaluated and fine-tuned. Firstly, the inputs for the programme were clarified, which include resources such as financial funding and human resources. Secondly, social prescribing processes were clearly defined. The processes include the internal process of the programme workflow and the external process of interfacing with community partners. Thirdly, the outcome for the programme was detailed. The Patient Activation Measure (PAM13) was selected as the tool to measure the outcome of patients who participated in the SCH social prescribing programme, a measurement that was adapted from the United Kingdom.

With the key project components in place, the team reviewed the enabling factors of the project, also known as implementation drivers. A combination of funding through grant applications with SingHealth headquarters and internal funds from SCH itself were secured for the programme. Programme leaders and champions were identified within the organization's leadership to play key roles in weaving the social prescribing programme into the hospital's operations. Internal stakeholders who were expected to interface with the Social Prescribing Team, namely the general population of hospital staff, were engaged through regular meetings and townhall sessions. Individuals with suitable traits to perform the role of social prescribing practitioners were identified and recruited into the Social Prescribing Team as Wellbeing Coordinators. The training of Wellbeing Coordinators was done through an ad hoc on-the-job training programme. Concurrently, the Team created a competency-based training programme for the Wellbeing Coordinators through training needs analysis with multiple stakeholders, definition of competency, curriculum design, instructional design, assessment and evaluation planning. A competency-based training programme was developed in accordance to the national skills training framework with the long-term objective of systematically training and developing new Wellbeing Coordinators.

Phase 2. DO

The second phase of the PDSA cycle is "Do", where the plans that were created in the first phase are carried out with intentional collection of feedback from stakeholders. A decision was made to actively implement the revised pre-pilot programme at one of three SCH sites as a social prescribing pilot.

There are two approaches for the "Do" phase. The "installation" approach is implementing the pre-planned strategy, whereas the "exploration" approach is monitoring the strategy as it is implemented, making adaptations where necessary. Since social prescribing is a relatively new intervention in care integration, the team expected extensive contextualization and adaptation of the programme in passage. Hence, it adopted the exploration approach. During this phase, the team field-tested the outcome measurement tool widely used in existing social prescribing practices. It also made connections with community assets and community partners to test on its social prescribing referral work processes. In addition to data collected in regard to work processes, the team collected feedback of the programme through surveys and interviews with patients, as well as internal and external stakeholders. Resource utilization was monitored to ensure proper financial stewardship. A four-module competency-based training programme was developed, and one of the four modules on social prescribing was taught to the practitioners and feedback was evaluated.

Phase 3. STUDY

The "Study" phase is a process where the effectiveness of the implementation drivers, as well as the receptiveness, outcome and fidelity of the intervention are evaluated. Amid the implementation of social prescribing in SCH, the COVID-19 pandemic hit the shores of Singapore in full force. The social prescribing pilot was halted as the site of implementation was converted into a community isolation facility for COVID-19 patients. Activities within the hospital and the community were severely curtailed. The "Do" phase ended prematurely, and the team decided to use the interim period to review and improve the programme. It is noteworthy that unexpected disruption brought by internal or external factors is not uncommon in real-life programme implementation. Hence, it is crucial for project teams to remain resilient and highly adaptive.

As is expected in an exploratory phase of implementation, fidelity assessment of the programme was infeasible. Drawing from this, data and feedback were collected to clarify components of programme to develop fidelity measures in preparation for the re-implementation of the pilot programme.

Numerous lessons were collected upon evaluation of the pilot programme. With regard to the key components (inputs, process, outputs), it was found that the clear definition of inputs for the programme was helpful for the team. The processes were found to require modification after implementing them with community partners. The outcome measure adopted by the team was found to be unsuitable for the local context. As for the implementation drivers, robust engagement with organization leaders and external partners was found to result in strong leadership support for the programme. However, internal engagement of the social prescribing practitioners was found to be inadequate. The Wellbeing Coordinators highlighted coping pressures due to the uncertain and dynamic nature of the pilot programme. As to the competency-based training curriculum, the team adjusted the lesson content with inputs from the learners, resulting in more comprehensive content.

Phase 4. ACT

The final phase, "Act", is where lessons from the previous phases are adopted in the project. It was during the protracted COVID-19 period that digital exclusion was discovered as a new social determinant of health for patients. Hence, a new component of social prescribing aimed at improving digital literacy and access for patients was developed, tested and incorporated into the programme. With learning from the Study phase, engagement activities were further enhanced to improve work processes between the Wellbeing Coordinators and other colleagues in the patient care frontline team. Additional support from the project management team was provided to the Wellbeing Coordinators through team reorganization. The on-the-job training was improved and provided to newly recruited Wellbeing Coordinators. The competency-based training curriculum was also finalized with feedback from Wellbeing Coordinators and learning from earlier phases. Lastly, new outcome measures were shortlisted and tested for applicability, validity and acceptability.

Henceforth, the project team planned to redesign the social prescribing programme with lessons from earlier phases and install the programme at a second SCH site with less restrictive COVID-19 measures. A full evaluation, including a randomized control study of the social prescribing programme is also under way, as is full accreditation by Singapore's national training framework for the competency-based programme in social prescribing. While one cycle of the PDSA cycle is completed, the Social Prescribing Team in SCH continues to adopt this framework to develop iterative improvements over time.

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