



NEIGHBOURHOOD
MODEL OF HEALTH AND WELLBEING

SOCIAL PRESCRIBING IN THE NEIGHBOURHOOD

*Building Consensus and Putting the
Policy Foundations in Place*

WORKSHOP

FRIDAY 18 SEPTEMBER 2026



Department of
Health

An Roinn Sláinte

Mánnystrie O Poustie

www.health-ni.gov.uk

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Developing a Social Prescribing Framework for Northern Ireland

Workshop | 18th September 2026



Welcome and Introductions



NEIGHBOURHOOD
MODEL OF HEALTH AND WELLBEING

Gillian Lewis

**Head of the Northern Ireland Health
Collective**

Gearoid Cassidy

**Director of Palliative Care and
Neighbourhood Policy, DoH**

Setting the Context



NEIGHBOURHOOD
MODEL OF HEALTH AND WELLBEING

Mike Farrar
Permanent Secretary, DoH

*Why we need to embed social
prescribing within the Neighbourhood
Model*



NEIGHBOURHOOD
MODEL OF HEALTH AND WELLBEING

Social Prescribing – My Experience

Kerry Grugan and Mandy Adams

SOCIAL PRESCRIBING

What do we mean by Social Prescribing?

Tony Doherty

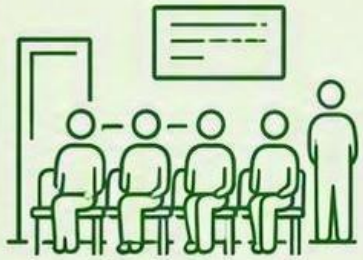
Co-chair, All-Ireland Social Prescribing Network

www.allirelandsocialprescribing.ie

ALL-IRELAND SOCIAL PRESCRIBING NETWORK



The need for social prescribing



High demand

High demand for consultations in primary and secondary care



Demand-capacity imbalance

Problems with access, waiting lists and ultimately negative outcomes



Non-medical need

A cohort of patients presenting who do not require a medical intervention



Need for viable alternatives - evidenced in prescribing activity



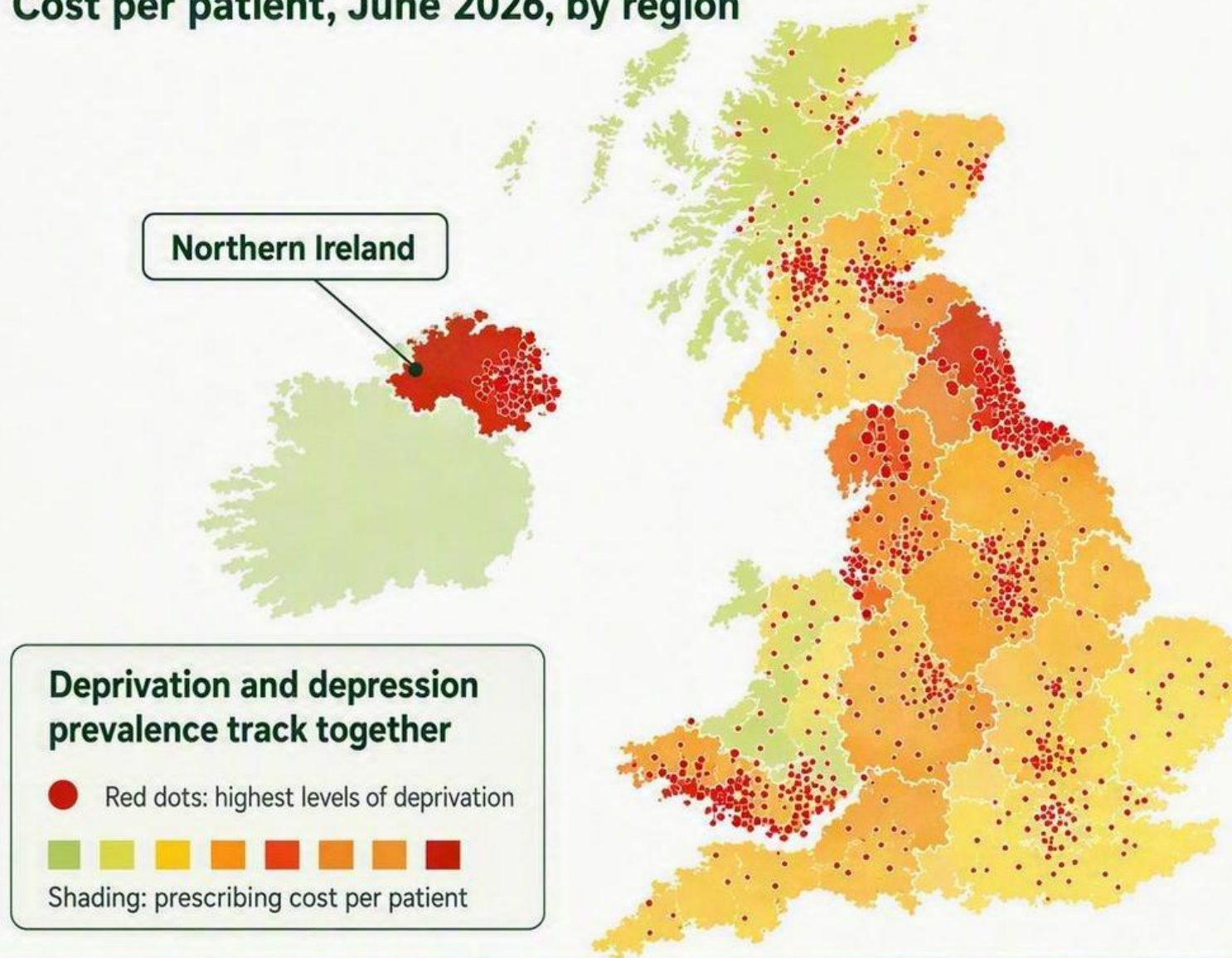
Despite the focus on using most cost-effective drugs,



prescribing for medicines such as antidepressants far surpasses comparable areas

Antidepressant prescribing: the case for another pathway

Cost per patient, June 2026, by region



Highest by some margin

Northern Ireland leads every comparator region



50% higher than Wales

And roughly double the North East and North West



Comparable deprivation, very different prescribing

The gap points to a need for alternative pathways



Social prescribing can reduce GP and secondary care consultations, and the prescriptions that follow

What Social Prescribing Is



“

A way to link medical care to non-clinical, locally delivered support services — enabling professionals to refer patients to activities and services that recognise a social model of health.



Wellbeing is multi-factorial

Health is shaped by a variety of social factors, not medicine alone



Empowers people

Patients and communities take an active role



Greater independence

Reduces reliance on primary healthcare



Better outcomes

For people, communities and wider society

What Matters to You?

What social prescribing actually is

“

It changes the core question from 'What is the matter with you?' to 'What matters to you?'

”



Relational and person-centred

An empathetic, preventative and restorative model



Prevents ill-health early

Anxiety, loneliness, social exclusion and long-term conditions



Reconnects to community

Gently and considerately, at the pace of the person at the centre



Assets-based

The person is included as an asset, not just a patient



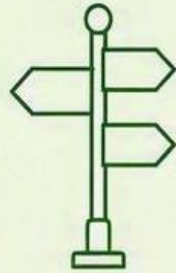
The Social Prescriber has a pivotal role

What Social Prescribing is not



Not the patient's job alone

Referral needs consent and active support



Not sign-posting

It is a relationship, not a direction



Not a brief intervention

Engagement runs at the pace of the person



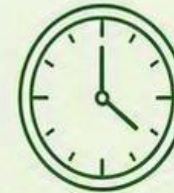
Not leaflet-dropping

Information alone changes very little



Not free or cheap

But not expensive — it must be properly funded



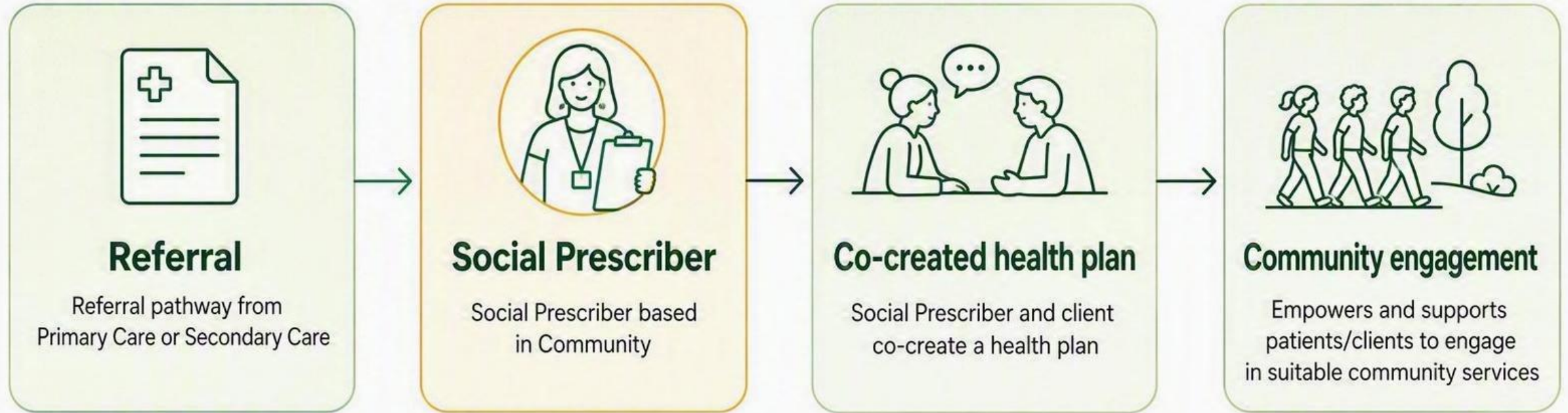
Not a transient fad

It is here to stay



Not to be taken lightly — it is proven to be very effective

Social Prescribing Pathway Example



Outcomes framework to measure health improvements

Key Features of Social Prescribing



A lead organisation

One accountable host for the service



A Social Prescriber

An individual or small team in post



A neighbourhood location

Rooted in the community it serves



Local activity offer

Access to a tier of neighbourhood-based activity



An adequate budget

Money follows the patient to the provider



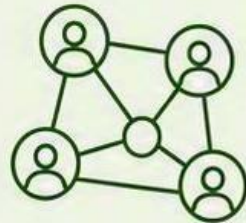
Intensive 1-1 support

Relationship based, at the pace of the person



Digital data platform

Consistent recording and outcome tracking



Networked practice

Linked for training, CPD and shared learning



Early intervention

Prevention and long-term condition management

The global evidence base

Social prescribing outcomes across four comparable health systems



Ireland

HSE-funded and nationally rolled out — our closest comparator



England

Link workers embedded in primary care, with national outcomes data



Canada

Rx Community: reduced loneliness and improved wellbeing



Australia

Strong primary care integration led by the RACGP



Consistent findings: better wellbeing and fewer GP contacts
Effect size varies, with economic impact the stronger effect
Returns of c.£2–£3 for every £1 invested

Other things to consider



All-Ireland School of Social Prescribing

AISPN concept paper for research, innovation and scaling up good practice - gaining traction in the Republic



Policy alignment

Reflected in the Mental Health Strategy and dovetails with People as Partners



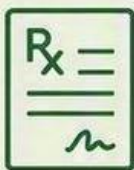
Adult Social Care reform

Fits the direction of travel for reform of Adult Social Care



Properly understood, social prescribing can deliver better health outcomes for thousands of people every year

To Conclude



A clarion call to action

Prescribing rates alone demand better pathways and outcomes for patients



Neighbourhood opportunity

An unprecedented opening to embed social prescribing



Do it right

If we are going to do it, a holistic model is the one to build



Scale and spread

It is already working well in several locations - build the capacity



Recognise our assets

The full breadth and depth of community assets



Local leadership

Create and support leadership in every neighbourhood



A shared enterprise

A shared prize for all



**With the information, intelligence and experience at hand,
we can create one of the best social prescribing models on the planet**

IMPACTAgewell®: Demonstrating the Financial and Social Return on Investment of Community Led Social Prescribing for Health and Care Services

Evidence from a nine-year model of integrated social prescribing supporting older people across Mid and East Antrim.

Sarah McLaughlin
Executive Director Health Programmes
Agewell Partnership



IMPACTAgewell® 2017-2026

- 3,919 older people referred
- 19 GP practices engaged
- 24 community partners
- 2,188 funded social prescriptions
- £2.94m invested
- 9 years of delivery





Assets!

• Issues

Benzodiazepine drug reduction programme referral

70 years young

Lives alone

She has a history of anxiety, depression, and lifelong trauma

Outcomes

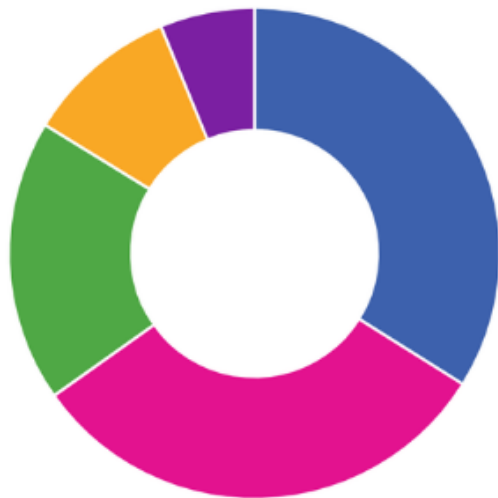
- Counselling Referral
- MEABC Wellbeing Team Referral
- Good Morning Referral
- Building Flourishing Friendships (BFF) Signposting
- Scam Savvy Referral
- U3A Signposting for art classes
- Cullybackey Community Partnership Referral
- Pest Control Support
- Will Writing information
- Keep warm pack
- Assisted bin collection form
- Age NI Benefit Check Referral
- Support in applying for Blue Badge
- Assisted Bin Collection application support
- Bryson Energy referral
- Handyperson Referral
- Agewell Volunteer Signposting

IMPACTAgewell®

Social Prescriptions

Referrals made based on social determinants of health

Agewell Referral Themes (n=899)



Health

34%

Long Term health condition support,

Home

31%

Home Maintenance, Energy support, crime prevention

Future

19%

End of Life Planning Support, digital access, legal issues

Wellbeing

10%

Bereavement Support, Counselling

Community

6%

Social Activities

Community Partnerships

2026- **24** Community Partnerships, creating **2,188** Social Prescriptions supporting Older People through:



IMPACTAgewell® USP

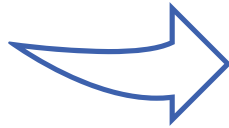


Where the money follows the person



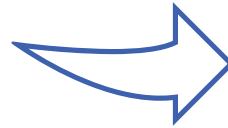
Funders

£ 2,935,827 of funding
invested over nine years
from The Dunhill Medical
Trust and SPPG.
Dunhill - £998,145.00
SPPG – £1,937,682.00



Agewell

Funding Invested in an
Assets Based Community
Development Approach to
improving the lives of
Older People



Community Partnerships

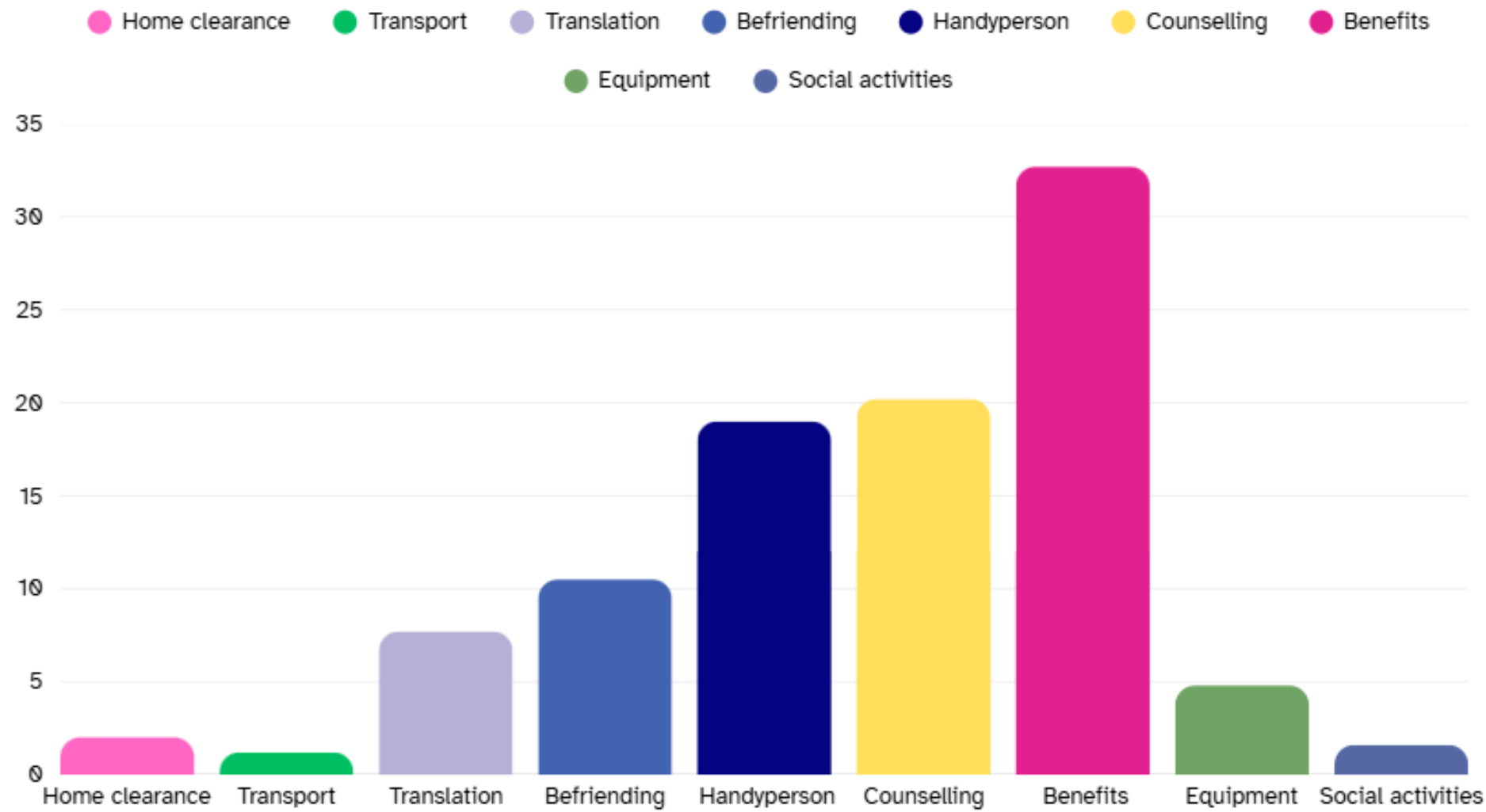
£25 per social prescription
invested in local
community groups



Older Person

Better **PHYSICALLY**
Better **EMOTIONALLY**
Better **CONNECTED**

Community Partnership Referrals 2025-2026



Evaluation Feedback 2025-2026

- **More than half of participants** reported improved overall life satisfaction following support from IMPACTAgewell®.
- **48%** felt less socially isolated.
- **54%** felt better able to manage their long-term health conditions.
- **55%** reported improved awareness of local support services.

Share the Learning Report 2021/2022

12

SUMMARY OF FINDINGS

Below is a brief summary of the key findings from the evaluation activities which have been completed to date:

FISCAL RETURN RATIO

£2.38 : £1

Dec. 2021

This means that for every £1 invested there has been at least £2.38 of savings generated in terms of unscheduled health and social care. health and social care.

SOCIAL RETURN RATIO

£2.22 : £1

Nov. 2020

This means that for every £1 invested, there has been at least £2.22 of a social return on investment when considering all service users, health care practitioners and carers.

This is a small reduction from the SROI value in NEF's report, but that was highly provisional because of the small number of carers included. We can be much more confident that this SROI is based on an accurate assessment of the impact on carers add more data

COMMUNITY PHARMACY RATIO

£5.81: £1

Nov. 2020

This means that for every £1 spent on community pharmacists within the project they delivered an invest to save return of £5.81

IMPACTAgewell® 2017-2026

Every **£1** invested generates **£2.38** economic value

Total Nine Years Investment: **£2,935,872.00**

Total Return on Investment: **£6,986,375.36**



112,514

GP Appointments



22,500

Attendances to
A&E



11,741

Hospital Bed Days

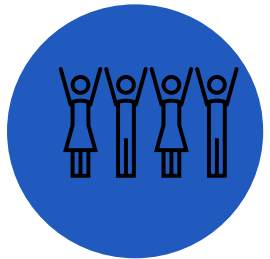


IMPACTAgewell

Outcomes for Older People and HSC



IMPACTAgewell



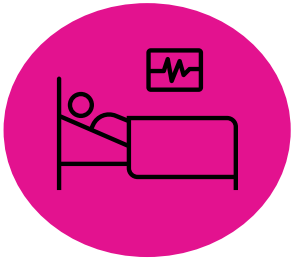
Increased community connection



Reduced Loneliness And social isolation



Improved Mental & Social Wellbeing



Reduced Health Care Costs per person



Enhanced Quality of Life



Stronger Partnerships across sectors



Reduced Hospital & AE Admissions



Reduced visits to GP



Reduce Health Inequalities

Further Information

Sarah McLaughlin
Executive Director Health
Agewell



Better
PHYSICALLY



Better
EMOTIONALLY



028 2565 8604

www.meap.co.uk



Better
CONNECTED



Sarah.mclaughlin@meap.co.uk

Defining Social Prescribing – Breakout Discussion 1

Northern Ireland – DRAFT

Social prescribing connects people to practical and emotional support in their communities. Social Prescribers take time to build trusting relationships, co-create a shared plan, which helps, support and empower people to find solutions to improve their health and wellbeing.

Wales

Social prescribing is an umbrella term that describes a person-centered approach to connecting people to local community assets. It can help empower individuals to recognise their own needs, strengths, and personal assets and to connect with their own communities for support with their personal health and wellbeing.

Ireland

Social prescribing is a means of enabling healthcare professionals and other professionals to refer people to a range of local, non-clinical services, primarily provided by the voluntary and community sector.

Principles for Social Prescribing - Breakout Discussion 2

NI Draft

1. **Relationship focussed:** a relationship between the social prescriber and the individual which has compassion and empathy at its centre
2. **Holistic and Person led:** takes account of the wider determinants of health, addresses health inequalities and helps people to increase control over their own health and lives
3. **A process:** which takes time to co-produce goals through an asset based approach and helps people to access a wide range of practical and emotional support
5. **Easily accessible;** for the individual and for referrers
6. **Community centred and reliant on partnership working;** delivered in local communities, strengthens community connections and resources and is delivered through partnerships across the public, community and voluntary sectors
7. **Safe and sustainable;** has mechanisms for quality assurance and outcomes measurement built in and is funded in a sustainable way

Building Blocks for Success - Breakout Discussion 3

Think about:

- **Partnership and governance**
- **Building on existing assets**
- **Supporting the workforce**
- **Sustainable funding**
- **Digital and data**
- **Evaluation**
- **Equity of access**



NEIGHBOURHOOD

MODEL OF HEALTH AND WELLBEING

Summary and Next Steps

Gearoid Cassidy
Director of Palliative Care and
Neighbourhood Policy, DoH



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Close

Gillian Lewis

**Head of the Northern Ireland Health
Collective**