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Good Faith Partnership

REPORT

Creating a Neighbourhood Health Service:

The role of churches and faith groups in social prescribing

Marianne Rozario with contribution from Esther Platt

Foreword by the Rt Revd and Rt Hon Dame Sarah Mullally DBE, Bishop of London

Theos is the UK's leading religion and society think tank. It has a broad Christian basis and exists to enrich the conversation about the role of faith in society through research, events, and media commentary.

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Published by Theos in 2025

ISBN 978-0-56-403953-1

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The Role of Churches and Faith Groups in Social Prescribing

Marianne Rozario with contribution from Esther Platt

Foreword by the Rt Revd and Rt Hon Dame Sarah Mullally DBE, Bishop of London

Endorsements

This report describes and calls for more faith groups and social prescribing services to knock on each other's doors and learn and build service pathways together to guide neighbourhoods and our nation to healthier, happier, more connected, communities together. Strategic leaders at national, local and neighbourhood levels need to consider how the F of Faith Communities fits into VCFSE service delivery.

Dr David Smart
Visiting Professor, University of Northampton
Retired GP

This timely report captures the best of current practice in integrating faith-based social action with NHS social prescribing, but reminds us there can often be a disconnect between the worlds of health and faith. As the NHS plans for its next 10 years, our faith communities can be part of a strategic shift from simply treating sickness to preventing it. Faith and health leaders alike should take on board these insights and recommendations and help realise the potential.

Jeremy Simmons
Policy and Programme Manager, FaithAction

As our system of health and care focuses more on prevention and as our understanding of mental health issues increases, social prescribing can play a vital role in improving the wellbeing of individuals. Churches and other faith groups often act as local community hubs, some offering services that can be described as social prescribing. Dr Rozario's report is a welcome addition to the discussion on linking faith groups into other parts of the system of health and care, to improve the wellbeing of individuals and local communities.

Lord Kamall of Edmonton
Shadow Minister (Health and Social Care)

There is now robust evidence that social prescribing is an impactful, inclusive and cost effective approach, and it should play a significant role in delivering the government's aims for greater preventative and community-based healthcare. There are valuable and untapped assets in communities across the UK which should be better connected to the health system, and social prescribing should be available in every clinical NHS pathway to enable this. This report provides direction for how we can connect the great community work of faith groups into our health service in order to promote the wellbeing of local communities.

Charlotte Osborn-Forde
CEO, National Academy of Social Prescribing

I wholeheartedly endorse the invaluable role of faith groups in the social prescribing framework, as outlined in this report. By fostering trusted relationships and providing holistic support, faith communities are uniquely positioned to bridge the gap between healthcare and wellbeing, offering a preventive approach to health that prioritises connection, care, and community.

Professor Dame Clare Gerada
Past President Royal College of General Practitioners

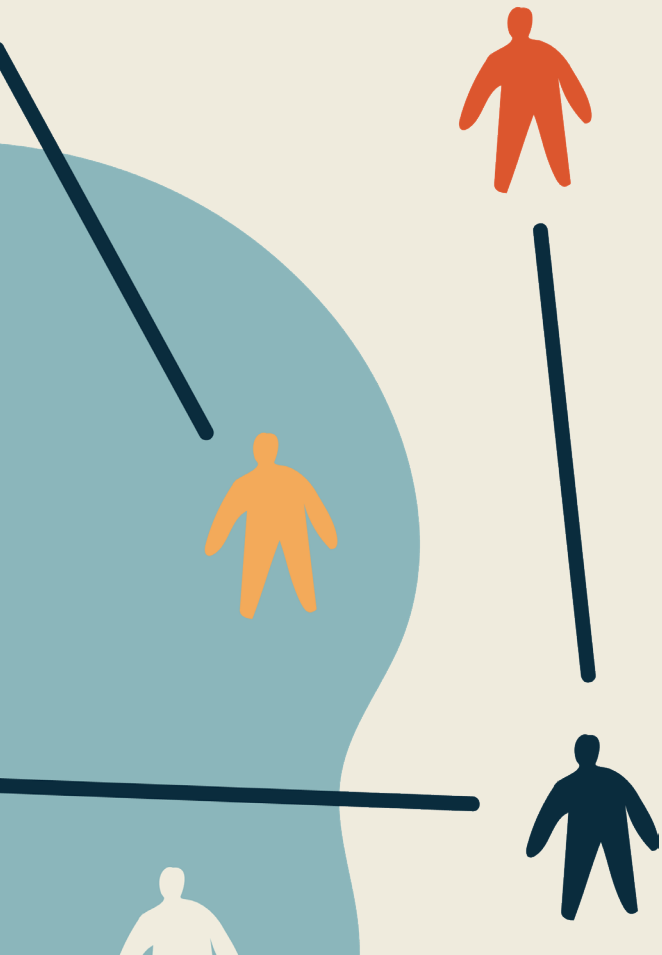
This report demonstrates the excellent work that faith groups are already doing to support communities across the UK. At the Good Faith Partnership, we want to celebrate this work and commend faith groups and health service providers alike to make use of this research and the 'how-to' guides in order to promote partnership and collaboration.

David Barclay
Managing Partner at the Good Faith Partnership

This report in 60 seconds

- The NHS and social care services in England are stretched to breaking point, grappling with record-high demand for GP appointments and secondary care services. Yet, one in five GP appointments are not for medical reasons, but rather requests for help with issues like loneliness, housing, or debt.
- Lord Darzi's 2024 report paints a stark picture of the NHS's current state but also offers a vision for its future: a shift towards neighbourhood-level care, preventing ill-health and tackling health inequalities, a vision echoed by Health Secretary Wes Streeting MP's ambition to turn the NHS into a "neighbourhood health service."
- Social prescribing – connecting people to community-based activities to benefit their wellbeing – can be part of that preventative solution. Churches and faith groups not only contribute significantly to social prescribing, offering networks and resources, but with their focus on community, relationship and holistic wellbeing, they can play a foundational role in preventative healthcare.
- Our research found that faith groups across the country already host a wealth of friendly, welcoming, and "referrable" activities. These groups act as "anchors of the community" with the ability to network and convene, provide resources, buildings and volunteers, and offer pastoral and spiritual care.
- However, there are barriers preventing a more integrated approach between faith and health including communication and administrative challenges. Therefore, this report outlines a model of relationship-building through active networking, engaged collaboration, and forward planning, unlocking the full potential of faith-based support.
- Ultimately, this report highlights the contribution of faith groups in social prescribing and puts forward recommendations for proactive collaboration between faith groups, the NHS and wider healthcare networks at the level of "neighbourhoods", "places" and "systems".

Acknowledgements



We would like to thank all who have supported this research project.

We would like to especially thank Dr David Smart, Dr Marie Polley, Jeremy Simmons, Monica Boulton and Dr Desi Gradinarova who gave up their time to serve on our steering group. Your expertise and reflections have made this research project richer.

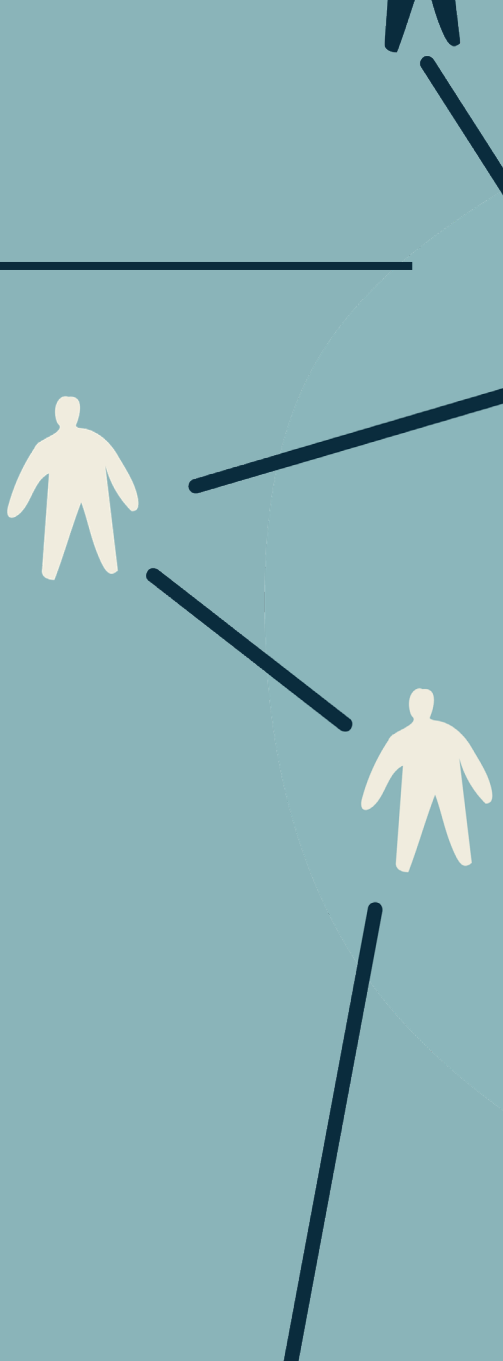
Our thanks also extend to Theos colleagues, especially Dr Madeleine Pennington, along with the Good Faith Partnership colleagues, particularly David Barclay, Claire Fenner Crawley and Jack Palmer-White. You have been a sounding board directing the shape of this project.

Theos and the Good Faith Partnership are very grateful for the support of the Sir Halley Stewart Trust for their generous grant enabling us to conduct important research.

Finally, this report would not be possible without the participation of those we interviewed and spoke with – healthcare professionals, faith leaders and representatives, charity representatives and those participating in activities. Thank you for giving up your time to speak with us and sharing your wisdom and experience.

Marianne Rozario and Esther Platt
January 2025

Foreword



The vision for our National Health Service as set out by its architect - 'From cradle to grave' - is still an oft-repeated cause for celebration. Universal care, free at the point of use, from birth to death, was a radical aspiration that we are rightly proud of.

Seventy-five years later, we are facing an important moment in the health of the nation. We are seeing the persistent and growing inequalities in health outcomes, and inequitable access to care. There is growing consensus that we must look beyond the clinical to address those inequalities, and that the medical model of care that we have requires change. As we prepare to 'shift' towards community based, preventative services, social prescribing is a key tool.

Social prescribing utilises existing community offerings as nonclinical remedies in recognition that some things can be treated both more effectively and more cheaply this way. The particular genius of this is that in doing so, people know each other better; relationships between statutory and community groups are formed and become well-trodden; and when moments of crisis arrive, not only are communities healthier at local level, but more resilient.

There is a faith group present in every community. Indeed, faith observance is higher in areas where deprivation is higher. If we are serious in the task of reducing health inequalities, faith groups are essential partners in this work. As this report sets out, faith groups offer an opportunity that primary care alone cannot.

This is not just in an understanding of people's holistic health, or the high numbers of passionate volunteers, or the material resources they may have to offer. It is trust.

Faith groups have often been rooted in their communities for generations and hold a trust that statutory bodies do not. This trust has been built as faith groups have stepped forward in provision and support of their communities over a long time. Of the institutions around us that have a stake in our health, I expect it would be faith groups that have the greatest insight into what it is to accompany someone 'from cradle to grave'. This makes them vital participants in the improvement of their communities' health, and efforts to build trust between communities and statutory bodies.

This report highlights the essential work already being done by faith groups, and offers practical recommendations and advice to health bodies and faith groups to work more closely together in social prescribing. I hope that it will prompt further collaborative work at neighbourhood, place and system level to work towards interconnected, resilient and healthy communities.

Foreword by the Rt Revd and Rt Hon Dame Sarah Mullally DBE, Bishop of London

Contents

Acronyms

DHSC: Department of Health and Social Care

GFP: Good Faith Partnership

GP: General Practitioner

ICB: Integrated Care Board

ICS: Integrated Care System

NASP: The National Academy for Social Prescribing

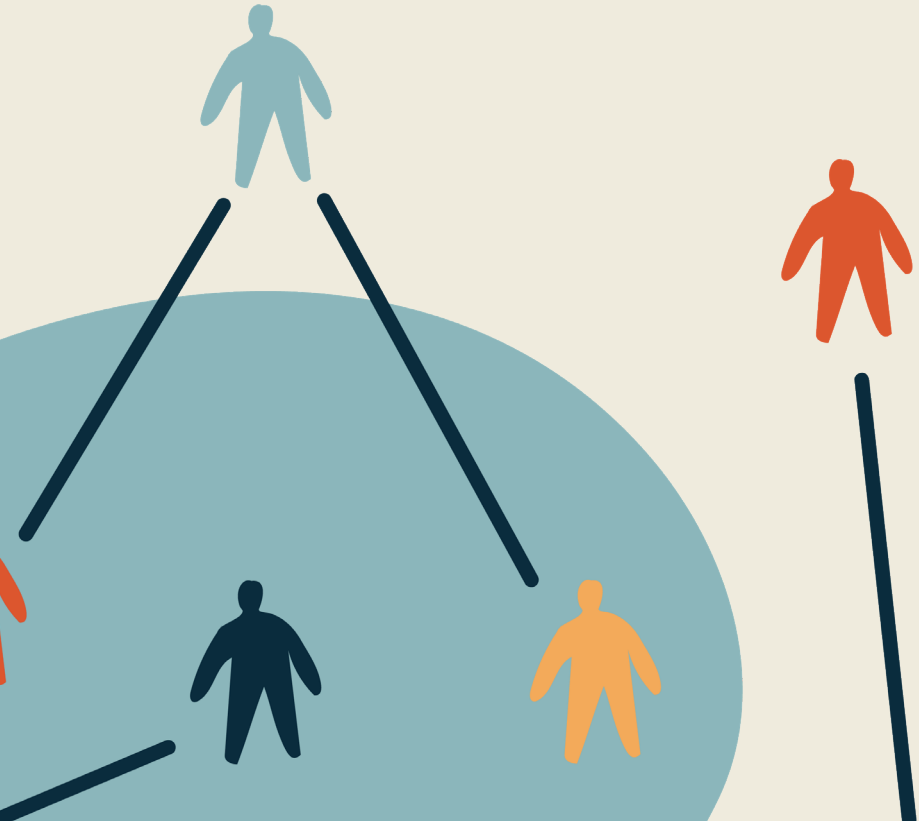
NHS: National Health Service

PCN: Primary Care Network

SPLW: Social Prescribing Link Worker

VCSE: Voluntary, Community and Social Enterprise

Executive Summary



The NHS is overwhelmed and in crisis, but one in five GP appointments are for non-medical reasons. It is also acknowledged that health outcomes are driven by socio-economic factors, including education, income and social support, yet the social factors underlying some clinical needs have not been prioritised and there has been underinvestment in community based healthcare. Today, there is a desire to shift from healthcare as a model of treatment to a model of prevention. Social prescribing – connecting people to community-based activities to benefit their wellbeing – can be part of that preventative solution.

Social prescribing plays a vital role in providing practical support for people who are struggling with loneliness, mental health conditions or financial issues such as debt or unemployment, etc. Along with other community groups, faith groups not only contribute significantly to local social prescribing networks, but with their focus on community, relationship and holistic wellbeing, they can play a foundational role in preventative healthcare through supporting individuals to access the right support early on.

This report found a large number of friendly, welcoming and "referrable" activities are hosted by faith groups – predominantly by Christian churches and charities – across the country. This highlights the multiple assets that churches and Christian groups along with other faith groups bring to social prescribing, including being anchors of the community, having the ability to network and convene within the community, providing resources through buildings and volunteers and offering pastoral and spiritual care.

However, we found a number of challenges preventing a better integrative approach between faith groups and social prescribers. There are communication challenges because faith and health communities use different language to talk about very similar things. It is challenging for faith groups to connect and maintain relationships with the ever-changing social prescribing system. Similarly, link workers and local health practitioners don't know where to go to connect with local faith groups. Furthermore, there are administrative challenges that slow processes down and a lack of funding to keep activities running.

Participants have highlighted the vital importance of relationships. Trusted personal relationships make a big difference in connecting groups with social

prescribing. Across the board, we found that health professionals and faith groups alike were positive about the suitability of faith group activities for social prescribing, with consensus at all levels of the health system that better relationships between the two will help to support more of the people in greatest need.

Despite some of these challenges, health professionals and faith communities appear to be collaborating on social prescribing at a high strategic level as well as at a grassroots level, albeit sporadically throughout the country. This shows that at a both macro and micro level there is consensus that faith groups bring positive results to social prescribing. There is also evidence to show that Social Prescribing Link Workers (SPLWs) are aware of referrable activities and services offered by faith groups. However, this report also found that collaboration is weakest at the middle strategic level, with engagement of faith groups not being strategically pushed from the top to filter down. Whilst there may not be a one-size-fits-all model, a better integrative approach between faith groups and health practitioners could revolutionise social prescribing.

Using the commonly identified three-tiered model of "neighbourhoods", "places" and "systems", we put forward recommendations for relationship-building to achieve a better integrated approach between churches and faith groups and social prescribers.

At a **neighbourhood** level: Faith groups should promote activities and services to SPLWs and GP surgeries, convene forums connecting faith and health and increase social prescribing literacy and engagement amongst their communities. Social Prescribing Team Leads and SPLWs should actively engage local faith communities, participate in their activities, go with their patients to faith-based services and seek out additional funding for such activities.

At a **places** level: Roundtables should be convened between leaders of faith groups, regional church leaders, leaders of charities and PCN clinical directors/ICB leads. Faith groups should designate a health and wellbeing lead advocating for social prescribing. Healthcare professionals should draw on the faith communities they have partnered with on other health initiatives such as the Covid vaccine rollout, encourage preventative strategies in the community including placing SPLWs in churches and employ GP chaplains.

At a **systems** level: NHS leaders, DHSC, NASP and leaders within faith communities should collaborate through existing avenues. Preventative initiatives into the community should be encouraged, including integrating Warm Welcome into social prescribing plans. A 'Faith Lead' should be created within NASP to convene national work and new funding for faith-based activities should be unlocked.

In October 2024, the Health Secretary Wes Streeting MP promised to turn the NHS into a "neighbourhood health service".[1] In order to actualise this vision, the contribution of faith groups must be fully recognised, and relationship-building – within neighbourhoods, places and systems – between faith communities, the NHS and wider healthcare networks must be established.

1 Christopher McKeon, "NHS will become 'neighbourhood health service', Streeting pledges", *The Standard*, 20 October 2024, www.standard.co.uk/news/politics/nhs-government-wes-streeting-health-secretary-labour-b1188909.html

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Recommendations

Recommendations for relationship-building within "neighbourhoods", "places" and "systems"

"Neighbourhoods" (covering populations of around 30,000 to 50,000 people) include groups of GP practices working with NHS community services through the formation of Primary Care Networks (PCNs). "Places" (covering 250,000 to 500,000 people) encompass a town or district which ICSs sit within along with local government, NHS providers, VCSE organisations, social care providers and others. "Systems" (covering populations of around 500,000 to 3 million people) include health and care strategy coming together.[1]

Using this three-tiered typology widely used amongst the health and care system, Theos and the Good Faith Partnership recommend the following to achieve a better integrated approach between churches and faith groups and social prescribing practitioners.

Neighbourhoods

Faith groups:

- Actively and continuously promote activities and services to local Social Prescribing Link Workers (SPLWs) and GP surgeries by sending them lists of what you offer, posting leaflets and posters for them to advertise, and adding them to your monthly newsletter (use our how-to guides for suggestions on how to do this).
- Convene regular forums or discussion groups between faith groups, SPLWs and any social prescribing stakeholders. This will allow for developing better local relationships, sharing of knowledge and collaboratively finding solutions to the needs of the community.
- Ensure your congregation and volunteers know what social prescribing is, and the importance of it (use our how-to guides as a reference).
- Draw on the expertise, knowledge and networks of healthcare professionals in your congregations to work more collaboratively with local health services.

- If possible, designate a community outreach lead within your congregation, who makes an active effort to build a relationship with the local Social Prescribing Team Lead (your SPLW will be able to connect you with this person).
- Invite SPLWs to work from your building or visit on a regular basis to make it a one-stop shop for service users.
- Engage and collaborate with other local faith groups doing social outreach so as to not overlap resources.
- Together with Social Prescribing Team Leads, seek out additional funding for activities and services offered by particular local faith groups, and opportunities for better training for volunteers.

Healthcare professionals:

- For Social Prescribing Team Leads or SPLWs – actively and continuously engage local churches and local faith groups by forming a relationship with the priest/minister, faith leader, charity representative or outreach coordinator. Participate in the activity organised by the faith group so that you understand what is on offer.
- Where possible, initially go with patients to activities run or supported by faith groups or at least communicate with faith groups when individuals are coming to them so that they know who is coming, when and what they might need.
- Together with faith leaders, seek out additional funding for activities and services offered by particular local faith groups, and opportunities for better training for volunteers.

Places

Faith groups:

- Pursue roundtables between relevant leaders of faith groups, leaders of local charities and PCN clinical directors to explore avenues of collaboration.

- Pursue roundtables between relevant regional church leaders (e.g. bishops), CEOs of regional charities and Integrated Care Board (ICB) leads to explore avenues of collaboration.
- Designate a health and wellbeing lead to be an advocate for social prescribing and ensure that any regional faith leader with responsibility for health (e.g. bishop, inter-faith partnership lead or regional church network lead) is aware of social prescribing and can advocate for increased integration.

Healthcare professionals:

- Pursue roundtables between relevant leaders of faith groups, leaders of charities and PCN clinical directors/ICB leads to explore avenues of collaboration.
- Re-connect with faith leads who were collaboration partners over the Covid vaccine roll-out or other health initiatives. Share current priorities for population health and explore possible areas for collaboration.
- Encourage measures that move preventative initiatives out of the GP surgery and into the community e.g. place SPLWs in community settings hosted by churches and faith communities including community cafes and Warm Welcome Spaces.
- Establish GP chaplains as a way of supporting patients through a dedicated listening and pastoral service. Link to The Association of Chaplaincy in General Practice for further advice and support in this.
- Create a regional online database with community activities including faith-based activities and services. Ensure such a database is funded for a long period of time with someone to regularly update it.
- Factor VCFSE delivery of services into future strategy, budget and commissioning plans.

Systems

Faith groups:

- Reach out to existing networks such as FaithAction and ChurchWorks to explore how you can connect with NHS leaders and other health stakeholders.
- Form an interfaith partnership on social prescribing before reaching out to health stakeholders. For example, create health and wellbeing interfaith beacons.
- Work with the Department of Health and Social Care (DHSC) and the National Academy of Social Prescribing (NASP) to integrate Warm Welcome into social prescribing plans through using the Warm Welcome map to identify local community spaces and services that can be networked into social prescribing.
- Work with national faith-based philanthropists to unlock new funding for faith-based activities, finding statutory match-funding where possible.

Healthcare professionals:

- Create a 'Faith Lead' alongside other sector leads within NASP to convene national work.
- Proactively and continuously engage churches and faith leaders in departmental consultations and through existing apparatus like the ChurchWorks Commission.
- Encourage measures that move preventative initiatives into the community by encouraging ICBs and PCNs to draw on the excellent collaborations from the COVID vaccine rollout and other health initiatives and pursue those partnerships in light of social prescribing.
- Work with the Good Faith Partnership to integrate Warm Welcome into social prescribing plans.
- Fund smaller projects and local churches and faith-based services.

1 www.kingsfund.org.uk/insight-and-analysis/long-reads/integrated-care-systems-explained#systems,-places,-neighbourhoods

Introduction

The National Health Service (NHS) and social care services in England are in crisis. Many people are struggling to access GP appointments and waiting lists for physical and mental health services continue to grow. At the same time, for those able to get a GP appointment, 1 in 5 patients reportedly have a problem that is not clinical but social.[1]

Reportedly, social and economic factors and physical environment together make up 50% of health outcomes.[2] Therefore, medicine can't solve the problem alone; community and relationships need to be part of the solution. Lord Darzi's recent report, published in September 2024, stresses the need to prioritise neighbourhood level care, prevent ill-health and tackle health inequalities. Investing in the community, he believes, is part of the solution. This is where social prescribing comes in.[3]

Social prescribing helps patients by referring them to local community activities to tackle the social and relational needs underlying their health issues. It plays a vital role in providing practical support for people who are struggling with loneliness, low-level mental health conditions and financial issues such as debt or unemployment. Faith groups contribute significantly to local social prescribing networks, and with their focus on community, relationship and holistic wellbeing, they can play a foundational role in preventative healthcare.

In October 2024, the Secretary of State for Health and Social Care Wes Streeting MP promised to turn the NHS into a "neighbourhood health service".[4] In order to make good this vision of "a revolution of prevention" and a "Neighbourhood Health Service", the contribution of faith groups must be fully recognised and proactive collaboration between faith communities, the voluntary sector and the NHS must be established. Theos and the Good Faith Partnership (GFP) believe such a collaboration, at the level of "neighbourhoods", "places" and "systems", has the potential to revolutionise social prescribing, resulting in success stories like those we have encountered during our research.

About the research

This report presents the findings of a research partnership between Theos and the Good Faith Partnership (acting as the secretariat to the ChurchWorks

Stories

Elenor is a 70-year-old woman from Lancaster who lives with her disabled daughter. Her husband of over 50 years died during the Covid pandemic and she has no other family or close friends still living. A local GP connected Elenor to volunteers at a local church who were offering to regularly call isolated members of the community. This was a lifeline in a time when she was feeling the loneliest – having someone on the phone to talk to weekly was what she needed.

Cecilia is a single mum from Poland currently living in temporary accommodation in London and experiencing economic hardship. With no family to support her, she is unable to work due to caring for her 1-year-old daughter. The local council referred Cecilia to a local church who offer a weekly foodbank, baby clothes and a café. She was very anxious and stressed before, but now feels like a weight has been lifted from her shoulders.

Bob is a 90-year-old man who lives by himself in a small flat near Manchester. At the start of the year, his energy supplier wrongly mailed him a bill for over £3000 which resulted in him considering taking his own life. A pastor of a local church found Bob walking down the street one day and invited him for a cup of tea at the church café. Social Prescribing Link Workers, who work from the café, were able to help Bob appeal against the extortionate energy bill and in addition ensured the council fixed the mould in his flat. Bob is now a regular at the church café, participating in board games until closing time.

Commission) to explore the role of churches and faith groups for social prescribing across England. The research aimed to understand the scope of faith engagement in social prescribing through evidencing activities and services run or supported by churches or faith groups that were connected to NHS or wider social prescribing networks. In doing so, it has uncovered the advantages of churches and faith groups becoming more integrated into social prescribing, as well as some barriers preventing a more integrated approach. We suggest that by forming better relationships between faith groups and healthcare practitioners – through active networking, engaged partnering and forward planning – social prescribing can be revolutionised at a "neighbourhoods", "places" and "systems" level.

Our key research questions were:

- What are some examples of social prescribing groups or activities run by or supported by faith groups?
- At a local and national level, what is the relationship between faith groups and social prescribers?
- What are the advantages of a relationship between faith groups and social prescribers?
- How could relationships between faith groups and social prescribing networks be improved or developed into a better integrative approach?
- What are some of the concerns and challenges facing faith groups engaging in social prescribing?

The research was conducted between October 2023 and July 2024 in person and online throughout England, comprising the following elements:

A ***scoping survey*** was completed by 51 SPLWs throughout England of which 33 were employed by Primary Care Networks, 15 by the VCSE sector, and the remainder by local authorities or other agencies. They responded to a list of 14 questions about their awareness of and referral to activities run by or supported by faith groups, the strengths of engaging with faith-based activities and concerns that have arisen. Given the sample size, the findings from this survey should be taken as indicative rather than conclusive data.

Following this, a series of ***37 semi-structured interviews*** were conducted by Theos researchers between November 2023 and April 2024. There were 16 interviews with NHS social prescribing practitioners and other healthcare professionals, including Social Prescribing Team Leads, members of GP leadership teams, the National Academy of Social Prescribing (NASP) leadership team, local authority leads, PCN leads, retired and current GPs, SPLWs, community connectors, population health leads and representatives from organisations supporting carers. In addition, there were 16 interviews with faith leaders or representatives which included a spectrum of religions: Christian pastors and church leaders, Christian charity CEOs, staff and volunteers, along with representation from a Sikh community centre, Muslim charity, a Hindu individual and Buddhist volunteer chaplain. Five interviews with service users were conducted throughout the country in Burnley, Lancaster, London, and Sussex.

In addition, ***3 focus groups*** for social prescribing practitioners were organised in the Black Country, Lincolnshire and Hampshire. This resulted in 10 participants in total with a mix of participants including link workers, senior link workers, community connectors, church-based social prescribers, strategic leads, primary care health leads, mental health leads and faciliators for adult daycare services for those with disabilities.

To showcase examples of best practice of faith-based social prescribing activity, several activities and services were visited throughout England. These ***case studies*** were based in Birmingham, Bristol, Burnley, Kidderminster, Lancaster, Lincoln, London, Northampton, Sussex and nationally. The activities we visited were predominantly Christian. Throughout these visits, Theos researchers used ***participant observation*** as a tool to understand their impact which included informally talking with several service users and volunteers.

Chapter One of this report sets out the context of social prescribing and provides a more substantive understanding of its positives and challenges based upon existing literature. Drawing on our original research, ***Chapter Two*** explores the advantages and opportunities of churches and faith groups working with healthcare professionals in social prescribing, by showcasing existing faith-based activities and services that SPLWs in England refer to and by highlighting four features of faith groups: (1) “anchors of the community”, (2) networks: convening power, (3)

resources: buildings and volunteers and (4) pastoral and spiritual care. ***Chapter Three*** discusses seven challenges that prevent a more integrated approach between faith groups and healthcare professionals in social prescribing: (1) mismatched language; (2) limited connections; (3) stretched capacity; (4) complex and slow processes; (5) no single database; (6) no additional funding or training; and (7) a fear of religiosity. Finally, ***Chapter Four*** looks at ways of active networking, engaged partnering and forward planning drawing on examples of each between faith groups and social prescribers. Alongside the recommendations put forward by this report, it argues for better relationships between faith groups and healthcare professionals within "neighbourhoods", "places" and "systems".

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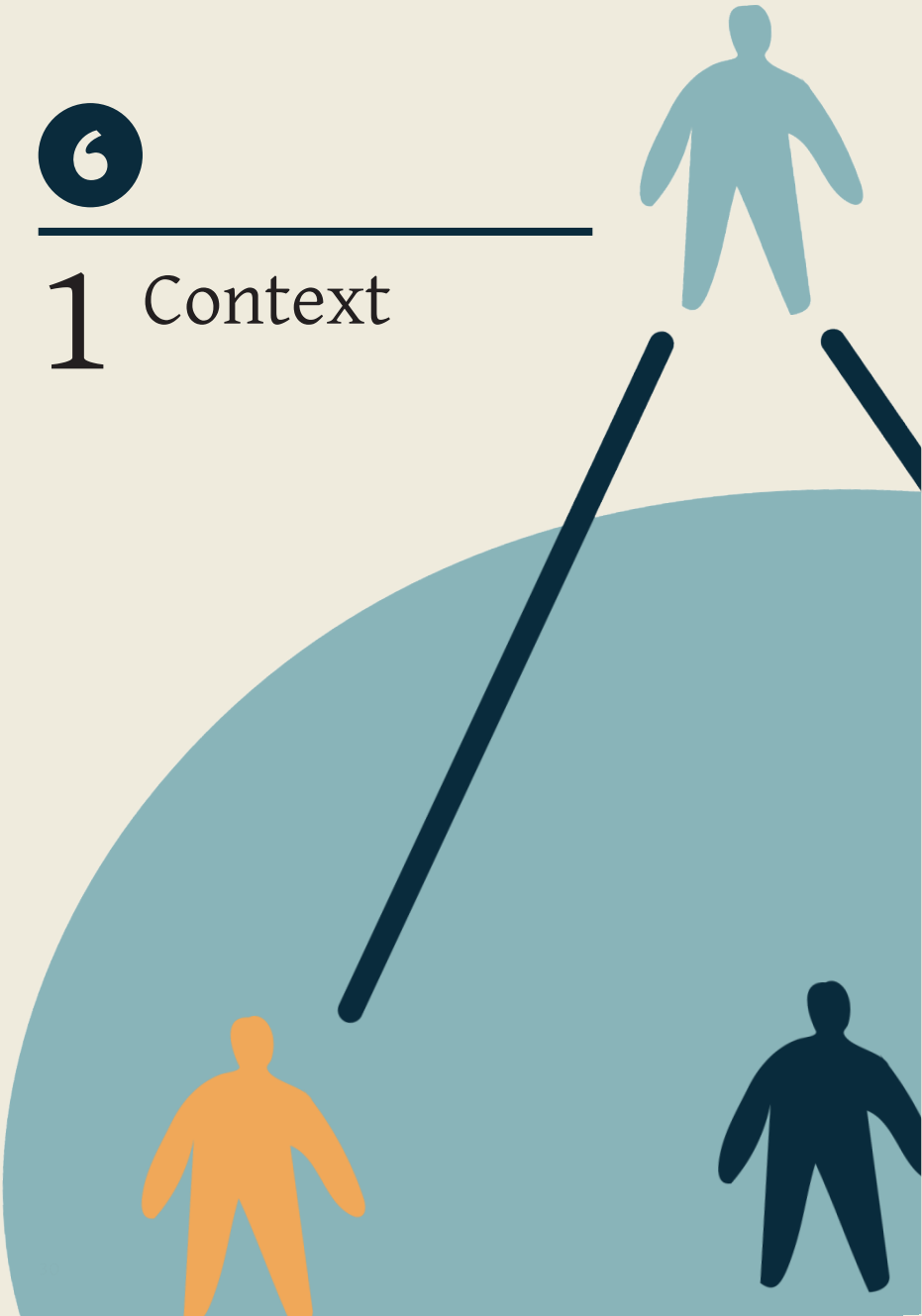
1 www.england.nhs.uk/2023/10/expanded-nhs-support-available-for-patients-in-gp-practices-across-the-country/

2 www.england.nhs.uk/blog/acting-on-the-wider-determinants-of-health-will-be-key-to-reduced-demand/

3 www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care

4 Christopher McKeon, "NHS will become 'neighbourhood health service', Streeting pledges", *The Standard,* 20 October 2024 www.standard.co.uk/news/politics/nhs-government-wes-streeting-health-secretary-labour-b1188909.html

1 Context



The Lord Darzi report, a 2024 report investigating the state of the NHS at the request of the newly-elected Secretary of State for Health and Social Care, found that many of the social determinants of health which included poor quality housing, low income and insecure employment have resulted in the NHS facing "rising demand for healthcare from a society in distress".[1] Lord Darzi stressed that this was because "we have underinvested in the community".

He found that

> *As of June 2024, more than 1 million people were waiting for community services, including more than 50,000 people who had been waiting for over a year, 80 per cent of whom are children and young people. By April 2024, about 1 million people were waiting for mental health services.*

Given this current situation, Lord Darzi desires to see the NHS go from "diagnose and treat" to "predict and prevent". Emphasising Lord Darzi's findings, Health Secretary Wes Streeting MP also committed to three "strategic shifts" for the NHS in the next 10 years which included moving care from "hospital to community", from "sickness to prevention" and from "analogue to digital".[2]

Social prescribing can be part of the response to the renewed focus on preventative neighbourhood healthcare.

What is Social Prescribing?

Social prescribing is, according to the international definition given by the Delphi study:

> *a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs, and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription: a non-medical prescription to improve health and wellbeing, and to strengthen community connections.*[3]

Other definitions or models of social prescribing exist.[4]

NHS England adopted social prescribing as one of the six pillars of their "Universal Personalised Care'" strategy in 2019.[5] They believed that social prescribing

and community-based support would benefit up to an estimated 900,000 people. The NHS "Universal Personalised Care" model recognised that in order to improve health, it would be necessary to go beyond the clinical side of medicine and connect "people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing".[6]

NHS England recruited more than 1000 trained SPLWs between 2020-2021 with a further increase planned for 2023-2024.[7] SPLWs, after receiving a referral usually sent by a GP, nurse, or healthcare professional, "link" people to non-medical activities and services to support their unmet needs with the aim of benefitting their health and wellbeing. SPLWs refer individuals to local activities provided by voluntary and community sector organisations. Such activities include art classes, befriending schemes, cooking, gardening, weight-management and nutrition interventions and a range of sports and exercise groups. Individuals could also be referred to advice services via local authorities or charities for welfare entitlements, housing, employment or volunteer opportunities or debt management.

Before the adoption of social prescribing into the NHS, it is reported that family doctors in Tower Hamlets have been practicing social prescribing since around the 1990s and Health Leeds has operated a social prescribing model for more than 20 years.[8] The Local Government Association suggests there are many examples of arts and exercise-on-prescription services dating back to the 1990s, as well as explicitly mentioning the social prescribing scheme in Bromley-by-Bow in London which was founded in 1984.[9]

Frank is an 80-year-old former veteran from Lancaster. He recently lost his wife, and his sons and grandchildren live hours away. Frank manages to live independently but struggles walking to the supermarket and doing household tasks. He doesn't like asking for help. Frank has never been a churchgoer but very much appreciates his GP putting him touch with volunteers from a local church who do his weekly shop and help with household tasks.

Case study

Riverside Vineyard Church, London

As part of the mission of Riverside Vineyard Church in Feltham, London, the congregation set up Riverside Compassion where they are committed to demonstrating their Christian belief in the love of God for everyone.

They offer numerous services including:

- Storehouse - A foodbank for those in need, as well as offering children's clothing, equipment and toys.
- ESOL classes – As language is often a barrier, they provide free conversational English language classes for those that don't have English as their first language. This often benefits people when looking for a job, with administrative tasks or in living in the UK in general.
- Job Club – In partnership with Christians Against Poverty (CAP), they run a Job Club that aims to give job seekers the skills to step confidently into employment. They offer practical sessions on topics including identifying personal skills and strengths, CV writing and interview techniques, plus individual coaching and group support time.
- Partnering with CAP and Community Money Advice, they offer free advice on how to budget and manage money better.
- Café – Every Thursday they have a café providing free refreshments, an opportunity to speak with volunteers and the chance to speak with other service providers.

What are some benefits and challenges of social prescribing?

Economic savings

Social prescribing is argued by some to be "an effective way of addressing social determinants of health while potentially reducing healthcare demand and costs".[10] There is even evidence suggesting that social prescribing reduces the financial strain on the NHS in the long term.[11]

Evidence suggests that there is a positive net social value for money invested: £3.42 return per £1 invested.[12] Additionally, there is evidence that it alleviates pressure on services, for example 60% reduction in GP contact times and 25% reduction in A&E attendance.[13]

However, others emphasise that social prescribing should not be viewed as a "silver bullet" to fix the pressures surrounding the healthcare system or used as a treatment for complex problems and social issues for which it may not be appropriate.[14] What is regarded as medicine and what is regarded as social care become entangled in social prescribing, and this blurring of the budget between health services and social services can be problematic.[15] Furthermore, some studies suggest that, despite several systematic reviews, the evidence of cost effectiveness of social prescribing is mixed. Studies are variously limited by the absence of a comparison group, the lack of follow-up periods and lack of clear objectives.[16]

Wellbeing impact

Beyond alleviating healthcare demand and costs, growing evidence suggests that social prescribing can lead to a range of positive benefits for one's health and wellbeing. In general, it is believed that keeping individuals involved in community life, keeping them active and improving their social connection is good for both health and wellbeing.[17] Evidence from examples of social prescribing suggests improvements in the quality of life, emotional and mental wellbeing and a decrease in levels of depression and anxiety in a patient who accesses these activities. For example, a community connector scheme in Bradford reported improvements in patients' health-related

quality of life and social connectedness. Similarly, a social prescribing scheme in Shropshire, evaluated between 2017 and 2019, found "people reported statistically significant improvements in measures of wellbeing, patient activation and loneliness".[18] This case study also found that GPs appointments were down 40% compared to the control group three months after the study.

At the same time, numerous academics argue that the lack of evidence (and in some cases low research quality)[19] on the impact of social prescribing is insufficient to provide definitive guidance on what works.[20] It is suggested that whilst academics and researchers have evaluated the potential of social prescribing initiatives, it is "too soon" in its rollout to evaluate its successes.[21]

Ana is a 50-year-old woman from Australia who now lives in the South of England with her husband. Ana loves to cook and takes real pride in cooking for her family and neighbours. However, she lost her sense of taste and smell due to Covid, and it still has not returned. Due to this, Ana felt like she has lost a sense of herself, and subsequently became depressed and isolated. After being referred via a link worker to a Christian community choir, Ana is finding a new love of singing and sense of community.

Faith groups for social prescribing

As above, there is widespread recognition of the role that communities play in improving health and wellbeing. Communities offer places for social connectedness which alleviates social isolation and loneliness, and communities have many services and activities ready to be used by individuals.[22]

Faith groups form part of the community-based response, and we believe have the potential to revolutionise social prescribing. However, there is currently limited literature on the role of churches and faith groups for social prescribing. Especially instructive is the Faith Action and VCSE report, *Inclusive Social Prescribing – Learning from engagement with grassroots VCFSE organisations* (2022), which engaged over

Case Study

Church on the Street, Burnley

Church on the Street (COTS) in Burnley is a faith in action charity that aims to "lift people out of poverty while providing a space for worship". Their activities are open to all and they like to consider themselves as a place that stands in the gaps of society to help those in need.

COTS was founded by Pastor Mick from the pavements outside McDonalds in Burnley. He had experienced first-hand the effects of drug addiction and poverty in Burnley, before turning it around and now dedicating his life to help others going through similar experiences to his own.

Now, COTS' vision is to "see the light of Jesus Christ shining in the gaps of injustice and the poor raised out of poverty". COTS runs numerous groups including a space for a café where people from all backgrounds gather regularly, forming friendships and playing board games with one another. They offer women and men's sessions and knit and natter groups. At their café, SPLWs from the area are present regularly to help those that walk through the door. In this way, health goes directly to the need within the community instead of waiting for those in need to find their way to the GP surgery.

25 faith and community organisations involved with social prescribing schemes. This study stressed the importance of faith communities familiarising themselves with local healthcare workers and their challenges and being clear on their assets in response to these challenges.[23]

Over the last few years, the ChurchWorks Commission have also brought together key stakeholders working at the intersection of faith communities and social prescribing. In their webinar with NASP in December 2022, they articulated the strengths churches bring to social prescribing schemes which included: strong community links, being skilled in welcoming and befriending, a potentially reduced stigma compared to statutory services, a deeper access to certain communities and a community-focused physical space.[24] The ChurchWorks Commission have played a proactive role in showcasing the value of church engagement in social prescribing and encouraging more churches to link with their local SPLWs.

In the next chapter we will turn to explore how churches and faith groups are contributing, and could contribute further, in greater detail.

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2 Faith provision in social prescribing

This chapter showcases existing faith-based activities and services that SPLWs in England refer to, and highlights assets and resources faith groups provide to social prescribing.

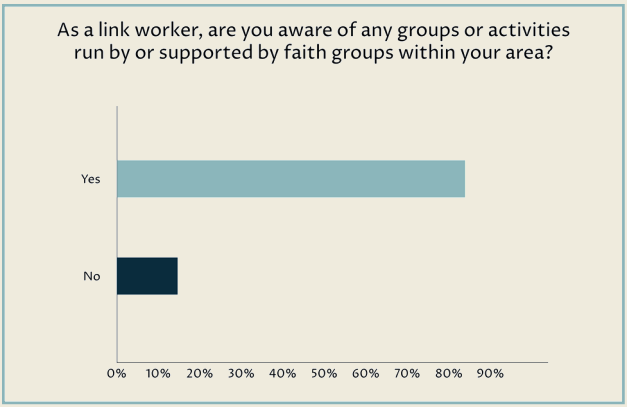
What activities and services do churches and faith groups provide?

Churches and faith groups offer numerous activities and services that SPLWs refer to. Throughout our survey to SPLWs and interviews we identified the following examples:

- advice groups
- arts and crafts courses
- baby groups
- befriending
- bereavement groups
- cafes and coffee mornings
- care home visits
- carer/support groups
- chaplaincy
- choirs
- Christmas gifts
- clothing banks
- cooking classes
- counselling
- creative and drama groups
- dance classes
- debt support services
- debt/poverty courses
- dementia groups
- English-language classes
- events and outings
- exercise classes
- food banks
- gardening groups
- groups for refugees
- homeless outreach
- knit and natter groups
- listening services
- lunch clubs
- mindful doodling
- mums & tots' groups
- spiritual support
- sports activities
- Warm Spaces
- washing machine facilities
- wellbeing groups
- women's and men's groups
- yoga classes

One of the questions we asked in our survey to SPLWs was, "Are you aware of any groups or activities run or supported by faith groups?". Promisingly 85% of

link workers responded "yes", highlighting that link workers are very aware of the activities provided by faith groups.



The Assets and Resources of Churches and Faith Groups

SPLWs were asked in our survey "If any, what are the strengths of engaging with activities run or supported by faith groups?". The top two pro-active responses were "community" (14 out of 52 link workers) and "support" (11 out of 52 link workers). Other responses were "welcoming", "service", and "activities". From these results, it appears that SPLWs value faith groups and that they recognise the strengths of the activities and services they provide.

Drawing on these answers as well as our interviews – both health and faith-based – we found several key features of the outreach of faith groups, reflecting the most common resources that pro-active churches and faith groups draw upon to improve the wellbeing of those in their communities. We can group these features into four themes: (1) "anchors of the community", (2) networks: convening power, (3) resources: buildings and volunteers, and (4) pastoral and spiritual care.

This section will consider each in turn, uncovering the ways in which churches and faith groups are working with SPLWs, directing their assets to form a better integrative approach. In highlighting these features, it is hoped that a) churches and faith groups realise their assets and resources and gain a better understanding

of what they offer, and b) healthcare practitioners engage with faith groups more proactively, having a better understanding of what they bring.

1. "Anchors of the community"

Multiple interviewees spoke of churches and faith groups as knowing and being known by their communities. As one interviewee put it, "they are an anchor point in the community".[1] Similarly, a lead representative of GPs said, "the penetration that the faith-based organisations have, with their local community… go far, far, far deeper than anybody".[2] Their ability to do so means that they are often considered as trusted sources in their communities; places and people that the community trust. As a Social Prescribing Team Lead stated, "they're a trusted source aren't they? The church leader or Reverend, whatever they are, they are the trusted person".[3] That level of trust within a community along with that ability to know the community is something that "cannot be measured how important it is".[4]

As "anchors of the community", churches and faith groups know the need in their communities. In fact, we found several instances of representatives from churches referring people to social prescribers from within their communities. As one SPLW stated,

> *So when we're running a food bank, for example in a church, a lot of the congregation will come to the pastor and say, I'm really struggling to feed my family, and he'll refer them in. So, I think a lot of faith leaders do social prescribing anyway. And they did it long before it was called 'social prescribing'. It's just helping people, isn't it?*[5]

Similarly, a lead representative for NASP observed that,

> *…social prescribing is just a modern term for stuff that had always been done, and faith groups have been absolutely at the vanguard of that. So whether it's been the historical issue of faith and providing charitable support, shelter and succour for the vulnerable… one of the first pillars of social prescribing…[it] is something that historically came from the churches in particular in the UK, but religious groups everywhere have led on the concept of donation of significant parts of one's income towards providing benefit to others.*[6]

Case Study

Ebenezer Church, Bristol

Ebenezer Church in Bristol has provided a Warm Welcome space in different ways in their church building over the last few years. There has been a Kintsugi Hope wellbeing group, a weekly community café with affordable cakes/light lunches, senior citizens group, and an After School Hangout. These have all been different spaces for a variety of groups in the local community to connect with each other and build relationship in a warm space. All are run by local volunteers with a heart to show generosity, welcome and hospitality to all. Recently, a group of young single mums shared about this being a safe space where they felt welcomed and not judged. Social prescribers have found that spaces of connection and community like their developing church community hub have made a huge difference to people's wellbeing.

Numerous interviewees echoed this sentiment stating that faith groups, especially churches, stand in the gap of unmet needs by statutory agencies. According to a SPLW in Burnley, "if there wasn't any (churches) in Burnley... truthfully, as an organiser, as a place, Burnley would be in a catastrophic state".[7]

Multiple church-based interviewees spoke about the longevity of the social outreach of churches. One inter-faith community worker stated that the common factor of faith-based social action was

> *longevity, it's the fact that they're here. And they stay here. And they're here from heart conviction rather than cash incentive, you know, which..., as soon as the cash gets cut, which [it] inevitably does, then people jump out of the way. These people are here for the long haul.*[8]

This idea of longevity in faith group's work was in contrast to healthcare settings that changed frequently – a barrier that will be expanded upon in the next chapter.

2. Networks: convening power

Beyond being "anchors of the community", churches and faith groups are also well networked amongst each other and the voluntary sector and have a considerable ability to convene action within the community. Several interviewees spoke of initiatives whereby faith groups partnered with health networks and stakeholders locally on issues that either explicitly or implicitly encompassed social prescribing. For example:

> *A GP in East London spoke about a Christmas pop-up initiative for families in a library with stalls for information about health visiting. GPs in the area had begun to recognise signs of poverty in the community to the extent that parents were not able to feed their children. Health services, community groups, and faith groups joined together to offer a day of activities and awareness to the community. At it, a local church provided all the food for the children – feeding around 600 children – and did so because they felt in that way at least it was one less meal parents had to worry about.*[9]

A community inter-faith worker in Brighton spoke of a pilot initiative between a local Muslim group, a non-denominational church, and an Anglican church. They began to work with each group, putting on training about social prescribing, designating social prescribing advocates in each, and forming relationships and networking. Through this pilot initiative they witnessed Brighton become an area better equipped to help the individual through a more collaborative approach.[10]

3. Resources: buildings and volunteers

Another key feature that churches and faith groups offer is resources through a) buildings; and b) volunteers. Both these assets are of great advantage to link workers who are in need of activities and services in locations at the heart of communities and run by people willing to care for their patients.

> Churches are places that tend to be located at the very heart of towns. A local authority lead commenting on churches said, *...they tend to be 1) very recognisable and 2) they tend to be in the heart of every community, centre or district centre, that includes even remoter communities where actually they might be the only community facility that's available. There is no other community infrastructure in these spaces, or the community infrastructure is located some distance away.*[9]

Similarly, a social prescriber from the voluntary sector also commented, "[The churches have] got a building, the fact that they've got a building is a massive thing".[10]

Churches and faith groups have buildings to offer, whilst healthcare services are resource tight. The social prescriber went on to say, "because in the NHS at the moment estates is a massive issue. There is not enough...".[11] She described how through social prescribing, a lot of new roles have been developed, but there was a lack of planning about where these new roles would be placed, where they would have appointments or see patients, and the NHS does not have enough infrastructure to house the new appointments. One solution to this is to utilise church buildings, by

Case Study

Broadmead Community Church, Northampton

Broadmead Community Church is a Baptist church in Northampton that also serves as a hub for local community groups. Social prescribers work with Broadmead Community Church and refer patients to some of their groups.

Activities they offer include:

- Just B – Wellbeing Café
- Table Tennis
- Baby Stars and Little Wonders (Parents/Carers and Children under 5)
- ROC Café – Wellbeing Café – Years 10-13
- TMX – Youth group – Age 8-13
- Good Companions – Club for the retired and lonely with lunch and activities
- Get Up and Go – exercise group
- Kintsugi Hope – Mental health/wellbeing course
- Living Well Carousel Course – Occupational health wellbeing course

From Sept 2021 to Sept 2022, Broadmead Community Church held local community conversations with GPs and social prescribers, discussing the local needs. Out of this came 5 workshop groups which revealed a need for conversation around social isolation and mental health. From this, their "social prescribing and voluntary sector" forum started.

Since 2023, it has been rebranded as "the community collaborative forum", runs bi-monthly and now includes members from St Albans Church, Abington Ave Church, LAP Lead, Public Health, Police Engagement Officers, Abington libraries, GPA, Living Well and C2C. The forum enables networking, builds relationships and trust, allows for the sharing of information and expertise, helps with problems that people are dealing with and enables working in partnership.

At Broadmead Community Church in Northampton they have set up a public forum as a place to gather bi-monthly stakeholders from churches, the voluntary sector, the NHS, local area partnership leads, GP representatives, police representatives and others. It is an informal space where relationships are being developed, good practice shared, local problems discussed and solutions for identified problems thought through collaboratively. As the representative of the organising church commented, it was a place to be "open and honest" and that people wanted it to continue as they found it "really informative".[11]

faith groups inviting link workers to work from and be based on their premises. She went on to say,

> *...through those actual physical buildings, there's an incredible opportunity there for the church at a strategic level, to go to the ICB and say, we have got all of these buildings now. How about it? Why wouldn't you have your social prescribing team based from one of those?*[12]

The House of Good: Health, published by the National Churches Trust in 2024, evidenced that the UK's churches take "an immense amount of pressure off the NHS and provide essential support services that it would cost an extra £8.4 billion a year to deliver" which is equivalent to nearly 4% of UK health spending.[13] However, they strongly argue that church infrastructure is dangerously underfunded which risks impacting the support churches give to the NHS.

Beyond infrastructure, faith groups also tend to have a body of volunteers willing to help. A local authority lead commented that these volunteers were simply there due to their "genuine desire to help. And that, you know, that resource, and that willingness of people to help can't be underestimated".[14] These volunteers are also often passionate about the cause they are helping with and are people who know the service users and have been based in that community with them. A leader of a social prescribing organisation mentioned about faith groups,

They've got a ready pool of very highly motivated passionate volunteers, a lot of whom have been around for years and years and years as part of that community. They have an established community. And that is a fundamental thing for a lot of the patients that we're working with.[15]

4. Pastoral and spiritual care

A further asset of churches and faith groups, identified in the interviews, is their provision of pastoral and spiritual care. This essentially is a preventative role where people are able to access advice and pastoral support to prevent escalation to more serious issues.

Churches and faith groups through their social outreach, whether it is directly linked to social prescribing or not, do it because they care about the wellbeing of the individual. One Christian leader who runs social prescribing activities in their church stated,

...we're not just processing numbers, we're not just bringing people in and ticking the box and churning them out the other end, we actually take time with people, we do offer that holistic approach.[16]

He went on to speak about the values they hold to – worth, hope, relationship, holistic approach, and empowerment – and how they treat people with dignity and honour because they are made in the image of God.

One idea that is being encouraged that showcases the spiritual and pastoral support of churches is the concept of GP chaplains. These chaplains are similar to those currently working in hospitals and hospices, but instead sit within or work directly with GP surgeries. A retired GP we spoke to, who is now a keen advocate for GP chaplains, stated,

It always struck me as being something of a conundrum and a paradox that chaplaincy, which provides spiritual care, was available in secondary care in hospitals, hospices, and so on, as a recognised need – indeed, some NHS documents say that all NHS patients should benefit from, or at least have the opportunity, for access to spiritual care – yet within general practice, and I was a

> *GP, which sees 90% of the traffic day by day, there's by and large no chaplaincy, no spiritual care. And that struck me as being a conundrum.*[17]

A GP chaplain service, according to our interviewee, would be a dedicated careful listening service that helps people with connections in their life including relationships with loved ones, connections in their local community, as well as possibly connections with a God or transcendence.

Derek is a recovering alcoholic from London. He has also suffered with his mental health for most of his life. He has tried time and time again to get clean but has slipped in and out of alcohol abuse all his life resulting in most of his family and friends disowning him. Derek really wants someone to talk to and was referred by the GP to a local church who provide a space for 1-2-1 conversation. He appreciates the space to talk, and that they have offered him additional support through their job club to find work.

Why do faith groups support social prescribing?

There is a complementarity between the intended aims of social prescribing and the purpose and provision of social outreach of faith groups – they both desire a holistic care of patients. As one healthcare professional put it,

> *...a primary advantage is for the individual patient - that they're getting holistic care, they're not just getting one need met, but they might get two or three needs met. So that's the primary advantage*[19]

Faith groups desire the holistic care of individuals in their communities. Churches and faith groups are places that are already providing activities and services, of benefit to the wellbeing of the individual, in communities throughout the country and have a mission of caring for those in need. Several people we interviewed remarked that the NHS did the medical side of care well, but did not do the community side of care as well. A retired GP commented that when he was practicing, he dreamed of having a

"holistic integrated approach with others who are providing some sort of community-based care in the locality of the surgery".[20]

More generally, the premise behind social prescribing fits with the Christian outlook of "loving your neighbour'". This idea is reflected in the Catholic social teaching principle of "solidarity" which requires individuals within communities to care for the wellbeing of the other, committing themselves to the "common good; that is to say, to the good of all and of each individual, because we are all really responsible for all".[21] The notion of "loving your neighbour" also featured in a previous Theos report, *Doing Good*[22] which speaks of a "Christian social liturgy". This is "a simultaneous expression of love of God and of neighbour, a way of worshipping God through finding and serving him in others." Such an approach was expanded further in Theos' *Growing Good*[23] report suggesting that "congregational social action" is "relational", "incarnational" and "spiritual". "Relational" as it is oriented towards the building of communities and interpersonal relationships and not simply a provision of services. "Incarnational" in that it emphasises being part of a community and not a client/provider relationship. "Spiritual" by it being motivated by collective and individual religious commitment.

Other faith groups also desire to care for those in their communities. In Sikhism, "sewa" involves acting selflessly and helping others without any personal gain or reward. "Tzedakah", a Hebrew word for charity and justice, is seen in Judaism as an obligation Jewish people have with God to help others as an act of generosity and justice. For Muslims, "sadaqah" is a voluntary charitable act towards others, whether through generosity, love, compassion or faith, to please God.

Conclusion

These four assets of churches and faith groups – (1) anchors of the community, (2) networks: convening power, (3) resources: buildings and volunteers, and (4) pastoral and spiritual care – are resources which faith groups can draw upon in their social outreach. SPLWs, proactively looking for community activities, should look at the activities and services of faith groups – and the assets they bring – which could potentially result in a more effective outcome for social prescribing. However, there are also some barriers preventing a more integrated approach, to which we now turn.

Case Study

GP Chaplains

A London-based GP shared with ChurchWorks Commission her perspective on the idea of GP chaplains.[18] Reproduced here with permission.

To say that General Practice in 2024 is an intense and busy environment doesn't start to give a sense of the context... Post pandemic inner-city London is on the edge. Everyone's on the edge. My colleagues are definitely on the edge and that is primarily because the need is so huge and the suffering is very real.

Like Brenda, who lost her mum on Christmas Day. She had had a lifetime of trauma and chronic health conditions. What she needed was space to process her loss, someone to listen who wasn't involved and was comfortable in talking about not just death, but making space to explore questions about why it happens; what happens next for her mum and for her.

Or the businessman who had always pushed himself to the limit. He'd always worked hard at his therapy and was making real changes in living sustainably but couldn't find real worth and often felt a sense of not being good enough. Yes, he needed good mental healthcare; he also needed time and encouragement to think about his identity.

Or the woman who has finally got beyond early pregnancy but is terrified about another miscarriage; or the one whose husband has had an affair but wants to carry on as normal when everyone else knows.

It's not just that we are not resourced to spend the time that these people need; despite spending long hours with them, it's not enough. It is also that they need something that we are not trained to provide. Healthcare isn't just about physical or mental healthcare; it's also about social healthcare; the issues around relationships, money, work, creativity, housing etc. But the piece that so many people forget is the spiritual healthcare, what gives meaning and purpose to life. This is the "why" questions, the big life events like births, deaths, losses and so many issues that are very hard to address in psychological therapy because they pertain to the meaning we ascribe to life and the world. Primary care chaplains do not tell patients what should give their life meaning; just like social prescribers don't tell patients who to be in

relationships with. But primary care chaplains do enable patients to explore what that meaning might look like for them and to help them live full lives within this.

The Mission Practice has had a chaplain for 25 years and he has been closely involved in many patients lives from births to deaths and funerals. Since October we have also welcomed Louise Cathrow, who is a volunteer chaplain. We are so fortunate that she has given her time to us and is already working closely with patients and starting to connect to local churches where they are best placed to support spiritual and pastoral needs and provide the community that will hold and support in the longer term. She has been fully trained by the Association of Chaplaincy in General Practice and is able to bring that expertise to our team. She is already exploring unmet needs amongst our practice population, like support for parents of children with neurodiversity.

We would love to see more professionals from local spiritual communities partner with us in this way. We want to see all our patients live life well because they are spiritually healthy and are supported to do this within their own neighbourhoods. We know that so much goes unsaid in our society which tends towards increasing isolation and individualism. We want to catalyse conversations that really matter about the big issues of life; in safe spaces; so that people can find relationships that are life giving, hope filled and can move towards fullness of life.

1 Participant interview 28.

2 Participant interview 8.

3 Participant interview 7.

4 Participant interview 19.

5 Participant interview 11.

6 Participant interview 16.

7 Participant interview 27.

8 Participant interview 35.

9 Participant interview 18.

10 Participant interview 33.

11 Participant interview 33.

12 Participant interview 33.

13 www.nationalchurchestrust.org/house-good-health

14 Participant interview 18.

15 Participant interview 33.

16 Participant interview 32.

17 Participant interview 36.

18 www.churchworks.org.uk/news/experiences-of-a-voluntary-chaplain-in-primary-care

19 Participant interview 36.

20 Participant interview 36.

21 St. John Paul II, On Social Concern, Sollicitudo rei Socialis, no. 38.

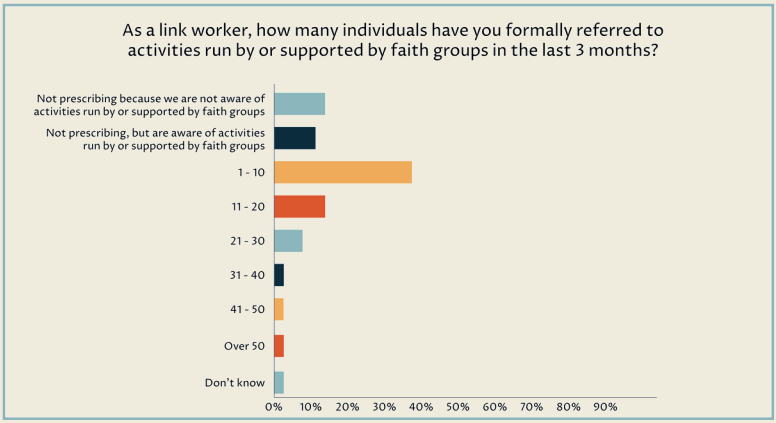
22 Nick Spencer, Doing Good: *A Future for Christianity in the 21st Century* (London: Theos, 2016), available online at: www.theosthinktank.co.uk/cmsfiles/archive/files/Doing%20Good%205.pdf

23 Hannah Rich, *Growing Good: Growth, Social Action and Discipleship in the Church of England* (London: Theos, 2020), available online at: www.theosthinktank.co.uk/cmsfiles/GRACE-CUF-v10-combined.pdf

3 Barriers to collaboration

As the last chapter highlighted, when faith groups and healthcare professionals work collaboratively in social prescribing, it can result in a positive impact on the wellbeing of an individual. However, there are several barriers preventing a more integrative approach. This section highlights those challenges which fall into seven categories.

These barriers might explain why it appears that whilst SPLWs know about faith-based activities, they are not as keen to send a patient to one. Whilst 85% of SPLWs said they were aware of any groups or activities run or supported by faith groups as evidenced in the previous chapter, when asked, "How many individuals have you formally referred to activities run or supported by faith groups in the last 3 months?" around 30% stated they did not formally refer anyone.



1. Mismatched language

One barrier preventing better integration between faith groups and healthcare professionals is a lack of understanding surrounding the language used by each group. Broadly-speaking, language, acronyms and systems in the NHS itself appeared hard to comprehend, especially to those outside the system. One interviewee reflected, "The NHS is good, but bewildering".[1] Another said,

> *GPs speak a very different language, to the NHS Trusts, to other aspects. So, within the NHS, because it's just an amalgam… it's so complex. There's a completely distinctive language and a completely distinctive style.*[2]

Similarly, those working in healthcare appeared baffled by faith terminology and practice. As a retired Christian GP said, "They don't speak the same language. So, someone needs to be bilingual, or at least a little bit of interpreting".[3]

From the perspective of churches and faith groups around the country, an understanding of social prescribing was patchy. The name "social prescribing" was also misunderstood at times as other similar roles to SPLWs exist outside the health service, including community engagement officers, local area partnership leads, and community connectors. Some faith leaders and representatives understood the concept, whilst volunteers supporting faith-based activities did not. Others, however, had no concept of it at all. As one church leader explained,

> *If you hear the word 'prescribing' in a church or in any other setting, you think that's to do with going to the doctors and, you know, it's a prescription.*[4]

However, multiple interviewees reflected that the concept of social prescribing simply needed to be explained to churches and faith groups in a language that was more accessible to them. Ultimately, as a lead NASP representative said, social prescribing is "what they (faith groups) were always doing, it's just supporting people… supporting and caring and loving people".[5]

2. Limited connections

Connections between faith groups and healthcare professionals are sporadic: in some areas it is working well whilst in other areas non-existent. Significantly, the connections are not strategic. One SPLW stated, "We don't have connections with local churches, mosques etc.[6] Similarly, an ICB lead stated,

> *I don't think we link in with them (faith groups) as much as we should as NHS and local authority partners. I think we link in with them sometimes. And I think the NHS probably links in with them quite well in terms of key things like COVID and things like that, but we don't do it on an ongoing basis.*[7]

It must be noted, according to our analysis, that the majority of current connections between faith groups and social prescribers are amongst Christian churches and charities. We found that non-Christian faith groups were less actively working with SPLWs or GP surgeries in terms of social prescribing but had good connections when it came to other health related issues including the Covid vaccine rollout and diabetes checks. Equally, when speaking with SPLWs, several commented they did not know of social prescribing activities run or supported by faith groups beyond Christian churches and organisations. As one SPLW in London said, "I haven't had that much contact with other faiths, really".[8] A local authority lead explained why by saying that "they (other faith groups) are not as well, not as visible. They're not as mature".[9]

Regardless of the differences across the different faith groups, communication between all faith groups and social prescribers could be improved. It appeared that some SPLWs often signposted patients to services rather than forming a relationship between themselves and community organisers and setting up referral pathways. A Church leader said,

> *I mean, I would say I've seen less people come through social prescribing recently. I'm not seeing the social prescribers and it's not because they're not doing the same work. I'm sure they are, but I just think, yeah, they're signposting people rather than actually coming with them anymore. Yeah. And I guess that's to do with workload.*[10]

As a lead NASP representative noted along with others, social prescribing should not be simply signposting, but rather "true community integration… standing shoulder to shoulder".[11] Furthermore, by only signposting, faith groups are not aware who is walking through their doors which has detrimental effect on funding applications which require proof of provision, as well as uncertainty around whether volunteers would be able to fully support the needs of the service users.

High turnover rates also lead to a lack of continuity and make it difficult to build trust. An interfaith charity worker spoke of the constant "churn" amongst social prescribers.

Case study

Bay Volunteers, Lancaster

Bay Volunteers is a community-based service co-ordinated by Hope Church Lancaster. The project began as a direct result of the COVID-19 crisis, when there was a recognition that many vulnerable people would be home alone, isolated and unable to access essentials, including food and medication. The immediate response at Hope Church was to create a helpline number for those in need of practical help or simply someone to talk to and to recruit volunteers able to respond to the need. The success of the helpline service was quickly recognised by Lancaster City Council and a partnership was established to create Lancaster District Support Line, later re-named Bay Volunteers.

A few years on, the service has been adapted to meet the needs of the most vulnerable members of the community, including those that remain house-bound whether due to age, physical ill-health, mental health conditions, fear, lack of confidence and/or skills and those that, if not for the service, would be socially isolated and lonely. They accept referrals either from partner organisations or via a direct self-referral.

Activities they offer include:

- shopping for/with someone
- collecting and delivering post/parcels (especially food collections)
- collecting and delivering prescriptions
- a listening call, visit or walk
- patient transport
- and digital support.

He said, "I guess what I'm talking about is consistency, and being able to have... the ongoing relationships, so relationships are good, but not necessarily ongoing because of churn".[12] Similarly, a church leader spoke of their relationship with SPLWs saying, "I mean, I'm still in contact with them via email. They change a lot. There's a lot of movement. So yeah, they like come and go".[13] High turnover rates are not only reported in the NHS, but other statutory agencies too including the Council and the police.

Katie is a single mum living in a council estate in the outskirts of Birmingham. She is struggling to afford new baby clothes, nappies and essential equipment for her newborn. After a visit to her local GP, they referred her to their charity which has a baby bank providing new mums who are struggling with baby clothes, nappies, formula and equipment. These items have been invaluable for Katie.

It's not only a high turnover in terms of personnel, but also in terms of projects due to limited timeframes of funding. A Christian charity CEO stated the lack of continuity due to funding restrictions is a barrier

> *...because if you're commissioned to do something for a couple of years, you're not quite able to achieve the outcomes in that couple of years. It's then almost inevitable that somebody else will come along and replace what you're doing and they will start all over again.*[14]

This constant change in personnel and projects due to funding restrictions leads to lack of trust developing between faith groups and healthcare. A Church leader explained that if projects are only funded for a short period of time, and then they cease to exist, trust plummets. He said

> *And so many projects are a two or three year base, and then they run out of money and they all stop and that's where the trust plummets, I think.*[15]

A relationship between healthcare and faith groups requires a good connection between the two, that develops over a long period of time, is sustainable and built on a relationship of trust.

3. Stretched capacity

One explanation for poor integration between faith groups and healthcare practitioners, expressed by multiple interviewees, is stretched capacity in the NHS. As one Social Prescribing Team Lead stated, "capacity is always an issue… so how much time you have to actually go out and do that engagement and build those relationships".[16] Others in the NHS stated they were "so overwhelmed".[17] A church leader in Bristol also spoke of capacity stating, "there's just not enough social prescribers to do the work that is available; they are literally at 100%".[18]

Lack of capacity is perhaps why some church representatives felt they often did not get a response from healthcare professionals. One Christian charity worker said,

> *I almost feel like if I was to reach out to [the] social prescribing team, that… my email would just land in somebody's inbox. I don't know. I might know the name of the person that I'm speaking to, but there's no relationship there. So yeah, I think the barrier is probably relational.*[19]

And as another Christian charity leader put it,

> *We tried to instigate that as church leaders and faith group leaders about five or six years ago. So, we invited the police in to have a meeting with us and they welcomed that… we invited head teachers in and they welcomed that… we invited the doctors in the NHS in and basically they said they were too busy.*[20]

It was also reported that churches too felt overburdened. One Christian leader running multiple activities in their church including a food bank, debt course, EOSL class and arts and crafts class, stated that,

> *Gosh, I mean, the biggest hurdle we've got right now, it's just meeting the need, frankly, just because there is so much need out there, we're a very poor borough in Hounslow… we are run off our feet.*[21]

She spoke about how as a church community they had to limit referrals to a shorter time frame to allow more people to access their food bank.

4. Complex and slow processes

Several representatives from faith groups desired more referrals from social prescribers but stated that they were put off by the complex systems and unnecessary administrative processes. One Hindu representative stated that they did not get referrals because

> *...as soon as I try and get referrals in... they would want to make sure I got the mechanisms in place, the process in place... (but) I don't have the funding in place for it. I don't have the capacity. So we'll do it informally.*[22]

It appears that there are also multiple referral pathways which churches and faith groups struggle to navigate. A Christian charity CEO said,

> *So many organisations have their own referral pathways, which requires different information... it's just, it's going through so many hoops, especially for the client on their journey. That's exhausting... So I think efficiency would be one massive thing. Everyone needs to abide by the same rules. Otherwise, it's chaos.*[23]

The same barrier was also stated by healthcare professionals. A lead representative for GPs stated that the administrative process forced upon community groups was unnecessary. She said,

> *You know, if the, if the local church is doing an obesity group, exercise group, then they need to let us know it's happening. But it's not for us to wreck it by putting CQC rules about it or referral criteria or standards criteria by to and evidence. It's about working together. And where it works best. You have social entrepreneurs working with social entrepreneurs trying to make a difference.*[24]

However, SPLWs also highlighted that administration processes in churches and faith groups are slow and not always quick enough to respond to their needs.

Case Study

Crafty mornings, Kidderminster

Crafty Mornings in Kidderminster is a two-hour session, with craft being the focus point, to gather people to create and develop friendship within the community, reaching out to those who are isolated and lonely. Those who attend the session step into a welcoming empathetic environment where individuals find connection, purpose and friendship. The group is run by an ordained Minister who is in regular contact with the social prescribers from the local area. She has received referrals of service users to join sessions of Crafty Mornings.

One lady came to Crafty Mornings after she had been looking after her sick husband for a long period of time; nursing him until he passed away. She then had a stroke compounding her isolation. She contacted her local social prescriber who made a referral to the group. As a result, this lady started to attend regularly and now is in a much better place and has also started going to her local church.

As part of our survey of SPLWs, one respondent stated,

> *Administration can be slow e.g. not someone separate employed within the organisation to manage correspondence so slow reply to emails / calls. Often people running services are working very much part time so unable to process more urgent referrals.*[25]

5. No single database

Several interviewees suggested the need for a single online database of community-based activities and services in a particular locality, including faith groups, that SPLWs can utilise. SPLWs stated: "It is difficult to find what churches are doing due to lack of advertising, whereas other providers are always advertising" and "their web sites and timings are not always up to date – only tend to use Facebook as a comms tool."[26] To overcome this barrier, various participants mentioned the desire for a single online database – "to get single repositories of information if you'd like the sort of social prescribing Wikipedia type thing".[27]

There are a few examples of existing social prescribing online databases. The Joy app[28], launched in 2019, is a platform intended for social prescribing that aims to connect health professionals to preventative care options around the country and includes faith-based activities and services too. Additionally, there have also been attempts to create a map of social prescribing services in particular regions through NASP.[29] These maps showcase various healthcare services offering social prescribing and can be used by potential organisations to better connect with healthcare professionals.

An interviewee also spoke of using the Homelessness online network Street Support[30] which connects local people and organisations in order to support those in need. Warm Welcome also have an online map locating Warm Welcome Spaces[31] in a local area detailing when they are open and what activities they offer. Another interviewee spoke of Well Aware[32] in Bristol which details community-based activities in different parts of Bristol, but felt it didn't work as a weekly calendar of events. Another example is Treacle[33] covering specifically Bradford in West Yorkshire and Bolsover in Derbyshire.

However, one of the major concerns with any online database is that it needs to be constantly updated and not become redundant once funding runs out. A lead NASP representative said, "This is something important that needs to be done, but... needs to be funded well, needs to be kept up to date".[34] The reality of this, to some, meant an online database might not be achievable. A lead representative for GPs argued, "It's impossible to get a register, because they change all the time... And somebody has to be funded to keep it up".[35]

Furthermore, several interviewees also argued that an online database that simply lists activities and services in the community could undermine the goal of social prescribing. They believed that social prescribers should form a relationship with leaders of community-based activities and take patients to such activities, not simply act as a directory which can be found on library noticeboards.

6. No additional funding or training

Many of the churches and faith groups we spoke with identified that, whilst they don't provide their community-based activities or services for money, there is often no funding available for the activities and services they run. An interfaith representative said, "I've advocated that the providers of funding and things like that should actually make those available directly to places of worship".[36]

It appears that funding associated with social prescribing mainly goes to link workers or to those roles that connect service users to activities than to the activities themselves. One Christian charity CEO said,

> *The criticism that can be raised and potentially there's some truth to this is that there is a lot of funding going into the kind of social prescribing function of the person who's supposed to know what's going on. And because there's lots of versions of this, there's a lot of funding going into it. But is there enough funding going into actual activity? And, you know, where's the resourcing of what the social prescribers are meant to be connecting to? I think that's a bit of a live question.*[37]

In a previous Theos report, *A Torn Safety Net*[38], it was identified that churches and faith groups themselves needed to find additional avenues of revenue in our

current financial climate to keep church buildings open and activities running. One Social Prescribing Team Lead we interviewed acknowledged that churches had capacity in their buildings but stated that "my only fear is how they keep paying all the bills".[39] Similarly, a SPLW stated that churches "have real limitations in how much they can help due to limited finances, personnel and resources".[40] Additional energy could be released for faith involvement in social prescribing by offering some (especially small) grants directly to faith groups.

Jaanvi is a refugee currently living in Birmingham who was referred to a local church who ran EOSL classes. She has been attending the classes regularly and her English is improving. Whilst there, the church was also offering drop-in sessions to help with opening bank accounts and booking health appointments. Jaanvi really struggled with these tasks due to her lack of English, but with the help of the church volunteers she is now finding it a lot easier.

In addition to the need for additional funding, there is a desire from both healthcare professionals and faith groups for more training for faith group volunteers who may come face-to-face with service users with complex needs. A Social Prescribing Team Lead said,

> *I think we've also got to be careful when we're referring people... A lot of the people within the churches are volunteers and they're not used to having to manage certain types of confrontation. And I think the NHS and people like myself, we need to maybe try and upskill them.*[41]

Upskilling or additional training for volunteers was identified by one church leader as the biggest barrier in them doing more work:

> *...so what holds us back from doing it more is staff...I'm the only paid member. Yeah, the cafe's run on volunteers. It's able to just run volunteers and that's great. But all those volunteers need training, they need supervision.*[42]

Case Study

Muslim Youth Helpline, National

Muslim Youth Helpline (MYH) was set up as a faith and culturally sensitive helpline service. It was set up in response to the absence of faith and culturally sensitive support services from mainstream providers and the culture of taboo and condemnation that surrounds youth issues in the Muslim community. In a community where most social issues are a cultural taboo, this increased numbers of young people resorting to self-harm and substance abuse for escape, and mental health problems appearing disproportionately higher. MYH recognised that at a time when young Muslims were being bombarded with negative media portrayals and an increasing number were suffering Islamophobia and discrimination, mainstream service providers were unable to meet the specific needs of young Muslims. Due to this unmet need, they set up the helpline.

Their helpline is free, and service users can contact them through telephone, web chat, email, and Whatsapp. All information is 100% confidential; they do not share this information outside of their organisation, except in extreme safeguarding situations. Their helpline workers are from diverse Muslim communities in the UK. They understand the issues Muslim communities face and are trained in faith and cultural sensitivity.

These findings echo other research which also found that a barrier to social prescribing was the limited capacity within the voluntary and community sectors.[43]

7. Fear of religiosity

Another barrier to integration between faith groups and healthcare professionals is the fear of proselytisation or of faith groups being too overtly religious. Proselytism has traditionally meant the attempt to persuade someone to change their religion, however it now implies using power and position or taking advantage of the vulnerable to recruit new adherents.[44] A Social Prescribing Team Lead said,

> *I suppose my only concern is I've said on two or three occasions, you know, you don't have to be churchgoers, I would be concerned if that religious element became too strong within whichever session they were taking part in.*[45]

Other SPLWs stated similar concerns, worrying that patients might have to take part in church activities or prayers, or sending a patient to a faith-based activity knowing they were of a different religion or of none.

However, other SPLWs stated that this fear was unfounded. One SPLW said:

> *There is often a perception that you have to be a church goer to attend their groups and the fear that they may be preached at! This in my experience is not the case.*[46]

Similarly, another SPLW stated, "I always introduce the activities as being held in a church etc., to gauge a reaction of unease, but never had anything to be concerned about".[47]

The faith leaders we spoke with understood this perceived fear from some SPLWs but encouraged them to attend and participate in their activities to show that the fear of proselytisation was not the reality. A Christian charity leader said,

> *I can empathise with that, but I don't think it's a reality. I think that people actually have a respect for what we do and can understand that it is different to church activities that happen on Sunday.*[48]

Another church leader said,

> *You can come to the cafe doesn't matter who you are, we've had Muslims, Hindus, we're not interested. That's not what we're about. We just want to make people's lives better.*[49]

She spoke of SPLWs who participated in their activities prior to sending patients and realised that the activities were not overtly religious but would give the patient a sense of hope again.

A previous Theos report titled *The Problem of Proselytism*[50] challenged assumptions about religious charities, arguing that there is little evidence that they proselytise as part of their community action. It also suggests different ways in which faith-based social action should have a relationship with statutory providers.

There is a sense that the religiosity of the activity or service simply needed to be stated to the link worker and the patient up front, and that they had a choice to attend or not. A population health representative highlighted,

> *Our social prescribers don't force people to get involved in one of the faith groups, they, they always offer a suite of options, where would you like to go? Here's what's available. And if people choose to go into the church setting, or the mosque setting, or whatever, they are going in, eyes wide open.*[51]

A related barrier, from an NHS perspective, is for social prescribing to be too closely connected with Christian churches and organisations above other types of faith-based groups. As the representative for NASP outlined,

> *The NHS is wary of being seen to actively support any one religious group or body over any other because of this issue about having to be seen to be totally inclusive and democratic and welcoming... So, I think I think NHS, specifically NHS, organisations are always a little wary unless things are seen to be multifaith in their approach and not exclusive of people who have no faith.*[52]

Some minority faith groups did feel that the NHS did not prioritise them. For example, a Buddhist chaplain who would like to collaborate more with the NHS on social prescribing complained about the lack of contact he had received.

Conclusion

These seven challenges are barriers preventing a more integrated approach in social prescribing between faith groups and healthcare professionals. Our next chapter looks at how to overcome these barriers by forming a better relationship through active networking, engaged partnering and forward planning.

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1 Participant interview 35.

2 Participant interview 28.

3 Participant interview 36.

4 Participant interview 34.

5 Participant interview 33.

6 Survey participant.

7 Participant interview 11.

8 Participant interview 9.

9 Participant interview 18.

10 Participant interview 26.

11 Participant interview 16.

12 Participant interview 35.

13 Participant interview 26.

14 Participant interview 30.

15 Participant interview 34.

16 Participant interview 11.

17 Participant interview 7.

18 Participant interview 34.

19 Participant interview 20.

20 Participant interview 31.

21 Participant interview 5.

22 Participant interview 10.

23 Participant interview 32.

24 Participant interview 8.

25 Survey participants.

26 Survey participants.

27 Participant interview 16.

28 www.thejoyapp.com/

29 nasp.communitymaps.org.uk/welcome; tphc.communitymaps.org.uk/project/london-social-prescribing-map

30 www.streetsupport.net

31 www.warmwelcome.uk/find-a-space

32 www.wellaware.org.uk

33 www.treacle.me

34 Participant interview 16.

35 Participant interview 8.

36 Participant interview 10.

37 Participant interview 14.

38 Hannah Rich, *A Torn Safety Net* (London: Theos, 2022), available online at: www.theosthinktank.co.uk/research/2022/11/07/a-torn-safety-net-how-the-cost-of-living-crisis-threatens-its-own-last-line-of-defence

39 Participant interview 19.

40 Survey participant.

41 Participant interview 19.

42 Participant interview 26.

43 Chris Drinkwater, Josephine Wildman and Suzanne Moffatt, 'Social prescribing' *BMJ*, (2019) 364.

44 Paul Bickley, *The Problem of Proselytism* (London: Theos, 2015), available online at: www.theosthinktank.co.uk/research/2015/10/20/the-problem-of-proselytism

45 Participant interview 19.

46 Survey participant.

47 Survey participant.

48 Participant interview 20.

49 Participant interview 26.

50 Paul Bickley, *The Problem of Proselytism* (London: Theos, 2015), available online at: www.theosthinktank.co.uk/research/2015/10/20/the-problem-of-proselytism

51 Participant interview 2.

52 Participant interview 16.

4 Relationship-building

A key way in which churches and faith groups and healthcare professionals can better work together is by, we suggest, forming deeper relationships. With better relationships comes a better integrated approach to social prescribing, benefitting the holistic care of patients.

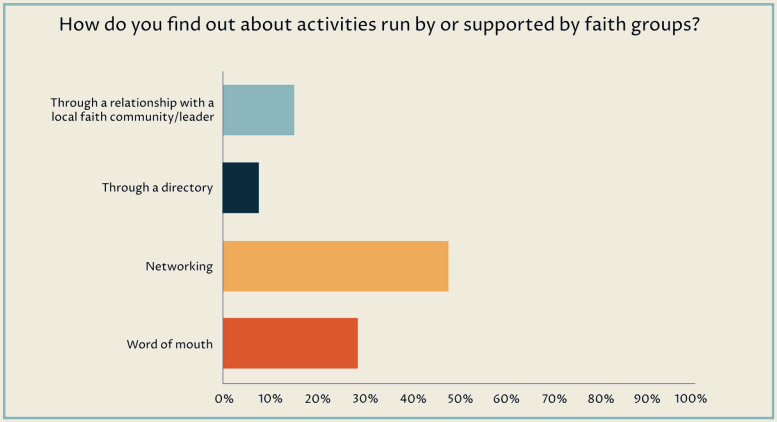
Relationship-building, in fact, is central to social prescribing. As a Christian charity leader put it,

> *It's about relationship, it's relationship that makes it work, the whole nature of social prescribing, when you think about it, it's about connecting people with other people so they can build relationships and overcome their loneliness and other issues. So, the whole thing from top to bottom has to be about relationship.*[1]

Findings from qualitative studies agrees with this suggesting that patients value a trusting and supportive relationship with their link worker, the time and space to address social problems, and link workers' extensive knowledge of the range of community support services available.[2]

Social prescribing works by relationships being built at different levels. Firstly, the patient and the SPLW form a relationship to assess the needs of the patient. The SPLW gets to know the patient and thinks through solutions to meet their needs (of which there might be multiple). Secondly, the SPLW forms relationships with those in the community who are offering activities and services, assessing their potential benefits for their patients. Thirdly, the patient forms a relationship with those running or volunteering at the activity or service, as well as with others that attend it. All the way along the chain, it is evident that relationships are essential to the success of a patient getting the support they need. However, it is important that these relationships are not solely dependent on individuals, but rather cultivating a culture of relationship-building between faith and health.

With the idea of relationship-building as the aim, this report now turns to ways in which relationships between faith groups and healthcare professionals can be fostered in social prescribing. From our analysis, we suggest that it requires active networking, engaged partnering and forward planning.



1. Active networking

According to the SPLWs we surveyed, nearly 50% said they found out about activities run or supported by faith groups through "networking". Therefore, more active networking can only improve knowledge sharing between faith groups and healthcare professionals. This is complimentary to an online database – a tool to know about activities but limited in enabling a relationship to be built.

Active networking requires both SPLWs and faith groups to actively reach out to the other on a regular and constant basis to share information. Several interviewees gave examples of active networking either through cold contacts or through forums. SPLWs contacted churches and faith groups by email, phone or visited in person to inform them of what their need was and how they could collaborate. Churches and faith groups too contacted their local GPs to tell them about the activities and services they offered and distributed leaflets and posters about them. As a retired GP stated,

> *I think on one level, it's incredibly simple that a church leader or whoever a faith community leader might be just gets on the phone to the local social prescribing team and begins a relationship... And it would be a simple question of SPLWs knowing what provision services are offered by the local faith communities... and to a degree vice versa.*[3]

Case study

Befriended, Sussex

Befriended is a Christian charity founded in 2017 working with local churches in Mid-Sussex aiming to end loneliness and isolation amongst older people living in Mid-Sussex. Social prescribers often refer patients to Befriended and receive their bi-monthly newsletter which is sent out to over 1000 people.

Services they offer include:

- Face to face or telephone befriending – volunteer regularly visits or telephones a housebound person
- Befriended balance – a prevention exercise class with stretches to the Psalms
- Monthly tea parties with an average of over 100 in attendance
- Befriended bereavement support
- Chaplaincy Befriended – chaplains taking church services every week into local care homes
- Befriended blankets – responding to the cost-of-living crisis
- Befriended bus trips – outings to theatre, gardens, places of interest
- Befriended community choir – an accessible choir to sing hymns and well-known songs from the musicals.

Their activities take place in church buildings and their volunteers/leaders are church members, and in doing so build bridges from the community to the churchort.

However, as explained in the previous chapter, there were also complaints from both sides about unanswered emails, high turnover rates leading to broken relationships and an uncertainty of not knowing whom to contact.

About two years ago, a social prescriber brought George and Heather to a local church community café. They were on their own a lot and didn't know many people in Northampton. They initially came to the café each Wednesday and, after chatting to others there, they started playing table tennis in the room next door. They are now regular attendees, and it has, in their words, "given them the community and love they were looking for". They have on occasion attended the church service on a Sunday too.

In spite of these difficulties, active networking requires a sustainable model of connection between SPLWs and faith groups on a regular basis. Two such models were evidenced by our interviewees. The first model was a regular gathering of key stakeholders, either monthly or quarterly. A representative from Ebenezer Church in Bristol said,

> *We have a networking group within our local communities here, where we bring together social prescribers, community workers, schools, NHS workers, health centres, etc. We bring them together to share what is going on in local communities, events, etc... We kind of take a bit of a lead on that as a church and kind of making sure it stays on track. And that's a great space where social prescribers come along to find out what is actually going on, on the ground.*[4]

A similar model is also running in Northampton led by Broadmead Community Church. A representative from the church spoke about having set up a forum for church representatives, SPLWs and other statutory agencies to gather, to explore local problems, share best practices and work collaboratively. Such forums and

networking groups are examples of ways of creating a culture of relationship-building rather than sporadic and ad hoc connections.

The second model of proactive networking is through individual connection. A Christian charity leader spoke about how she would individually befriend her local SPLWs and GPs and take them out for tea and cake on a regular basis. She said,

> *So every doctor surgery in the area received a letter or newsletter from us… I then arranged meetings where I would invite them [social prescribers] to come and join with coffee and we would have conversations and I would tell them about what we were doing. Then when I took over the role, I then I made it a point to meet with them every sort of three months at least… Everybody receives one of our newsletters, which used to be an A4 size. Now it's six pages and a diary of what's happening every month. They all get posters to put up in the local surgeries.*[5]

2. Engaged partnering

More than active networking, engaged partnerships between faith and healthcare representatives collaboratively working together is necessary. A number of churches and Christian charities we spoke to, who do not have a partnership with healthcare, welcomed the idea. A Christian charity leader who runs social outreach activities in Manchester said,

> *So any opportunities to engage with other organisations, including social prescribers, or you know, NHS in it in any capacity, then we will always take the opportunity to do that… but at the moment, I don't think there's a strong referral pathway.*[6]

Several interviewees highlighted a thriving partnership, be that collaboration on a specific project or on a more informal but regular basis. For example, a SPLW from London spoke about how they partnered with a volunteer from a local church to set up a weekly art class that now forms part of their wellbeing network. She said,

> *We hold an art class there on a Wednesday. So that was initially a pilot for three weeks, and they've been doing that for the whole year now. So that's been quite successful.*[7]

A partnership could also be on a regular basis beyond just a specific project. Examples of this included social prescribers working from or based in churches. Revival Fires Church in Dudley near Birmingham have NHS social prescribers in their congregation whilst they also host lots of community groups such as coffee mornings, English-language classes, and support groups for migrants. Because members of the congregation in a personal capacity know what the church can bring, they are therefore able in a professional capacity (through social prescribing) to refer patients to the activities of the church.

Another example of this occurs at Church on the Streets in Burnley. On a monthly basis, a group of SPLWs attend their café morning, and one SPLW visits at least weekly so that he can meet with those in the community who are most in need and less likely to access NHS services. The SPLW stated,

> *To be here and also be a resource for them here to use to better serve the service users coming in… having me here on site in the community means that we start, we can actually reduce the revolving door process for GPs, we make healthcare more accessible, helps people overcome barriers within like the health service, but also it's about partnership working and about working together.*[8]

The success of this example is due to an intentional partnership whereby SPLWs are based within a church building. It evidences that investing in regular partnership can have a preventative impact on community health.

Furthermore, engaged partnerships have been highlighted at a more regional level. In Lincolnshire, in the mental health space, there appears to be a successful partnership between health and community groups. During one of our focus groups, it emerged that five years ago there was a desire to develop wellbeing hubs – community safe spaces throughout the area as a collaborative project between the NHS and community and faith groups. Advocated by the then Neighbourhood Lead, the project came about due to the recognition of the NHS' strength in clinical support and the churches' expertise in community support.

Listening to those on our focus group, there now seems to be a thriving partnership between the NHS, faith groups and the voluntary sector in this area. This partnership is an example of how collaboration can achieve a more joint up approach in a particular area benefitting communities in an entire region.

Case study

Westbury on Trym Methodist Church, Bristol

Westbury on Trym Methodist Church, based in Bristol, had an ambition to find new ways to connect with the community and better serve their needs. Gina joined the church's Grave Talk initiative – an approach designed to help people plan for death well. After being inspired by meeting someone from another parish and being bereaved herself, Gina decided to set up a café-type space for bereaved people to come together, encouraging open conversation over a cuppa and cake. Sometimes people open up and talk about deeper feelings and their bereavement, but it's also a space to enjoy each other's company.

Space to Grieve has run for over four years and is attended by around 15 to 20 people every month. The approach is to support people in the long-term, once the immediate grief and funeral have passed, and they are adjusting to life without their loved one. In Gina's personal experience, what she needed after her bereavement was a space to laugh again and be normal. "There is a hole in your life, and you need to find a way to carry on."

As part of the church's desire to explore how they could better support the local community, Gina connected with a local social prescriber. They now promote Space to Grief through local publicity and posters in the church, they talk about it at memorial services and work with social prescribers to attract new members of the community. Although it's been challenging to get things moving, social prescribers are now referring people struggling with grief to the Space for Grief project. The church is also exploring how the church and the NHS can work together.

Ignacio is a 40-year-old man from the Philippines, who has been working in London for a number of years. He works in the manufacturing sector, but due to a recent motorbike accident, is not able to work. Ignacio doesn't have a lot of savings as he sends a lot of his money back home to support his family there. He was referred to a food bank run by a local church to help him temporarily whilst he is unable to work.

3. Forward planning

Once relationships have been formed and partnerships built, forward planning is about looking ahead towards an even more integrative approach. This requires strategic conversations at the local ("neighbourhoods"), regional ("places") and national ("systems") level. Speaking of these relationships, a recently retired Christian GP commented,

> *It's probably very piecemeal, and good in some areas and non-existent in others. And I think we're still fairly near Ground Zero into the two groups, not really understanding each other, not aware that they can work together. But I think the ground is breaking up.*[9]

Relationships at these three levels – neighbourhoods, places and systems – between churches and faith groups and healthcare professionals are currently sporadic throughout the country and there is not often a strategic plan for partnership. At a "systems" level, conversations between Christian leaders and NHS leaders in social prescribing seemed to have occurred, and relationships were warm in certain parts of the country. A lead representative for GPs stated that,

> *Strategically, at the top, there's really good connections, I know that we've got someone who is sort of the top, he's working very, very closely with the Mayor of Greater Manchester around churches and faith. I know that they have got a really good network across faith, interfaith group networks, where they're working across.*[10]

Other interviewees spoke of national Christian leaders having one-off meetings with leaders in social prescribing to try and push forward a more collaborative approach.

However, there was evidently minimal input at a national level from other faith groups. A lead representative from NASP said, "I would love to see a multi faith group set up… to work with somebody like NASP or NHS England… come up with some commitments to collaborations".[11] But ultimately nothing will happen without effective planning at a regional or local level.

At a "places" level, it seemed uncertain how best to integrate faith groups at an ICS level. Speaking of relationships at an ICS level, an interviewee said,

> *I think there are very few big examples of how ICBs have done this really well, I'm not aware, none are coming to my mind… the ICBs have had so much to deal with to just get set up and structured and work out which way is up that they are mostly these still fledgling organisations.*[12]

They went on to say,

> *Ideally, you would want, you know, regions of churches to work with Integrated Care Boards at the obvious level at which to do good stuff that has relevance to communities, that is at a reasonable size scale to attract investment. But I'm not sure that the maturity is there yet of integrated care boards and integrated care systems to embrace that.*[13]

At a "neighbourhoods" level, at the level of operation of PCNs, there were limited relationships being developed. As a lead representative of GPs commented,

> *From the PCN point of view, I don't think the PCNs have got any relationships, if I'm being honest, or very few. Where they have it, it'll be through the link worker, or it'll be through if they are using voluntary organisation to host link workers on their behalf.*[14]

Case Study

Karis Neighbour Scheme, Birmingham

Karis Neighbour Scheme in Birmingham was started by Karis Medical Centre in 1997. The GPs saw that there was more to people's needs than they could meet – emotional, spiritual and social needs – which are just as important as physical needs. As a Christian GP practice, they envisioned the role of churches to help those in the community, partnering with them to provide social and practical assistance to people who were coming in with health issues. Now, Karis Neighbour Scheme is a small charity working in the community to offer support and friendship to those who need it the most.

Services they offer include:

- Advocacy and Advice: advice, help with benefits and general advocacy at a weekly drop in and through appointments with a Welfare Rights Advisor.
- Karis Befriends: befriending and neighbourly help for older people which includes home visits, support at appointments or help to get out and about to social activities.
- Listening and guidance: a professional, confidential NHS service where people are truly listened to through a talk with a Chaplain for Wellbeing.
- Children and families: working with families who are new to the area or who are feeling isolated, lonely or going through a difficult time. They offer help and support at home or to appointments and groups, helping families meet new people and feel settled in the local area. They run a Baby Bank for new mums and families in specific need where they offer help with second-hand baby clothes and equipment.
- Other: practical help such as DIY skills, regular art groups, English classes, and one-off events and trips.

It was suggested that perhaps PCNs didn't need to be more involved but rather be enablers. Our interviewee continued by saying that PCNs needed to

> *...allow their personalised care roles to move away from the practice and more into those communities and use those community activities, venues. Whether that's a mosque or Church of England, or whatever that is to reach out proactively to reach groups of people that wouldn't necessarily go into the GP practice... So the PCN they need to allow that to happen. So they need to give that person the time to engage with the groups and the ones facilitating the groups, etc. Without that time, you can't do it.*[15]

However, there were excellent examples of planned collaborations between local churches and individual Social Prescribing Team Leads, SPLWs or specific GP practices. Some examples of best practice are highlighted throughout this report in our case studies. A lead representative for NASP commented,

> *I think the examples are more of the micro level of individual GP surgeries or primary care networks who have these have appreciated the resources on their doorsteps. They're more local and ultra local, I would have thought, yeah.*[16]

There were limited good practice examples amongst other faith groups. An interfaith worker suggested that different faith groups could come together in a particular area and form an interfaith hub and then collectively they could offer activities and services that could be prescribed to.

Active networking, engaged partnering and forward planning within "neighbourhoods", "places" and "systems" will look different and serve different purposes but relationship-building at all levels between faith groups and healthcare professionals is essential.

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1 Participant interview 30.

2 Chris Drinkwater, Josephine Wildman and Suzanne Moffatt, 'Social prescribing' *BMJ*, (2019) 364.

3 Participant interview 36.

4 Participant interview 34.

5 Participant interview 12.

6 Participant interview 34.

7 Participant interview 9.

8 Participant interview 27.

9 Participant interview 36.

10 Participant interview 7.

11 Participant interview 16.

12 Participant interview 16.

13 Participant interview 16.

14 Participant interview 7.

15 Participant interview 7.

16 Participant interview 16.

Case Study

Revival Fires, Birmingham

Revival Fires in Birmingham began a Listening and Guidance Wellbeing Project. A member of the Church, who was also a clinical lead in the NHS, heard of chaplaincy in general practice, with outcomes that said 4-6 sessions with the Listening and Guidance team member was as effective as antidepressants.

When asked if their Church could support the emotional and spiritual care of a region by offering volunteers they answered 'yes!'. The pilot began during the Covid-19 pandemic and went from 1 volunteer to now 3 staff. At the heart of the Listening and Guidance Wellbeing Project is spiritual care and wellbeing, it attends to non-medical needs of patients who book GP appointments because they didn't know where else to turn. Reducing GP time and easing pressure on an overstretched service are some of the benefits. Referrals for people experiencing loss, grief, bereavement or a change in life's circumstances where they are experiencing anxiety are received. Patients shared their experience of the service to their GP saying, "I felt listened to, no one else had time for me" and "I was able to drop off everything I was carrying, I looked forward to these appointments and felt better."

Revival Fires hosts a Listening and Guidance Support Group each week attended by 8-10 regulars and others who attend to support their friend or relative attending. It is hosted by one of the social prescribers and volunteers from the church team. Activities offered vary from coffee and chats, colouring, some of the group bring dominoes/cards to play and others bring their knitting or card making. Outcomes include support from one another and being offered prayer and pastoral support from the team.

In addition, Revival Fires hosts a Migrant Support Group for refugees and asylum seekers to come to the coffee shop and meet others for peer support, encouragement and volunteering opportunities to support with their emotional and spiritual wellbeing. Run by church volunteers, they also offer ESOL classes in partnership with Brushstrokes Charity and these students attend the drop ins. Support is very practical, finding out about how to open bank accounts, get eye tests, register with doctors, get advice on qualifications and transferring credits to begin work in the UK.

Furthermore, Revival Fires hosts Parent & Infant Emotional Wellbeing Group who meet weekly for parents of little ones for parenting and prayer support. It is open to all parents and carers with a free breakfast and run by the church team and volunteers. Outcomes are feeling better connected with others, feeling supported in their parenting journey and having somewhere to ask questions.

6

Conclusion: why collaborate?

Why should healthcare practitioners work with faith groups?

For a while, there has been a growing interest (especially within the NHS) in a more personalised approach to healthcare delivery.[1] The NHS "Universal Personalised Care"[2], first published in 2019, demonstrates this with social prescribing featuring in it. More broadly in medicine, there appears a push away from "over medicalising" health problems with prescribing drugs, and towards giving healthcare clinicians access to non-medical interventions that should reduce unnecessary prescriptions and referrals.[3] More recently, the Darzi report 2024 and Wes Streeting's vision for a "Neighbourhood Health Service" where prevention is the first order, highlights a renewed impetus for a community-based approach to preventative healthcare. Alongside this, the NHS is resource tight and overwhelmed – with an extensive funding hole and long waiting lists –and social prescribing has the potential to reduce the financial strain on the NHS in the long term. There appears to be a focus on the fact that in order to be more preventative and therefore cut costs at a primary care level and a more acute level, we have to be more focused on holistic needs of people, of the importance of public health and of the social determinants of health. Therefore, the fact that faith groups are at a neighbourhood level, are accessible and are able to care for people in a holistic way means that they are a great asset for prevention and therefore cutting costs and implementing the government's plan for the longer term.

Why should faith groups collaborate with healthcare practitioners?

Churches and faith groups have always been caring for others as part of their social outreach to their congregations and wider community. They do so, drawing on Christianity primarily, because at a community level they believe in "loving their neighbour" as part of their Christian social action. Most other faiths too have some element of caring for those around them. Faith groups are able to do this, as we have highlighted in this report, by being "anchors of the community" playing a crucial role in providing buildings and volunteers, networking and convening within the community and offering pastoral and spiritual care.

Faith groups already significantly contribute to local social prescribing networks, and with better integration and better relationships between healthcare and faiths groups, they can play a foundational role in this new vision for preventative community-based healthcare.

In order to actualise the vision of a "Neighbourhood Health Service", the contribution of faith groups must be fully recognised, and relationship-building – within "neighbourhoods", "places" and "systems" – between faith communities, the NHS and wider healthcare networks must be established.

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1 Chris Drinkwater, Josephine Wildman and Suzanne Moffatt, 'Social prescribing' *BMJ*, (2019) 364.

2 www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

3 Martin Roland, Sam Everington, and Martin Marshall, Social prescribing-transforming the relationship between physicians and their patients. *New England Journal of Medicine*, 383:2, (2020), pp.97-99.




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Creating a Neighbourhood Health Service: The role of churches and faith groups in social prescribing

One in five GP appointments are for non-medical reasons. At a time when demand for GP appointments is at an all-time high and the pressure on secondary care services is overwhelming, social prescribing – connecting people to community-based activities to benefit their wellbeing – can be part of a preventative solution.

Along with other community groups, faith groups not only contribute significantly to local social prescribing networks, but with their focus on community, relationship and holistic wellbeing, they can play a foundational role in preventative healthcare.

This report found a large number of friendly, welcoming and "referrable" activities are hosted by faith groups across the country. Interviewees described the strengths of these groups as anchors of their community, having the ability to network and convene, providing buildings and volunteers and offering pastoral and spiritual care. That recognised, there are barriers preventing a more integrated approach between faith groups and healthcare practitioners including communication and administrative challenges.

Theos and the Good Faith Partnership call for the contribution of faith groups in social prescribing to be fully recognised, and for proactive collaboration between faith groups, the NHS and wider healthcare networks – at the level of "neighbourhoods", "places" and "systems" – to be established.

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Front cover image: Emily Ikoshi

'THEOS'

ISBN: 978-0-56-403953-1