Social Prescribing: The role and experiences of local voluntary sector infrastructure organisations

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Executive summary

This report summarises the findings of research NAVCA conducted with approximately 50 of its member organisations, through workshops and interviews. Most NAVCA members are involved in local social prescribing delivery, either through hosting link workers, or through delivery of their core infrastructure roles of supporting a strong and vibrant VCSE sector, supporting coordination of the sector, and providing intelligence and insight on the needs and opportunities within the sector.

In 2019, the NHS Long Term Plan committed to rolling out social prescribing link workers across all primary care networks in England. NAVCA members welcome NHS's roll out of social prescribing and the expanded funding of social prescribing link workers. However, the rapid roll-out has led to some unintended practical challenges for NAVCA members on the ground, particularly in areas where the NAVCA member holds the link worker contract. For example, NAVCA members felt that national guidance on link worker salaries could be more flexible. NAVCA members would also like to see a greater acknowledgment of the wide range of functions that sit around a social prescribing scheme that ensure its success, such as organisational development, community capacity building and volunteer development, as well as more clarity between the link worker role and those wider roles.

Additionally, NAVCA members reported that, whilst they strongly welcome the expansion of social prescribing, an upsurge in referrals has highlighted unmet needs in the system and in communities, and under-resourcing of community-based service provision. This is compounded by competitive commissioning processes and a disconnect between the service demand that social prescribing generates and local commissioning and service planning processes.

As for schemes run in-house by primary care networks there are many examples of link workers being well embedded in the community and working collaboratively with voluntary sector provision, but our members in some areas reported link workers operating in isolation, which can lead to unnecessary duplication of effort.

More generally, NAVCA members are concerned about the capacity of the whole system to react to the needs of people with more complex needs. This presents challenges around VCSE capacity to meet these needs, for instance the training and development of staff and volunteers, and the need for support and development around inclusion, which must be recognised and supported.

NAVCA is supporting our members to remove barriers and resolve these challenges. Many of the recommendations herein point to the need for a more systemic and holistic approach to planning and commissioning at place level, better use of data to support more agile local commissioning and more consistent engagement in the development of local social prescribing implementation plans. New structures such as integrated care systems, as well as new ways of working in the wake of the pandemic, provide an invaluable platform for collaboration across sectors to do things differently and better. The voluntary sector, through NAVCA members, is ready and willing to provide a more strategic voice.

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1. Introduction

This report explores the experiences and views of NAVCA members on how the roll-out of social prescribing is generating benefits and opportunities, and on how some challenges that have arisen can be ironed out as the welcome expansion of social prescribing continues.

NAVCA members are local voluntary, community and social enterprise (VCSE) sector infrastructure organisations, often known as 'voluntary action' or 'councils for voluntary service', and many hold link worker contracts or have involvement in social prescribing in some way.

This report makes recommendations to a variety of stakeholders involved in the commissioning and delivery of social prescribing and wider support activities.

The key questions explored include:

- What should the role of leaders and structure be at a system, place and neighbourhood level,[1] and what would good look like?
- What commissioning models could further support the systemic delivery of social prescribing?
- What support does the VCSE sector need to engage effectively with local social prescribing to deliver the stated benefits?

The findings and recommendations will be of particular interest to:

- NHS England and NHS Improvement[2]
- National Academy of Social Prescribing
- National, regional and local voluntary sector infrastructure organisations
- integrated care system leaders
- anyone associated with social prescribing schemes locally.

1.1 About social prescribing

One in five GP appointments is about a non-medical need.[3] Social prescribing provides a solution to this in that it enables health professionals and other agencies to connect people to practical, emotional and social support in their community. Social prescribing builds on good practice in

[1] 'System', 'place' and 'neighbourhood' are geographical delineations currently used by NHS England and other public bodies. 'System' is the area covered by the 42 new integrated care systems across England, 'place' refers to a district, county, borough or local authority area, and 'neighbourhood' usually refers to an area covered by a primary care network.

[2] Hereinafter referred to as 'NHS England' for simplicity.

[3] Torjesen I. Social prescribing could help alleviate pressure on GPs. BMJ, 2016

local communities and formalises a process that has gone on forever: helping people to find the support that best meets their needs and supporting them to reach those services or activities when necessary. By directing patients away from medical interventions and more towards social or community activities, the hope is that people become less reliant on pharmaceutical drugs and NHS provision, thereby gaining more self-reliance and benefitting from more appropriate and holistic interventions to support their health and wellbeing. As a bridge between clinical services and the VCSE sector, social prescribing can both enable people to access individualised help, and support community-based efforts to address the social determinants of health.

Social prescribing began to be talked about as a distinct concept in the early 2000s, and various studies in that decade showed benefits both to patients and to local health economics. In 2019, the NHS Long Term Plan made a significant commitment to social prescribing and committed to rolling out social prescribing link workers across primary care networks in England. NHS England is now leading the roll-out of social prescribing. NHS England exceeded its target of 1,000 link workers by March 2021 with this number rising so that 900,000 will benefit from a referral to social prescribing by 2023/24.

'Social prescribing link workers' are professionals that support clients to identify their goals through conversation and support them to benefit from appropriate services. They are sometimes employed within the NHS, mostly by primary care networks (PCN), but in many cases the function is outsourced, and many NAVCA members hold contracts for delivery of the link workers. They also sometimes go by other names such as 'social prescriber'.

1.2 About NAVCA

NAVCA is the national membership body for local infrastructure organisations (LIO) which provide support and development for voluntary and community organisations. Our 180 members across England support over 200,000 local charities, voluntary groups and social enterprises at a community level, helping them to thrive and deliver essential services. NAVCA has been a member of the VCSE Health and Wellbeing Alliance since its inception in 2017.

NAVCA members play an integral role in local health and care systems by:

- bringing the voice of people and communities to bear in decision making and strategy setting
- using their intelligence and relationships to influence and coordinate
- acting as the local VCSE sector's voice in strategic discussions
- supporting frontline organisations to deliver effective services and foster collaborations.

NAVCA members are directly involved in social prescribing as coordinators of local schemes and providers of link workers, acting as a strategic voice for the VCSE sector in local commissioning processes and providing the capacity building and community development functions that are essential to create and sustain the thriving and vibrant communities that social prescribing is dependent on.

1.3 Methodology

NAVCA commissioned Lev Pedro & Associates to design and deliver a programme of 'collaborative policy making' with key stakeholders on the expansion of social prescribing. The consultants, NAVCA staff, national policymakers and a sample of senior staff from NAVCA member organisations developed the research questions collaboratively. The starting point for discussions was the national rollout of social prescribing link workers. But conversations were broader given the role of NAVCA members in the design and delivery of longstanding activity that links people with health issues into practical, social and emotional support and activities.

This research included:

- One-to-one conversations with NAVCA members involved in previous strategic discussions on social prescribing, one NHS England policymaker and NAVCA staff, from which we defined the research questions
- Workshops with NAVCA Members and NHS England policy makers on 24 February and 2 March, which brought learning so far and developed draft recommendations.
- Further one-to-one conversations with NAVCA members
- A 'sense-check' workshop with NAVCA members as part of a health strategy day on 31 March, leading to the drafting of this report

Approximately 50 NAVCA members were involved at one or more stages of the engagement, which means that more than 50 place areas across England were involved.

All stages of the process involved policymakers from NHS England.

2. The link worker and associated infrastructure functions

NAVCA members feel very positive about many aspects the expansion of social prescribing and welcome NHS England's commitment to it through the funding of link workers. Social prescribing delivers a great opportunity for the VCSE sector to be better connected to the NHS, and this enables better collaboration across sectors for the benefit of individuals and communities.

As with any new large-scale development, some unintended challenges have arisen, which NAVCA members feel should be ironed out if social prescribing can achieve the best outcomes. The challenges discussed below relate mainly to

- how link workers are employed
- subcontracting arrangements
- how the link worker role interfaces with other infrastructure roles.

2.1 Employing and hosting link workers

Social prescribing link workers are funded through the NHS Additional Roles Reimbursement Scheme (ARRS). This funding goes to primary care networks (PCNs). PCNs then either employ link workers directly or commission a link worker service from the private or VCSE sectors. This section of the report is concerned with outsourced provision, in other words, where the NAVCA member organisation runs the local social prescribing scheme.

NHS England actively encourages PCNs to contract with the VCSE sector to host social prescribing link workers, and this is strongly welcomed. The NHS recognises the VCSE as flexible, agile and close to communities, particularly those that statutory services find 'hard to reach'. However, our members highlighted some challenges relating to how national policy is applied locally which should be addressed as the scheme expands further.

One of the main issues that was discussed was that while the total funding envelope for link worker roles is about right, a lack of flexibility in how the funding can be apportioned between direct salary costs and the wider 'support costs' of link workers is causing significant problems. 'Support costs' include a wide range of organisational functions that are required to effectively support and deliver the link worker role, beyond the normal employment on-costs of national insurance and pension contributions, which the guidance does allow. These include:

- training, supervision and professional development, and building capacity to work with people with more complex needs
- IT, telephony and office accommodation
- travel and transport
- HR and governance costs.

NHS England guidance on link worker hosting was revised to allow for an additional £2,400 per link worker for management costs associated with outsourcing, which equates to about 7%, with an additional weighting in London. (This amount is over and above the guided £34,000 for the post plus employment costs.) However, for the LIOs involved in this study, this was unworkably low given that management costs typically run at around 20% when considering the wider costs of delivery, such as workforce development to support those with additional complex needs and wider infrastructure roles (see section 2.3 below) and has led in some cases to VCSEs withdrawing from contracts. NAVCA members feel that this must be addressed either through ARRS or through some additional funding mechanism if a healthy market in link worker hosting is to be grown.

We heard examples of how the change to include a contribution to management costs came too late to prevent a breakdown in relationships and contracts. For example, one LIO that was awarded a contract to employ eight link workers early in the roll-out reported that the PCN did not allow them to use some of the PCN funding towards the cost of the management and supervision of that staff team. This led them to decline the contract award, as it would not have been deliverable without a funded manager post.

Another NAVCA member managed to make savings of £5,000 per annum on the contract but was not allowed to invest this into associated support costs that would have enhanced the service delivery.

We also heard about the notable differences around this issue when comparing urban and rural areas. For instance, the relatively low cost of transport for link workers in cities compared to those travelling around large rural PCN footprints, where both the larger distances involved and the high cost of rural public transport or need to use a car, caused distinct challenges. For example, a link worker in inner London may be able to travel easily by bicycle, whereas in a large rural PCN area, distances might exceed 100 miles.

Further, we heard about the challenges around flat rate expectations of salaries, which, prior to the addition of the London weighting, did not take account of the variance in geography.

This inflexibility is further complicated in areas where social prescribing type schemes already existed and existing providers took on the contracts for new NHS-funded link workers. Having to employ these link workers on different terms and conditions caused management complexity and other difficulties, especially before the additional management costs became available. We heard from one NAVCA member about how a VCSE partnership in the locality had a social prescribing service including link workers and community builders which had been running successfully for five years. Plans were developed for this existing consortium to take on the PCN link worker contracts, but discussions broke down over the lack of funding for management costs.

Complications also arise when one local infrastructure organisation holds link worker contracts with multiple PCNs. For example, if a LIO holds one contract for two link workers, one for four link workers and one for eight link workers and is making economies of scale by delivering a unified service, the funding inflexibility does not allow them to use the economies achieved to resource the additional cost of managing different levels of delivery in different areas. Again, this points to a need to allow local providers of the link worker contracts to be able to move expenditure around.

Recommendations:

PCNs should allow providers to exercise flexibility in how they apportion costs within the overall financial envelope.

NHS England should revisit the guidance and support PCNs to take a flexible approach to contracting independent providers for link worker hosting.

NHS England should explore ways to increase the availability of funding support costs, either through the Additional Roles Reimbursement Scheme or through alternative mechanisms.

This will allow providers to budget for additional management complexities, align link worker employment contracts with other roles and use savings to fund wider costs. It will also increase the number of VCSE providers that are willing to take on link worker contracts.

2.2 Subcontracting link workers

NHS guidance allows link workers to be subcontracted. For example, the main contract holder might want to embed a specialist mental health link worker in a relevant local mental health support organisation, or a consortium of organisations might put forward a bid for a link worker contract as a consortium. This supports the NHS's aim that all partners across a system should collaborate more, which leads to better quality and better coordinated services.

The NHS England guidance on this is designed to encourage such collaborative approaches. However, NAVCA members told us that in many areas PCNs are not allowing providers to subcontract, despite the guidance that they can.

Recommendations:

PCNs should encourage collaborative approaches to delivering link worker hosting contracts and allow contract holders to subcontract (as provided for in national guidance).

NHS England should clarify to PCNs that subcontracting and consortium approaches to delivering the link worker function is encouraged, and support PCNs with practical information on managing multi-level supply chains.

If PCNs have concerns about managing contracts where there are multiple levels of contracting, they could seek expert guidance, for example from NCVO's web content on collaboration and consortia.

2.3 The infrastructure functions associated with social prescribing

NAVCA members highlighted that there needs to be better acknowledgement of the breadth of functions that are required to make social prescribing schemes work well, and better planning for how these functions are funded and embedded within social prescribing schemes.

Some NAVCA members talked about the 'ecosystem' for social prescribing, and the functions that need to exist within that ecosystem for social prescribing to be most effective. These include:

- **the core referral process –** the basic link worker role to support clients to identify their goals through conversation and support them to benefit from appropriate services; in some areas this is supported with a digital platform to aid easy referral.
- **the 'directory'** – maintaining an accurate directory or online platform of community services to which referrals can be made and identifying and filling gaps. (This would incorporate intelligence from link workers and service users.)
- **access and inclusion** – ensuring that frontline services to which referrals are made firstly have basic due diligence in place, such as capacity and safeguarding (where appropriate), and secondly have practices and procedures in place to include those with higher needs, or a wider diversity of users (See the section on inclusion on page 18)

- **practice development** – sharing and learning from good practice; professional and clinical development of staff, and capture and involvement of service users in the design and development of practice
- **community capacity building** – supporting residents to set up peer support and informal networks and community-based activities
- **organisational development** – supporting frontline VCSEs to have the systems and processes in place to effectively manage referrals, including the development of good governance, for example using the Charity Governance Code
- **volunteer development** – supporting, managing and developing effective volunteering roles that contribute to the good functioning of SP schemes and provide development to volunteers
- **the 'infrastructure' function** – stimulating community development through collaboration among service providers, providing a coherent voice and influence for the VCSE sector, facilitating collaboration across the system footprint, coordinating external funding bids, and so on.

The above are all separate functions requiring different expertise, knowledge, connections and skill sets, and the last three in particular (organisational development, volunteer development and infrastructure) are specialist roles that generally only specialist infrastructure organisations and volunteer centres have the expertise to deliver. Whilst NAVCA members felt there is potential for LIOs and link workers to work together on some aspects of these functions (particularly community capacity building, for example supporting simple peer support networks), they felt in most instances link workers should not be seen as the primary delivery agency of these functions. Instead, they feel further thought needs to be given as to how these essential functions are resourced.

We did hear examples of how PCN-employed link workers are duplicating, give the impression of duplication, or raise a risk of duplicating, existing social prescribing type activity. This suggests more could be done to strengthen local implementation planning, particularly between NHS bodies (who in the main fund link workers) and local authority partners (who have historically provided more resource for VCSE activity and VCSE capacity building). This is especially pertinent in areas of high health inequality because resources and access to services are already more stretched.

It is intended that systems should be developing system-wide implementation plans for social prescribing. It was interesting that none of the NAVCA members that took part in this research mentioned this plan, which suggests that in many areas such a plan has not been developed, or if it has, it is not well embedded. NAVCA members should be influencing these plans.

NAVCA members felt that NHS guidance on these supporting functions does not go far enough and that the need for specialist infrastructure to support social prescribing should be acknowledged and funded at place level, and there could be economies of scale in taking a system-wide approach to this.

Recommendations:
Systems should work together with **LIOs**, **local authorities** and the VCSE (through system-level VCSE alliances) to engage in more cross-sector local implementation planning that considers both the hosting and mechanisms of link workers and the funding and supporting of the VCSE sector and infrastructure more widely.

NAVCA should advocate for social prescribing implementation plans to be codesigned in all system areas.

NHS England should work with cross-sector partners to strengthen its requirement on local systems to facilitate the codesign of local implementation plans, with specific regard to the need for, and resourcing of, the full range of infrastructure functions.

2.4 Ensuring sustainable local infrastructure

A well-functioning local infrastructure organisation is a crucial part of the local public service landscape, and they play a vital role in health systems.

Unfortunately, there are now place areas that are no longer covered by a local infrastructure organisation, and in many areas, where LIOs do still exist, their core funding has been reduced to unworkable levels. This is a great disadvantage for all sorts of reasons: the lack of (or lack of capacity of) an infrastructure organisation impacts on the VCSE sector's ability to generate income, recruit volunteers, form partnerships, have a strategic voice, work collaboratively with the public sector, and many more. But specifically in relation to social prescribing, the lack of local infrastructure prevents all those development functions described above from happening, or leads to link workers attempting to plug the gap without the required expertise. This affects the ability of a social prescribing scheme to function optimally.

Several NAVCA members reported that by their very nature as a local infrastructure organisation, they see the necessity for these roles and just do them, even without associated funding, and this places further pressure on their organisations.

Recommendation: Local systems should work collaboratively across the public sector to ensure that there is sustainable local infrastructure provision in all place areas. In areas where there is no local infrastructure organisation, or small LIOs with limited capacity, this might require working with existing organisations to fill gaps or in some areas the creation of new organisations or services. We are not advocating that this is the NHS's responsibility alone, but that ICSs and CCGs can play a brokerage role and lead collaboration across public sector bodies.

Recommendation: PCNs should recognise the importance and value of VCSE infrastructure functions in supporting the effective delivery of social prescribing and work collaboratively across the public sector to ensure that there is sustainable local infrastructure provision in all places to meet the demands of social prescribing.

2.5 The 'community capacity building' and 'organisational development' functions

Given the fluid nature of service provision, with activities and services starting and stopping, organisations opening and closing and so on, it is a challenge to keep abreast of the services and activities to which referrals can be made.

There is therefore a particularly strong need for community capacity building and organisational development of VCSE organisations, especially in areas of high health inequality where there is often less VCSE provision. NAVCA members highlighted how this can be part of a wider strategic approach. In one example, the National Lottery Community Fund and Big Local funded these aspects, which enhanced and made the social prescribing service more holistic.

Despite this, NAVCA members felt that there is a lack of clarity around the scope of these functions and how they relate to link workers. NHS England guidance is that the link workers should have a role in quality-checking the services to which referrals are made. Whilst members understand and agree with the need for quality assurance on the ground, this can cause a lack of clarity as to the boundary between the link worker role and the role of capacity builders, which are usually based in LIOs. Members did not want to say that link workers should never get involved in capacity building, and many highlighted the very important role for the link worker in building community capacity, such as identifying service users with similar needs or issues and facilitating networking and self-help among them. It is more a case of link workers needing to understand and build relationships with those already undertaking capacity building activity and working with them to enhance this rather than duplicating.

This supports the need (as stated above) for a shared local social prescribing implementation plan, which would provide clarity on these functions, who delivers what, and how link workers and capacity builders should collaborate. Without this there is tendency for confusion of roles and duplication of effort.

Recommendations:

ICSs should support and resource link workers and LIOs to codesign local social prescribing implementation plans, which include plans for the community capacity building, organisational development and volunteer development functions.

LIOs should contribute to the development of local social prescribing implementation plans, providing insight on their local sector's capacity, needs and opportunities.

NHS England should work with its partners to clarify and provide a clear joint support offer.

NAVCA members advocate that an asset-based community development (ABCD) and genuine coproduction approach should be taken to community capacity building at a local level.

Recommendation: NAVCA could support its members to share learning around asset-based community development and share learning and expertise with statutory sector colleagues.

2.6 The 'volunteer management' function

Volunteering plays a very significant role in social prescribing, as it does in all public service delivery. Many social prescribing schemes create formal volunteer roles, which both enhances the social prescribing service and builds capacity of the individuals volunteering. However, NAVCA members argued that the recruitment, training and retention of volunteers does not 'happen by magic', and there needs to be a proper funded volunteer management function to support this.

There are other examples where social prescribing schemes facilitate the creation of more informal roles, often called community connectors or active citizens, that build social capital, community resilience and expand the reach of social prescribing into different community groups.

Recommendation: Systems must recognise the importance of volunteer recruitment, management and retention as a necessary function that supports successful social prescribing and facilitate the resourcing of this function.

2.7 National and regional structures to support link workers

NAVCA members reported that there is currently a 'patchwork' of support structures and programmes at national and regional level, including NHS England regional facilitators, PCN advisors and learning coordinators, regional coordinators from the National Academy of Social Prescribing and initiatives such as the VCSE Leadership Programme and the Population Health Management programme. Members have found it challenging to make sense of these, and how to use those offers to best benefit their work.

In most areas of England there is no longer a regional infrastructure body, so the obvious forum for joining it all up is lacking.

Recommendations:

NAVCA should continue to work closely with the remaining regional infrastructure bodies, the National Academy of Social Prescribing (NASP) and NHS England regional teams to ensure that regional infrastructure supporting social prescribing is well joined up, and gaps in areas where regional infrastructure no longer exists are filled with appropriate support.

NHS England should set out a clear offer for systems so that link workers can make better sense of and use the offer strategically. It should also encourage NASP and other regional bodies to do the same.

NHS England should further develop links between social prescribing and other NHS England programmes of work (such as the VCSE Leadership Programme and other work on health inequalities) and build networks that will enable sharing of knowledge and strategic thinking across programmes and agencies.

3. Collaborative working across sectors

Anecdotal evidence from NAVCA members suggests that where social prescribing schemes are either delivered in the VCSE or where there are strong collaborative working relationships between NHS-led schemes and the VCSE, the schemes are far more effective.

There are examples of link workers being well embedded and connected to other parts of the system. For example, in one area the link workers and Macmillan 'signposters' work as a combined team, collectively overseen by the local infrastructure organisation and Macmillan. They previously worked outside of the sector and had very limited knowledge of referral routes and the wealth of services that could be referred to. Now clients of both services are hugely benefitting from the combined intelligence held by the joint team.

However, NAVCA members reported that in many areas, social prescribing is still in a 'silo', cut off from both the rest of the VCSE and the rest of the NHS ecosystem and wider public services. There is often a lack of connection to existing assets and services, and, as stated above, a lack of relationship between the link workers and the VCSE. NAVCA members felt that social prescribing should be better embedded in the whole system at system, place and neighbourhood level, from strategic planning to delivery to evaluation and data sharing.

Social prescribing cannot be a process 'done to' the VCSE by the NHS. It needs to be co-designed and co-delivered in true equal partnership with the VCSE, regardless of whether the link worker contracts sit within the VCSE or the PCN.

NAVCA and its members also recognise that working in this way is new for some parts of the NHS. This presents an opportunity for the VCSE to help the NHS undertake culture change, and help to develop more self-help, asset-based and preventative approaches to tackling some of the health issues that the NHS has struggled with, including addressing the wider social determinants of health and health inequalities.

Recommendation: System leaders should facilitate co-design processes to ensure the link workers are well embedded in existing VCSE networks and referral mechanisms; and support a change of culture towards more collaborative and asset-based planning processes.

4. Commissioning, funding and sustainability of frontline services

Whilst NAVCA members support the expansion of social prescribing, they are concerned that the increased demand on frontline services, without increased resourcing, is challenging their capacity and sustainability. This in turn causes a risk for the effectiveness of social prescribing.

With greater devolution of planning and spending to ICSs, there are opportunities for partners across all sectors (NHS, VCSE, local government and the independent grant-giving sector) to consider the impact that social prescribing is having on service demand and work together to address these systemically.

There is also a need to improve the flow of data and intelligence from link workers to strategic decision makers and planners in the wider system.

4.1 Sustainability of frontline service provision

Given the personalised nature of social prescribing, the support and activities that link workers connect people into could be almost anything. NAVCA members highlighted how, in order for social prescribing to remain effective, the referral process needs to be supported by a broad and sustainable ecosystem of community activity - both in terms of citizen-led self-help and more formal services through organisations. All recognised, however, the challenges in achieving this against a backdrop of funding cuts to the VCSE sector through the period of austerity, and the impact of the Covid-19 on VCSE income.

NAVCA members were supportive of the growth of social prescribing and felt the increase in link workers is needed to meet the growing demand from individuals for such support, especially following the effects of the pandemic. However, there are concerns about how this will continue to be a sustainable model when the supply of activities and support in communities that people are referred to is not supported to grow and, because of the pandemic, has in some cases diminished.

Members discussed how there may need to be targeted funding to rebuild lost services either through existing or new providers, ideally building on the existing social assets in an area and making intelligent use of data collected by social prescribers. Members discussed how current system reforms may present opportunities to address this issue in a different way at a system-wide level and how a more coordinated and strategic approach to funding the sector in local health and care systems would be beneficial.

Recommendations:

ICSs should work with partners including the VCSE, local authorities and grant funders, to understand the needs of the local population and develop a sustainable local offer of activities and support to enable social prescribing to be most effective.

NHS England should make it a requirement of ICSs to work with all partners to develop a sustainable local offer of activities and support to enable social prescribing to be most effective.

NAVCA members recognised that it is not, and should not be, the NHS's responsibility to entirely fund the VCSE sector. Many highlighted examples of innovative local approaches to overcome these funding issues. In one area they developed a place-based giving fund in partnership with the local authority and local businesses.

Recommendation: NHS England should support systems to create local partnerships to identify shared resource to support the growth and sustainability of frontline services.

4.2 The case for 'funding follows referral'

When social prescribing was originally conceptualised, it was envisaged that, like a medical prescription or referral, funding would follow the social prescription. This was an element in the Rotherham pilot scheme that was credited for the scheme's success in reducing public use of secondary and primary care. (Although that scheme had a well-defined target population and was not a universal offer.) The VCSE sector has been campaigning for this for years. But it is now apparent that there is unlikely to be NHS funding for all the activities and support that people are linked into by social prescribing, and also, in many cases, other funders (such as local authority housing or the police and crime commissioner) are more appropriate funders or commissioners.

A better way is a population health management approach which systematically capture the real-time data on service demand and supply that link workers pick up, together with the vast wealth of data and intelligence gained in the VCSE sector, and to use this data to adjust service provision through more agile commissioning at place level.[4]

[4] ***Making better use of voluntary sector data and intelligence in health service planning***, NAVCA & partners, September 2021 (NAVCA website)

Recommendation:

Local commissioners should support and resource the VCSE to systematically capture data from social prescribing service user needs, service demand and service supply, and use the data to inform agile commissioning at place level.

NAVCA should support the VCSE to work with ICSs at place level to use data, intelligence and insight to understand the needs of communities, including information coming from social prescribing referrals (rather than continue to make the case for 'funding follows referral').

VCSEs should work with commissioners and system partners to capture and share data, intelligence and insight on community needs and VCSE delivery to inform local priority setting and service design.

4.3 Commissioning processes

The competitive commissioning environment that still exists is pushing the VCSE through unnecessary competitive processes. This is detrimental to outcomes, as it encourages competition and protectionism and inhibits collaboration for the benefit of users.

With a shift in policy away from the internal market in the NHS (as outlined in the NHS Long Term Plan), now is an ideal moment to re-examine processes at system, place and neighbourhood levels and design systems that facilitate better collaboration, better use of community assets and better involvement of patient and user lived experience. Collaborative commissioning processes can encourage providers to work together to build local assets and services, rather than putting local providers in competition with each other and with out-of-area providers.

NAVCA members believe this shift in commissioning practice will also help foster a wider debate about prevention and bringing interventions further upstream. This also presents an opportunity: if we can develop better cross-sector mechanisms for working across a complex system to support social prescribing, this could be a helpful starting point for tackling other issues such as health inequalities, specific health conditions or crisis response.

Recommendations:

Local commissioners should work with the VCSE to design approaches to commissioning which facilitate better collaboration, better use of community assets and better involvement of patient and user lived experience.

ICSs should involve the VCSE in health and care systems at all levels, and facilitate VCSE input to system leadership, convening and commissioning, not just considered as a service provider.

ICSs should facilitate a strategic plan for supporting the sustainability of the VCSE sector as a whole, and in ensuring that there is 'join-up' between the service user demand that social prescribing generates and commissioning processes.

The **VCSE** should work to develop consortia and alliances where it makes sense – at system, place and neighbourhood level. There is learning from the NHS England VCSE Leadership Programme on this.

There are examples of how VCSE can be engaged strategically in systems from the NHS England VCSE Leadership Programme.

5. Inclusion of people with greater needs

To address inclusion of service users with higher levels of need, or those who traditionally experience systematic disadvantage or exclusion, there are examples of delivery models where specialist link workers have responsibility for specific patient groups or excluded groups, such as children and young people or BAME communities. This better connects people with local community activity, and helps them access relevant services and support, and in NAVCA members' experience can help level up access. However, NAVCA members highlighted the need for greater focus on additional or complex needs at the point of the referred-to activity or service. Some raised concerns that individuals with a higher level of need are being referred to community activity that may not have the capacity to fully meet their needs. Examples include where English is a second language or there is a mental health issue or a disability of some kind. In order to build more inclusive communities, this issue should be addressed systemically.

Our members reported how more formal charitable organisations usually have systems and procedures for ensuring inclusion in their services, but this might be a challenge for small, volunteer-led community groups, where a lack of resource or internal capacity can present an issue around how to accommodate that client. We heard how a lack of funding or capacity building support available to these groups prevents them from identifying and implementing improvements for greater access and inclusion. This can impact negatively on the person being referred, but also existing members of the group.

In one example we heard how link workers started referring men with complex mental health needs to a self-help group, which caused the format and focus of the group to change, and as a result many original members stopped attending. This highlights the need for appropriateness in the referring process, an understanding the landscape of service provision, as well as the need to systematically resource capacity building for the VCSE to meet higher levels of need.

Also, people's needs can change, and it was noted that sometimes a service user might need to be supported back into a higher level of service, particularly in the situation of escalating poor mental health, and often the referral routes to get the person quickly to the support they needed were not in place.

This again points to the need for developing an inclusive local offer of community groups as well as strong cross-sector liaison. Better knowledge of local provision and better mechanisms for liaison and referral back into the statutory sector will lead to much better referring. This requires

a strategic approach where the NHS, local authorities and VCSE are regularly reviewing provision, and potentially resourcing the development of specific capacity.

Recommendations:

Social prescribing schemes should continue to employ specialist link workers targeted to specific communities or patient groups and encourage greater collaboration between these specialist link workers and local VCSE support and development activity to stimulate or support existing activity that is appropriate and inclusive for specific needs.

Social prescribing schemes should ensure effective pathways for those with more complex or acute needs and a clear 're-escalation' process for when a person needs to be redirected to higher tier services.

Local commissioners and **PCNs** should encourage greater collaboration between specialist link workers and local VCSE support and development activity to stimulate or support existing activity that is appropriate and inclusive for specific needs.

Frontline VCSE providers should have the confidence to be able to decline referrals on the basis that they are not best placed to accommodate them and be willing to identify development needs that could enable them to become more inclusive.

Systems (system, place or PCN level) should consider issues of inclusivity in local implementation plans and work with partners to identify resources for training and support for smaller VCSEs to develop and embed inclusive approaches, and **NAVCA members** should advocate locally for this and position themselves to be commissioned to deliver this.

Local contract holders should audit the accessibility of provision they refer to and work with local support offers to identify and act on development needs that could enable them to become more inclusive.

NHS England should continue to support and inclusive approach to social prescribing by identifying and sharing examples of inclusive practice.

NAVCA should members to share learning around the impact of inclusive approaches and approaches to supporting inclusive VCSE services, and to amplify examples of good practice through its networks.

The above recommendations should lead to a stronger, more inclusive network of community services and activities.

6. Summary of recommendations

	NHS England	ICS leaders
Implementation planning	Make development of a place-based implementation plan for social prescribing a requirement for every ICS, with specific regard to the need for, and resourcing of, the full range of infrastructure functions.	Work collaboratively to develop a shared local implementation plan for social prescribing. The plan should consider the ways of working resources and assets required to deliver an effective and sustainable local social prescribing ecosystem, considering the role of link workers and how to support the capacity, quality, inclusiveness and sustainability of VCSE provided 'prescriptions'.
Link workers and associated functions and collaboration	Revisit guidance and support PCNs to take a flexible approach to contracting independent providers for Link Worker hosting, including subcontracting and consortium approaches. Explore ways to increase funding link worker support costs through the Additional Roles Reimbursement Scheme or alternative mechanisms. Work with partners to clarify existing support and continue to build a joint offer that is easily understood and accessible to all involved in the Social Prescribing ecosystem. Further develop the links with other NHS England programmes (e.g. VCSE Leadership Programme and Health & Wellbeing Alliance) to support sharing of knowledge and strategic thinking.	Recognise the importance and value of VCSE infrastructure functions in supporting the effective delivery of social prescribing and work collaboratively across the public sector to ensure there is sustainable infrastructure provision in all places to meet the demands of social prescribing. Recognise the importance of volunteer recruitment, management and retention as a necessary function that supports successful social prescribing and facilitate the resourcing of this function. Facilitate co-design processes to ensure the link workers are well embedded in existing VCSE networks and referral mechanisms; and support a change of culture towards more collaborative and asset-based planning processes.
Commissioning, funding and sustainability of frontline services	Make it a requirement of ICSs to work with all partners to develop a sustainable local offer of activities and support to enable social prescribing to be most effective. Support systems to create effective local partnerships to identify shared resource to support the growth and sustainability of frontline services	Work with partners including the VCSE, local authorities and grant funders to understand the needs of the local population and develop a sustainable local offer of activities and support to enable social prescribing to be most effective. ICSs should involve the VCSE in health and care systems at all levels, and facilitate VCSE input to system leadership, convening and commissioning, not just considered as a service provider. ICSs should facilitate a strategic plan for supporting the sustainability of the VCSE sector as a whole, and in ensuring that there is 'join-up' between the service user demand that social prescribing generates and commissioning processes.
Inclusion	Continue to support an inclusive approach to social prescribing by identifying and sharing examples of inclusive practice.	Consider issues of inclusivity in local implementation plans and work with partners to identify resources to support smaller VCSE organisations to develop and embed inclusive approaches.

	Place and neighbourhood commissioners	NAVCA
Implementation planning	Work collaboratively to develop a shared local implementation plan for social prescribing. The plan should consider the ways of working resources and assets required to deliver an effective and sustainable local social prescribing ecosystem, considering the role of link workers and how to support the capacity, quality, inclusiveness and sustainability of VCSE provided 'prescriptions'.	
Link workers and associated functions and collaboration	Recognise the importance and value of VCSE infrastructure functions in supporting the effective delivery of social prescribing and work collaboratively across the public sector to ensure there is provision in all places to meet the demands of social prescribing. Take a flexible and permissive approach to commissioning Link Worker hosting, allowing flexibility in how providers apportion costs within the overall financial envelope and encouraging collaborative approaches such as subcontracting and consortia models.	Continue to advocate for local social prescribing implementation plans to be codesigned in all system areas and share examples of positive approaches through its networks. Support members to share learning around the role of asset-based community development in delivery of Social Prescribing through its networks. Continue to work closely with regional infrastructure bodies, the National Academy of Social Prescribing (NASP) and NHS England regional teams to ensure infrastructure supporting social prescribing is well joined up, and gaps in areas where regional infrastructure organisation no longer exist are filled with appropriate support.
Commissioning, funding and sustainability of frontline services	Support and resource the VCSE to systematically capture data on social prescribing service user needs, service demand and service supply, and use the data to inform agile commissioning at place. Work with the VCSE to design approaches to commissioning which facilitate better collaboration, better use of community assets and better involvement of patient and user lived experience.	Support the VCSE to work with ICSs at place level to use data, intelligence and insight to understand the needs of communities, including information coming from social prescribing referrals
Inclusion	Continue to commission specialist Link Workers focused on specific communities or patient groups will deliver greater inclusivity. Encourage greater collaboration between specialist link workers and local VCSE support and development activity to stimulate or support existing activity that is appropriate and inclusive for specific needs. Ensure effective pathways for those with more complex or acute needs and a clear 're-escalation' process for when a person needs to be redirected to higher tier services.	Support members to share learning around the impact of inclusive approaches and approaches to supporting inclusive VCSE services, and to amplify examples of good practice through its networks.

	Local VCSE infrastructure & wider VCSE sector
Implementation planning	Work collaboratively to develop a shared local implementation plan for social prescribing. The plan should consider the ways of working resources and assets required to deliver an effective and sustainable local social prescribing ecosystem, considering the role of link workers and how to support the capacity, quality, inclusiveness and sustainability of VCSE provided 'prescriptions'.
Link workers and associated functions and collaboration	LIOs should contribute to the development of local social prescribing implementation plans providing intelligence and insight on their local sector's capacity, needs and opportunities
Commissioning, funding and sustainability of frontline services	VCSEs should work with commissioners and system partners to capture and share data, intelligence and insight on community needs and VCSE delivery to inform local priority setting and service design. VCSEs should develop consortia and alliances where it makes sense.
Inclusion	Local contract holders should audit the accessibility of provision they refer to and work with local support offers to identify and act on development needs that could enable them to become more inclusive. Local infrastructure organisations should advocate locally for resources for training and support for smaller VCSE in access and inclusion issues.

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