

Changing lives, changing places, changing systems

Making progress on social prescribing

Reflections from leaders with an interest
in place-based health and community wellbeing



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Summary

In 2020 National Voices published a [report](#) exploring the experience of voluntary, community and social enterprise (VCSE) sector organisations in relation to the NHS roll out of social prescribing through primary care networks. This report identified a mutual interest across the health and VCSE sectors in realising the potential of social prescribing to drive a shift towards community-based, person-centred support. However it also identified a need for a wider range of organisations to come together in support of making this happen.

In summer 2021, National Voices, in partnership with New Philanthropy Capital and supported by NHS England and NHS Improvement, convened a series of discussions with key stakeholders across sectors around how to galvanise action.

We heard cross-sector support for action to realise the potential of social prescribing as a driver of system change. As a personalised, holistic, targeted, community-based and preventative approach to support more people to live well in the community, social prescribing embodies the shift we all want to see across the health and care system. This is ever more vital in the context of the pressures that people and communities face with the impact of the pandemic now compounded by the cost of living crisis. It is also critical given the strain being felt right across statutory health and care services, including the need to address the elective care backlog. The NHS investment in social



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prescribing link worker roles represents a tangible investment in capacity to support a range of shared priorities including tackling health inequalities, levelling up communities and improving health and wellbeing. However participants recognised that a cross-sector effort was needed to develop the wider ecosystem into which social prescribing fits – this includes NHS funded social prescribing link workers, as well as other staff and volunteers working in ‘connector’ roles within communities, the agencies which identify and refer people into these connectors, and the wide range of activities, services and organisations with which people are ultimately connected, and which support healthy communities. This will require a commitment to doing things differently – working collaboratively in new structures and in new ways – across all sectors, including the VCSE sector.

Cross-sector planning and coordination



Every ICS must have structures to support cross-sector collaboration, strategic planning, and funding of social prescribing ecosystems.



Social prescribing will not realise its potential unless we have the right structures and systems in place to support it. We heard that newly forming Integrated Care Systems (ICSs) have a key role to play, and in some areas are already gripping this agenda. However other areas will continue to lag behind without clear direction from the centre. If we are to realise the potential of social prescribing, every ICS must have structures to support cross-sector collaboration, strategic planning, and

funding of social prescribing ecosystems. However central requirements must allow enough flexibility to build mechanisms suited to local context. In most areas it will be more appropriate for plans to be developed at place level, with the ICS taking an oversight role.

NHS England and NHS Improvement should require every ICS to have:

- **A named body with responsibility for leading on developing local cross-sector plans for social prescribing and securing cross-sector investment** in social prescribing ecosystems, across the formal health system and the VCSE sector. Depending on the local context, these functions may be carried out by primary care networks, place-based groupings such as Health and Wellbeing Boards, local VCSE Alliances, or by ICSs themselves. They should be built upon existing collaborations wherever possible
- **Oversight of delivery of local social prescribing plans across their system**, with a particular eye on managing the demands placed on core partners, including the VCSE sector

To be effective, social prescribing link workers must be embedded within wider “social prescribing ecosystems” – contributing to and drawing on the work of far wider group of partners. In many areas cross-sector collaborative bodies have already been established to work on other agendas and new VCSE Alliances are being developed to support the sector to engage with ICSs. It may be most appropriate to task these existing collaborations with work on social prescribing. It will be important to avoid multiple directives for collaborations coming from different parts of the NHS. Partners will



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only be able to engage if structures make sense and demands on time are managed. To achieve this:

- **NHS England and NHS Improvement must streamline the ask it makes of the VCSE sector at local, regional and national levels:** It must align the messages being sent, requirements being set, and support offers being made across programmes for collaboration between the VCSE sector and health system at national, regional and local levels. These include programmes around reducing health inequalities, population health management, anchor institutions, community connector or development programmes, voluntary sector partnerships and social prescribing
- **ICSs must commit to building on existing collaborations wherever possible:** ICSs must map and understand existing structures for collaboration and cross-sector working before establishing new mechanisms to support strategic planning around social prescribing

The Social Prescribing Maturity Framework¹, being developed by NHS England and NHS Improvement, offers an opportunity to set out clearly the roles and responsibilities of NHS bodies at system, place and neighbourhood level in the strategic planning and delivery of social prescribing.

Coordinated funding for community capacity

Social prescribing link workers can only be effective if they work in the context of thriving communities. The funding for community activity has always come from a wide range of sources across sectors and this will continue to be the case. However there may be opportunities to ensure that funding from different sources is better aligned with the overall needs of local populations, particularly those living with high burdens of ill health and inequality. This would also support funders in channelling their support to places and activities where it is most needed, reducing duplication and maximising impact. The rich insight

¹The Social Prescribing Maturity Framework will be published on the Social Prescribing Collaboration Platform see: <https://future.nhs.uk/connect/ti/socialprescribing/grouphome>. Please contact england.socialprescribing@nhs.net to join



There is a huge opportunity if we can support a smooth flow of data across local and national actors, and sectors, around the needs being identified by social prescribing link workers.



being generated by link workers and held by community organisations, needs to be brought together with data gathered in Joint Strategic Needs Assessments, and as part of Population Health Management and the new Core20PLUS5 health inequalities approach, to inform local funding priorities and plans.

To enable adequate investment in community capacity to support social prescribing and other community wellbeing approaches:

- **ICs must commit to contributing funds to build community capacity** where need is identified through social prescribing, as part of a coordinated, collaborative approach involving a range of national and local funders

This should be led by a designated body at system, place or neighbourhood level (as recommended above). Options for funding will likely range from collaborative commissioning of provider alliances, through to grant funding and even micro-grants to seed fund community activity, peer support etc.

Bringing together funding across sectors – including from statutory and charitable funders – to support work to achieve agreed outcomes, has significant potential to deliver better results, while avoiding duplication and high procurement costs for all involved. However we heard that long-term planning for funding of community capacity must be informed by realistic expectations around charitable funders' ability to work in partnership with the statutory sector, and to provide long-term revenue funding.

Better data to unlock commitment

Across all sectors we saw that improving the flow of data into and out of social prescribing could unlock strategic commitment and investment. There is a huge opportunity if we can support a smooth flow of data across local and national actors, and sectors, around the needs being identified by social prescribing link workers, and the capacity available to meet these needs in each area. We can also do more to ensure that the rich insight into community assets and needs held by community organisations informs approaches being taken. To do this:

- **Data strategies and protocols for ICs must allow partners in social prescribing to share data:** NHS England and NHS Improvement must prioritise this agenda, including clearing pathways for the timely and efficient sharing of data with VCSE partners
- **Insights from the community, including qualitative data and stories must be part of the picture:** NHS England and NHS Improvement needs to support ICS leaders in creating space for qualitative insights and stories from the VCSE to inform their work, particularly to support understanding of the needs of more marginalised communities
- **The burden of data collection must be minimised:** NHS England and NHS Improvement needs to support ICS leaders in limiting the burden of bespoke data collection across sectors, using data that is already collected wherever possible
- **Existing data must be shared:** Data gathered and analysed locally for other purposes – e.g. population health management, high intensity use services, hospital discharge etc – should be used to inform and support proactive social prescribing link working and insights from social prescribing should inform these wider programmes.
- **Data must flow between national and local levels:** National service providers should seek out data from local social prescribing services to help understand

patterns of need across communities. Establishing effective protocols should be a priority for those developing data strategies.

Getting the message across

While the people we talked to were enthused by the potential of social prescribing, there remain significant gaps in understanding across key sectors which needed to be engaged. There is work to be done to communicate the long-term strategic commitment to social prescribing. We recognised a need for clearer, and tailored, communication – particularly from bodies such as the National Academy for Social Prescribing and NHS England and NHS Improvement - to:

- **Make clear how social prescribing fits with wider strategy:** Communications should emphasise the strategic importance of social prescribing. They should make clear how social prescribing supports the long-term shifts envisaged for the health and care systems and the core purposes of ICSs around improving population health, tackling inequalities, enhancing productivity and value for money and supporting broader social and economic development across communities
- **Make clear how social prescribing impacts key outcomes such as inequalities and service demand:** Health partners need to be explicit about how social prescribing links to the priorities of other key partners including national government departments, local authorities and charitable funders
- **Make clear that the NHS investment in social prescribing link workers is a contribution to wider community capacity – and that social prescribing is a cross-sector programme with cross-sector leadership and funding:** There are opportunities to demonstrate this more 'generous' framing through key NHS England and NHS Improvement publications

Introduction

This report presents the findings from a programme of activity undertaken in summer 2021 by National Voices in partnership with New Philanthropy Capital, and supported by NHS England and NHS Improvement.

The programme was designed to follow up to the National Voices' 2020 [report](#) Rolling out social prescribing, with an emphasis on galvanising action with stakeholders beyond NHS England and NHS Improvement.

Its aim was to identify how best to capitalise on the opportunity created by NHS England's investment in the recruitment of social prescribing link workers within Primary Care Networks. The vision is that developing effective and sustainable place-based infrastructure for social prescribing, within newly forming Integrated Care Systems (ICs), will contribute to work to reduce health inequalities and improve community wellbeing, as well as to a range of other mutually valued outcomes.

The programme sought to identify:

- Practical actions that could be taken by a range of individuals and organisations
- Areas for action at national level – for consideration by the cross-Governmental working group on social prescribing.

It was taken forward through a series of roundtables held in summer 2021 with leaders from four key groups:

- ICs
- Central Government departments and national bodies involved in the design and delivery of services that meet needs around welfare, work, housing etc.
- Funding organisations
- Local government and organisations with an interest in place-based health

Detailed recommendations for future action were shared with NHS England and NHS Improvement throughout the programme.

This short report summarises the insights from those discussions and reflects on what needs to happen next to progress social prescribing and maximise its ability to contribute to system change and wider policy objectives.

By publishing this summary, we hope to encourage a cross-governmental and cross-sector response to social prescribing, to ensure it can fully contribute to addressing health inequalities and improving community wellbeing.

Context

For the NHS, social prescribing is a relatively new model of care that improves health and wellbeing of individuals, builds community capacity and reduces demand for statutory services from health services, to social care, to housing advice, and particularly reduces pressure on GPs. It sits at the heart of NHS ambitions for system change as a practical embodiment of personalised, joined up, preventative, community-based care that addresses the social determinants of health. However, in many communities, approaches that link people with health issues to wider non-medical support are well established, and work to help people live healthy, fulfilling and active lives is core business for much of the voluntary, community and social enterprise (VCSE) sector. NHS funded social prescribing link workers are part of a broader ecosystem of support – which includes other staff and volunteers working in ‘connector’ roles within communities, the agencies which identify and refer people into these connectors, and the wide range of activities, services and organisations with which people are ultimately connected, and which support healthy communities.

Social prescribing started in the VCSE sector, but in 2019 in recognition of its impact, NHS England and NHS Improvement made it national policy to reimburse the cost of social prescribing link workers recruited by primary care networks (PCNs) across England. This significant investment was intended not just to grow a specific workforce, but to catalyse wider transformation in health and care services as envisaged in the NHS Long Term Plan, and underpinned by the commitment to Universal Personalised Care. Policy on social prescribing needs to be understood in the context of the wider system shift of which it is part.



Social prescribing has a critical role to play in delivering core priorities around reducing health inequalities and supporting people to stay well in the community as NHS backlogs are cleared.



The NHS Long Term Plan envisaged that social prescribing link workers would work alongside other roles being created in primary care as part of multidisciplinary teams. These teams include other personalised care roles like community pharmacists, mental health workers and health and wellbeing coaches. Social prescribing is part of a wider suite of community-based interventions including programmes around hospital discharge, and high intensity use services in Accident and Emergency. Together these programmes are part of an overarching shift towards greater collaboration between health services and systems and the capacity and assets of their wider local communities. The Plan envisaged that this would be funded by bringing together resources across systems to support thriving healthy communities. However, as the National Voices’ report in 2020 identified, there was still considerable work to do to realise this vision and much of the change that needed to happen to make social prescribing work, lay beyond the control of NHS England and NHS Improvement.

Making this shift happen is now more urgent than ever. The Covid-19 pandemic laid bare again the devastating realities of health inequalities across our communities and has shown that we need to do better at reaching into marginalised communities and closing the gaps in the support available in the most deprived areas. The pandemic has also increased the urgency of finding ways to support people to stay well within

their communities – reducing pressures on health and care services. Social prescribing has a critical role to play in delivering core priorities around reducing health inequalities and supporting people to stay well in the community as NHS backlogs are cleared.

More positively, in many places, the pandemic brought down barriers to collaboration and led to creative thinking about how to meet health and wellbeing needs drawing on the strengths of all sectors. Link workers were recognised as vital parts of the local health and wellbeing ecosystem and often played a crucial role alongside other community linking roles in coordinating support. Throughout the Covid-19 lockdown many social prescribing link workers, often based in the VCSE sector, helped to bridge the gap between health services and the capacity of communities to respond to people's needs. Often social prescribing link workers proactively contacted people known to be at particular risk (either due to their clinical conditions, or due to their wider circumstances) to offer additional support. This proactive approach is now being taken into business as usual.

However we know there is more to be done to support the shift envisaged in the Long Term Plan. While the roll out of social prescribing continues – with over 1600 link workers already in post across PCNs² – the need for more support in the community will only grow as we move into pandemic recovery, facing ongoing pressure on health and care services and with people managing long waits for elective treatment.

If social prescribing link workers are to be able to play their role effectively, then we need to ensure that the wider social prescribing ecosystem into which they fit is properly planned and resourced, with cross-sector plans and investment not only in link workers but also the support and activity into which they link individuals.

This will require action not just across the newly forming ICSs and place-based groupings such as Health and Wellbeing Boards, but also within national statutory and non-statutory bodies – including those with responsibility for issues such as housing, money, work and mental health.

²At September 2021



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Through our conversations about social prescribing with leaders from across sectors a number of consistent themes for action emerged. These are explored in the subsequent sections.

Creating mechanisms for collaboration across places and systems

Social prescribing is a whole system intervention which is most effective in the context of thriving communities and wider system collaboration.

Through our engagement we recognised the need to engage a wide range of partners at national, system and local levels (Figure 1).

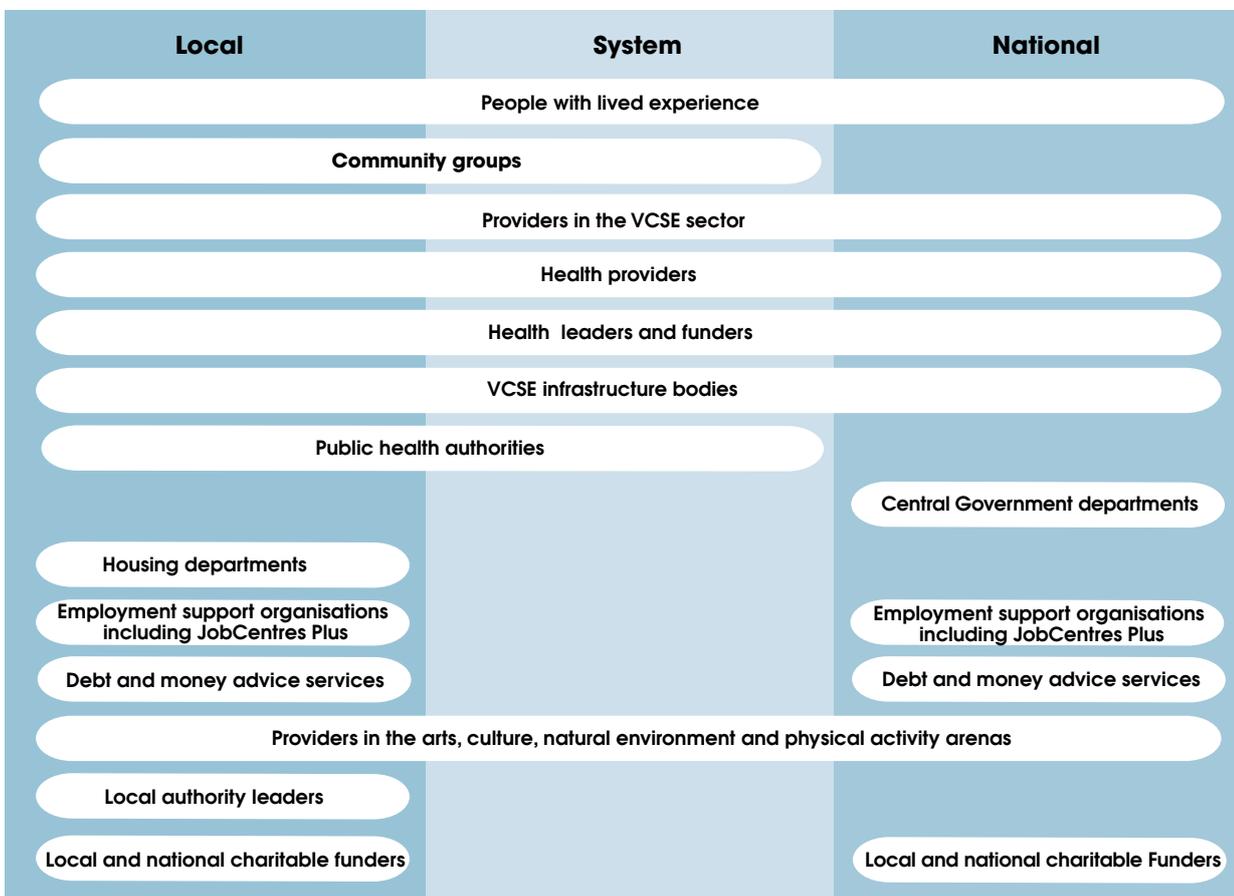
Collaboration will be vital to close gaps in support and activities in communities and to ensure that social prescribing informs and is informed by wider planning and commissioning of community-based services

across health, care, local authorities and beyond.

However we know that collaboration is not easy – it takes time and resource to build relationships and establish ways of working. There is still work to do within the VCSE sector to shift away from competition and towards collaboration. And, beyond this, new relationships need to be built with a range of organisations, many of which are under pressure and going through periods of change.

Figure 1: Who needs to be part of social prescribing planning?

Level of operation:



There need to be structures, within every ICS, to support collaboration. Without a clear directive from the centre, we know that some areas will not make progress. However at the same time we heard that central requirements for bespoke structures just for social prescribing would not be helpful. In many areas there are already established mechanisms for collaboration; there is work underway, as part of ICS development, to establish cross-sector partnerships at system, place and neighbourhood level, including in PCNs around population health management and tackling health inequalities; and VCSE Alliances are being brought together to support the sector to work with ICSs.

What is needed is clarity on the baseline functions required, and flexibility to deliver these by building on existing community assets – the relationships and connections as well as the formal structures. To do this there needs to be coordination across the different workstreams seeking to foster partnerships across NHS bodies and the VCSE and others.

We need all areas to have structures in place for collaboration, planning, and funding. We need:

- Structures to enable strategy and planning for social prescribing - encompassing the recruitment and deployment of link workers across communities, and the community-based support and activity
- Structures for collaborative funding and commissioning
- Mechanisms through which the intelligence that emerges through social prescribing about community needs can inform the wider provision of local services from both statutory and VCSE sector providers.

In many areas, place-based structures will be most appropriate, but ICSs should have a role in oversight, ensuring that there is progress towards mature social prescribing ecosystems.²

We recommend:

- **ICSs should be required to designate a named body with responsibility for leading on developing local cross-sector plans for social prescribing and securing cross-sector investment** in social prescribing ecosystems, across the formal health system and the VCSE sector. Depending on the local context, these functions may be carried out by primary care networks, place-based groupings such as Health and Wellbeing Boards, local VCSE Alliances, or by ICSs themselves. They should be built upon existing collaborations wherever possible
- **ICSs should be required to have oversight of delivery of local social prescribing plans across their system**, with a particular eye on managing the demands placed on core partners including the VCSE sector

Structures for strategy and planning

The work to support and develop the social infrastructure that people need in communities requires a strategic commitment and clear joined-up plans across sectors and at all levels of the new NHS structure – system, place and neighbourhood. Plans should cover the recruitment and deployment of social prescribing link workers (as part of joint workforce plans as envisaged in the Integration White Paper), and the funding and delivery of wider community support and activity needed for social prescribing to be effective.

Work to develop and and sustain the social infrastructure that provides community-based support is often place-based. Historically it has been led by local authorities, often working with voluntary sector infrastructure bodies. In most areas this will be the right level for these conversations to continue, so we need

³The Social Prescribing Maturity Framework will be published on the Social Prescribing Collaboration Platform see: <https://future.nhs.uk/connect.ti/socialprescribing/grouphome>. Please contact england.socialprescribing@nhs.net to join

to ensure the structures within PCNs and ICSs support this. But the precise structures needed for strategic planning are likely to differ in different places.

The original [guidance](#) for social prescribing included a requirement for shared plans for social prescribing to be developed by clinical commissioning groups. However implementation has been patchy. The creation of ICSs offers a new opportunity to address these gaps.

However we must avoid reinventing wheels. There are existing alliances, models and approaches in local areas which bring together the key partners to make social prescribing a success – in some areas Health and Wellbeing Boards do this, in others forums have been brought together by community foundations, in others there are existing social prescribing networks. We need guidance that outlines the arrangements that encourage this work, while offering enough flex for local areas to build on what is already working.

Building genuine collaboration is not easy. It requires a cultural shift across organisations. Culture change can be encouraged from the centre, but it can't be mandated from the top down, nor can processes be 'lifted and shifted' from one place to the next.

In some areas the roll out of social prescribing has provided the catalyst to conversations about collaborating across sectors, but in others this work has been started through other routes – as a response to other NHS agenda (such as health inequalities), led by local government, driven by the VCSE sector, or kickstarted by crisis management in the early days of the pandemic. The push towards developing



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All stakeholders recognise the need for cross-sector funding for social prescribing, but shifting from this recognition to a commitment of funding remains the challenge.



infrastructure to support cross-sector working continues to come from a number of angles – for example with new guidance from NHS England and NHS Improvement requiring ICSs to develop infrastructure to support strategic relationships, embedding the VCSE sector into ICS governance, leadership and decision making.

All groups welcome this focus on collaboration, but we need to avoid creating overlapping infrastructures. Having to deal with multiple structures creates barriers to engagement among vital partners, especially in the VCSE sector. These barriers can be particularly felt at both ends of the spectrum – by the smallest community organisations (which often work with the most marginalised communities) and by national bodies (often with specialist expertise in supporting groups with complex needs). Across the spectrum it is already a struggle to navigate the different local arrangements and find the capacity to deal with different parts of different systems individually. Many organisations therefore find it hard to bring their resources to the table.

There are opportunities for streamlining, however. For example, in our discussions with funders, we recognised that in key fields such as arts and culture and physical activity, regional posts are being created to coordinate links between community-based provision and social prescribing. Bringing together this newly created regional capacity and resource may offer one solution to capacity constraints that limit VCSE sector engagement with key structures at present.

Creating clear, and simple structures for strategic planning on social prescribing is vital for success. This means:

- **NHS England and NHS Improvement must streamline the ask it makes of the VCSE sector at local, regional and national levels:** It must align the messages being sent, requirements being set, and support offers being made across programmes for collaboration between the VCSE sector and health system – at national, regional and local levels. These include programmes around reducing health inequalities, population health management, anchor institutions, community connector or development programmes, voluntary sector partnerships and social prescribing
- **ICSs must commit to building on existing collaborations wherever possible:** ICSs must map and understand existing structures for collaboration and cross-sector working before establishing new mechanisms to support strategic planning around social prescribing

The Social Prescribing Maturity Framework, being developed by NHS England and NHS Improvement, offers an opportunity to set out clearly the roles and responsibilities of NHS bodies at system, place and neighbourhood level in the strategic planning and delivery of social prescribing.

Structures for collaborative funding and commissioning

Levelling up social infrastructure will be vital if social prescribing is to realise its potential in addressing health inequalities and if we are to ensure that the needs and priorities being identified by social prescribing link workers can consistently be met.

While the NHS has invested significant sums in social prescribing link workers, effective social prescribing relies on a wider ecosystem with strong communities and

social infrastructure with which people can connect for support and activities. Not all communities have the same access to community groups, activities and services. Social infrastructure – from community spaces, to VCSE services – tends to be weakest in more deprived areas. Without new investment, social prescribing will only work in areas where communities are well organised and supported, and this will further entrench health inequalities.

All stakeholders recognised the need for cross-sector funding for social prescribing, but shifting from this recognition to a commitment of funding remains the challenge.

The longer-term shift envisioned within the NHS Long-Term Plan ought to lead to a transfer of statutory resources from traditional health and care services towards community-based services. This will take time, so we need to ensure that the structures we develop today to support social prescribing are fit for purpose – with both short-term mechanisms to fill gaps in community capacity that are identified through social prescribing, and the mechanisms to ensure that future investment plans are built on insight about the needs and assets of communities.

Funding for social prescribing needs to flow from the right strategic relationships and a shared vision. The best mechanisms for funding are likely to differ from one community to the next, and they should be built on what is already working well. It doesn't make sense to have separate funding conversations about building community capacity for each of the different pathways and policy arenas where it is of interest, because the same community groups and activities are called upon as part of a wide range of programmes including discharge support, anticipatory care and addressing health inequalities.

Communities' social infrastructure is a key tool in keeping people healthy and reducing health inequalities. It is highly relevant to social prescribing, but is also vital for wider agenda including population health management and addressing health inequalities.

The funding for this social infrastructure has always come from a range of sources, including from various NHS and other statutory bodies who fund community connecting / building / capacity within their local VCSE sector organisations, and the national and local charitable funding and voluntary income on which those organisations also rely. This cross-sector funding model needs to continue, with ICSs recognising their part and making a shared strategic commitment to strengthen this community capacity on which they will increasingly rely, not just in relation to social prescribing but across their wider agenda.

It makes sense for some specific funding to be allocated to social prescribing activities – as already happens in some communities – potentially in the form of community development / capacity building funding spent directly by link workers. However, social prescribing link workers will always need to draw on support and resources far beyond those that could be directly funded through ring-fenced pots. To support social prescribing ecosystems we are likely to need a combination of bespoke structures and funds to support activities specifically linked to social prescribing – e.g. shared social prescribing funds held at ICS or place level to support priority activity e.g. around reducing health inequalities – and a broader commitment to investment in community-based activity across systems.

Link workers also draw on wider statutory and non-statutory provision. In National Voices' 2020 [report](#) we explained how link workers regularly identify needs in relation to welfare, work and housing as well as wider health and social care services such as mental health support. Since the start of the pandemic this aspect of link workers' caseloads has only increased. Some of this support comes from statutory services and is funded through a complex range of national and local structures. Many social prescribing teams have relationships with providers of these services locally, but building these relationships can be a drain on capacity. There are also gaps in provision, on the one hand, and national providers struggling to link in their support through local mechanisms on the other. So there are



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opportunities to make things work better.

Joint commissioning groups have come together in some places to pool resources for the community-based activities and support social prescribing identifies as needed, in other areas there are plans to use evidence emerging from the social prescribing link workers to inform local commissioning decisions. However elsewhere there continues to be a disconnect between the pace of the recruitment of link workers and funding to develop the capacity of community-based services and assets to respond. This is a problem, especially in the context of the current fundraising environment and the wider impact of the pandemic on VCSE sector capacity.

In many areas we will need new structures to support cross-sector investment in social prescribing ecosystems, to ensure that funds are channelled towards the places and activities where they are most needed, and in line with priorities identified through processes such as Joint Strategic Needs Assessments, Population Health Management processes and the new Core20PLUS5 inequalities approach. By bringing together funding from different sources there is an opportunity better align spending with the overall needs of local populations, reducing duplication and maximising impact.

One of the key areas of interest to NHS leaders is tapping into sources of voluntary income, potentially creating shared funding pots at an ICS level. However, while this idea was attractive, in our discussions we identified some complexities in making this happen in practice. For example independent funders told us that they



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should not be thought of as a bloc – each has their own funding priorities, processes and restrictions which limit the extent to which they can supply funding to other organisations' programmes. We also heard that many funders were not able to fund activity which could be considered the responsibility of statutory services, and that few would fund services in the long term, preferring to pilot and test new approaches which could then be absorbed into the statutory offer. Structures need to be designed to recognise voluntary funders' operating models and to be realistic about the extent to which charitable funders can provide long-term revenue funding for needed services.

While the pandemic has accelerated moves towards collaborative funding across statutory and charitable funders and commissioners, most continued to fund in specific areas and towards specific objectives. This is unlikely to change. This is a challenge for social prescribing which by definition meets a wide range of needs and achieves a wide range of outcomes.

Funders and commissioners told us that there would be potential to bring together funding across sectors to support community capacity. However, to unlock this, potential funders would need to be confident that investing in shared funds for social prescribing was the best way of meeting the needs of their core constituencies / addressing their core areas of interest. Unlocking the rich insight that link workers have into the challenges individuals face in different communities and to the gaps in provision would be one way of making the case for such funding. However at present this data is inaccessible. Improving the flow of data around the needs being identified

through social prescribing, the capacity of the community to respond and the outcomes that can be achieved through these approaches will be critical to making progress.

Better data would enable funders to demonstrate that their funding objectives were being met. This will remain a prerequisite for bringing more funding partners into alignment with the social prescribing and community wellbeing agenda.

To enable adequate investment in community capacity to support social prescribing and other community wellbeing approaches:

- **ICS must commit to contributing funds to build community capacity** where need is identified through social prescribing, as part of a coordinated, collaborative approach involving a range of local and national funders

This should be led by a designated body at system, place or neighbourhood level (as recommended above). Options for funding will likely range from collaborative commissioning of provider alliances, through to grant funding and even micro-grants to seed fund community activity, peer support etc.

Bringing together funding across sectors – including from statutory and charitable funders – to support work to achieve agreed outcomes has significant potential to deliver better results, while avoiding duplication. However we heard that long-term planning for funding of community capacity must be informed by realistic expectations around charitable funders' ability to work in partnership with the statutory sector, and to provide long-term revenue funding.

Structures for sharing data and insight

As an holistic service, working with people across all of the issues which affect their lives, social prescribing generates huge insight into the needs and ambitions of people living in different communities.

One of the areas that most excited the stakeholders to whom we spoke, was the potential of the rich insight generated within social prescribing services around local needs, assets and priorities. However making this data easy to capture and ensuring it can flow across organisations within different places and systems remains a challenge.

At the same time social prescribing schemes would benefit from tapping into others' networks and knowledge to understand community capacity and need, so they can tailor support and provide proactive specialist support where needed. This insight is not always found in formal quantitative data, but rather in qualitative data and



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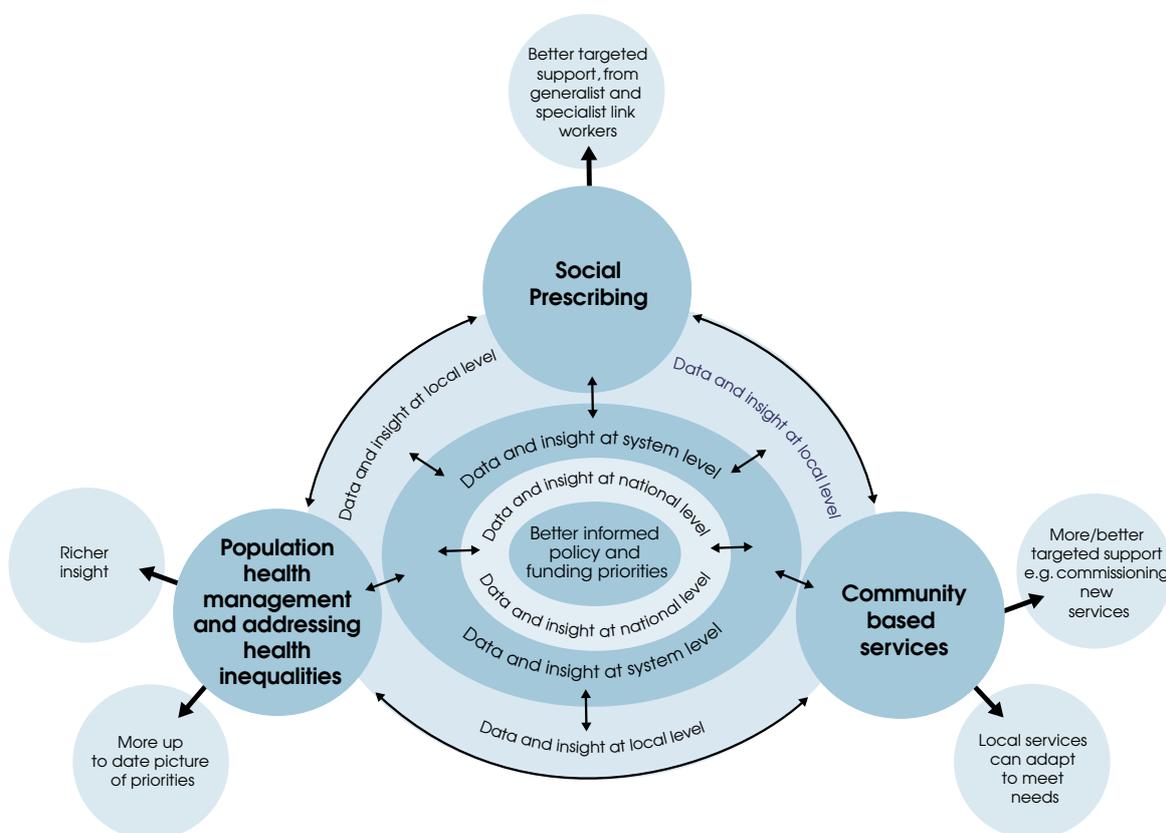


stories from the VCSE sector and other groups in the community – particularly for marginalised communities. All of this data is needed to support social prescribing.

We also need to share data about the impact of work in communities. Creating structures to support data sharing across sectors, in relation to the needs identified by social prescribing link workers and the capacity of local community organisations to respond, will be vital. We need new structures to enable timely and efficient data sharing across NHS bodies and VCSE sector organisations.

It will also be important to ensure that data from local social prescribing schemes can

Figure 2: Improving the flow of data to support social prescribing



be brought together and shared at system level and with national partners. As well as referring people to support from local organisations social prescribing link workers also identify needs for services which are commissioned, funded and provided at national level – by both statutory and VCSE sector organisations. We need to ensure – for example – that insights from local schemes around gaps in support for mental health services, or job support can be quickly identified and shared with those making national policy and funding decisions. Data from local level should be shared at national level to inform funding and policy decisions in key departments including the Department for Health and Social Care, but also the Department for Levelling Up, Housing and Communities, Department for Work and Pensions and Department for Digital, Culture, Media and Sport.

While there are emerging mechanisms (including some digital tools) for capturing basic data around referrals and some outcome measures, there is still more to be done to create a virtuous circle of data flow across both statutory and non-statutory services in the wider social prescribing ecosystem and from local to national level. The trick will be, wherever possible, drawing on data that is already being collected and analysed to understand the picture across systems, rather than creating bespoke mechanisms. This must include insight from people and communities, including qualitative insights around the needs of marginalised communities. This should be taken forward as part of wider work going on across the NHS to support emerging ICSs to develop data strategies.

Improving the flow of data into and out of social prescribing could unlock strategic commitment and investment. There is a huge opportunity if we can unlock better data across local and national activity. To do this:

- **Data strategies and protocols for ICSs must allow partners in social prescribing to share data:** NHS England and NHS Improvement must prioritise this agenda, including clearing pathways for the timely and efficient sharing of data with VCSE partners
- **Insights from the community, including qualitative data and stories must be part of the picture:** NHS England and NHS Improvement needs to support ICS leaders in creating space for qualitative insights and stories from the VCSE to inform their work, particularly to support understanding of the needs of more marginalised communities
- **The burden of data collection must be minimised:** NHS England and NHS Improvement needs to support ICS leaders in limiting the burden of bespoke data collection across sectors, using data that is already collected wherever possible
- **Existing data must be shared:** Data gathered and analysed locally for other purposes – e.g. population health management, high intensity use services, hospital discharge etc – should be used to inform and support proactive social prescribing link working and insights from social prescribing should inform these wider programmes
- **Data must flow between national and local levels:** National service providers should seek out data from local social prescribing services to help understand patterns of need across communities. Establishing effective protocols should be a priority for those developing data strategies.

Developing understanding of social prescribing

To make progress at the pace that is needed stakeholders need a clear understanding of social prescribing – what it is, how it works and (critically) the outcomes it supports. Yet during our discussions, and in line with our findings in 2020, we found gaps in understanding of what social prescribing is and how the investment in social prescribing link workers fits into the wider policy agenda. These gaps actively hinder progress.

The basic premises of social prescribing – that many of the determinants of our health and wellbeing sit beyond the reach of the health system; that community-based responses have a vital role to play in supporting people to recover and stay well; and that person-centred and holistic support is vital – are widely understood and accepted. The question social prescribing answers is one that is of interest to a wide range of actors across sectors. However awareness of social prescribing as a response to these issues remains low and discussions can be caught up in concern about language and leadership.

There are two key issues:

- General lack of awareness among those outside the health system / with minimal contact with the VCSE sector / primary care
- Misperceptions of social prescribing as a medical model among those closer to the health system but without experience of social prescribing in action

As a result even those working on directly relevant agenda – such as tackling health inequalities, improving community wellbeing,



The question social prescribing answers is one that is of interest to a wide range of actors across sectors.



levelling up or building community capacity – do not necessarily recognise social prescribing as an approach that could support their aims.

This matters because as a result:

- Opportunities are missed for other parts of government, civil society and funders to piggyback / build upon the investment being made by NHS England in link workers, to support the development of community-based responses
- Overlapping and duplicating solutions are developed in isolation

There is still work to do to get across what social prescribing is really about. This means focusing less on the link worker role and the detail of the model and more on the instrumental role social prescribing can play in achieving a range of core objectives that are of interest to critical actors who have the power to make things happen. There are three elements that need to be communicated better:

- How social prescribing is set within a wider ecosystem of community health approaches
- The impact of social prescribing on a wide range of priority outcomes including reducing health inequalities and demand for statutory services
- Social prescribing as part of a strategic shift towards more preventative, holistic, equitable health and care, and more community-based services

The social prescribing ecosystem

One tension uncovered during our conversations concerned the framing of social prescribing. Many highlighted the potential benefits of moving to a more generous framing, recognising how social prescribing link workers fit within a wider

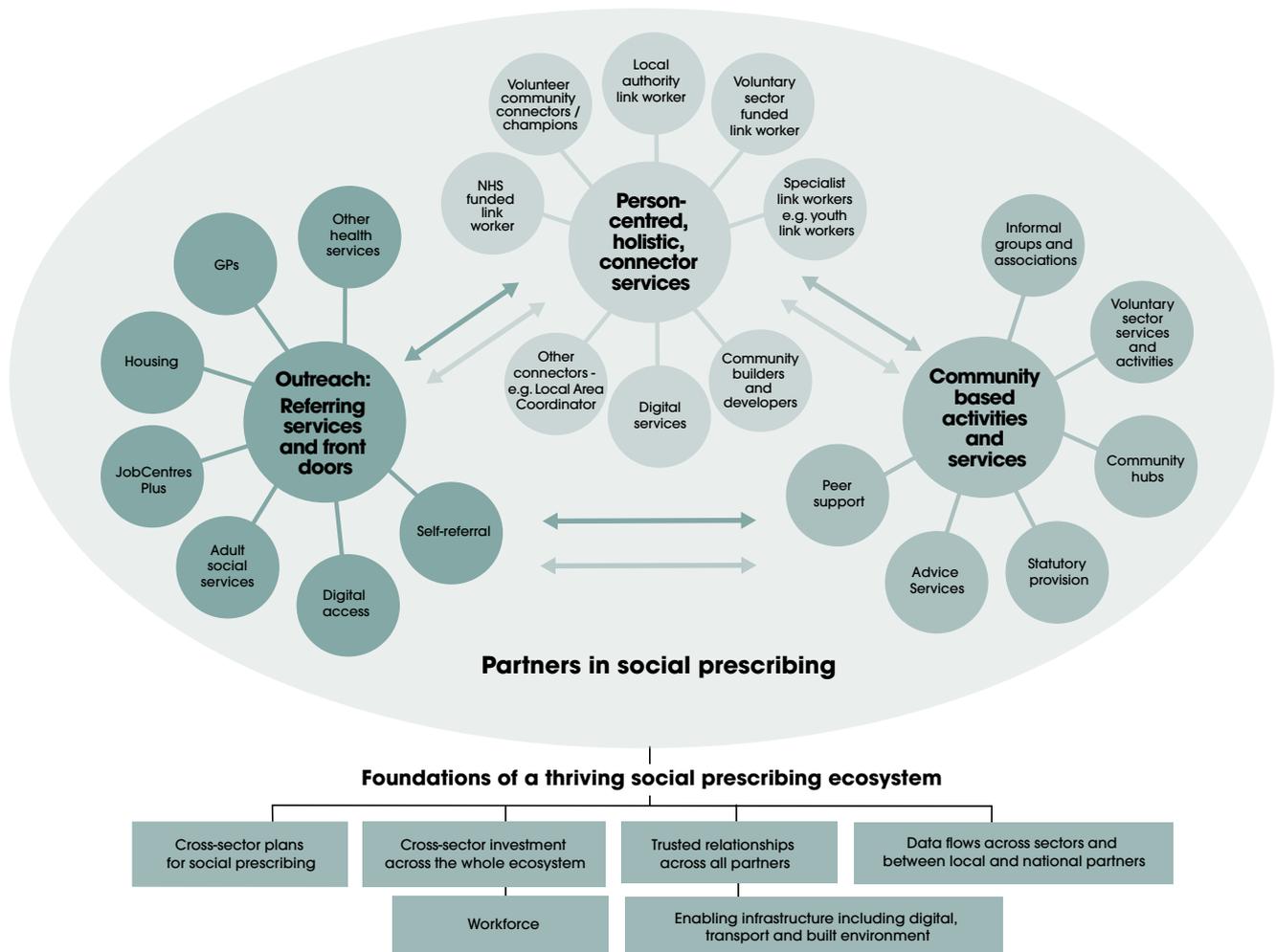
ecosystem of initiatives bridging between the VCSE sector and the health system and providing person-centred and holistic support. Better communication of the ecosystem in which social prescribing sits would enable more stakeholders to feel ownership of social prescribing, increasing support for its roll out.

Stakeholders were clear that NHS England and NHS Improvement has a critical role in providing the guide rails for social prescribing across NHS, for example through national guidance and maturity tools. However there needs to be a flexible approach to the wider ecosystem so that local systems can be built around other schemes already

working in their areas, and can flex models to their particular community needs, assets and capacities.

In this 'generous' framing of social prescribing the NHS funding of social prescribing link workers is understood as an injection of new capacity into a wider ecosystem upon which social prescribing relies. All parties within this ecosystem need to be involved in discussions about how to develop social prescribing in their communities – and should be included in the process of developing local social prescribing plans. It is therefore vital that NHS communications make clear that social prescribing is not 'owned' by the NHS.

Figure 3: Local social prescribing plans need to encompass the whole ecosystem



To encourage a shared sense of 'ownership' of social prescribing across sectors:

- **Social prescribing leaders - including the National Academy for Social Prescribing and NHS England and NHS Improvement - should make clear that the NHS investment in social prescribing link workers is a contribution to wider community capacity - and that social prescribing is a cross-sector programme with cross-sector leadership and funding:** There are opportunities, for examples in the Social Prescribing Maturity Framework being developed by NHS England and NHS Improvement to set out this more generous framing.

The impact of social prescribing on social need

We heard that current communications around social prescribing do not always support stakeholders' understanding of the issues it addresses and the extent of its impact across their core areas of concern and priorities.

Communications tend to emphasise where people end up – telling stories of people engaging with sports /arts / leisure activities. The role of link workers in supporting people with critical issues such as housing, welfare and work is less well-understood, despite being at the heart of link workers' activity, and critical to their work in more disadvantaged communities.

Getting across this wider impact of social prescribing will be vital in engaging the interest of key partners – including central government departments such as the Department for Levelling Up, Housing and Communities, Department for Work and Pensions and Department for Digital, Culture Media and Sport; and in engaging charitable funders who may be interested in specific social issues.

It will also be important in demonstrating the critical role social prescribing can play in addressing health inequalities. We know that even before the pandemic, the most developed social prescribing schemes already engaged in proactive approaches to address health inequalities - with outreach programmes and specialist support for more marginalised communities. During the pandemic the shift towards proactive working accelerated and in future the demand for support for increasingly complex need is likely to continue.

This is a vital part of the social prescribing story, but if it is to be understood we need clearer communication about the impact of social prescribing in addressing the full range of social issues, especially in marginalised communities. This will help leaders across sectors and in government to understand the importance of social prescribing. To tell this story leaders will need to draw on a wide range of data from across various sources, including qualitative insight and stories from the VCSE sector and wider community (see section above).

To improve understanding of the impact of social prescribing:

- **NHS England and NHS Improvement should work with leadership bodies across local government, VCSE organisations and charitable funders** to develop tailored communications to raise awareness of social prescribing to demonstrate its alignment with their priorities
- **Social prescribing leaders should make clear how social prescribing impacts key outcomes such as inequalities and service demand:** Health partners need to be explicit about how social prescribing links to the priorities of key partners such as national government departments, local authorities and charitable funders

Social prescribing as part of a strategic shift

Many felt that the framing of social prescribing in the national narrative does not always reflect its strategic importance. This was seen as a missed opportunity. Social prescribing tends to be seen as a niche health intervention rather than as a programme for public service reform rooted in the NHS Long Term Plan and across government.

While emphasising the model and role of link workers in supporting individuals is important for implementation, the messages around social prescribing as a driver of systemic change – towards collaborative, community-based, preventative support – can be lost. Leaders across sectors share a vision of a long-term shift from a medical towards a social model, and a passion for a future in which the distinction between “medical”



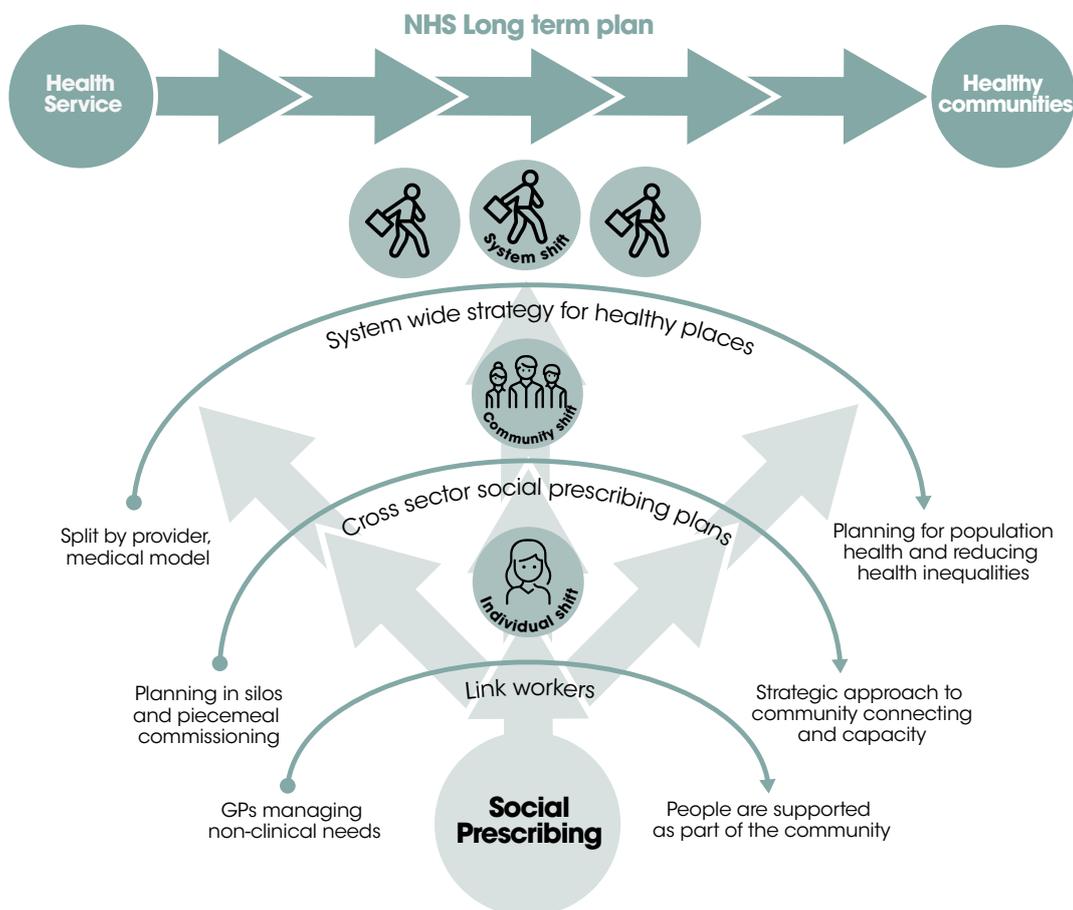
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and “social” prescribing is no longer in focus, and we simply have the “right prescribing” for each individuals’ needs. However, this long-term vision is not always the focus of social prescribing communication.

We heard how this has implications for wider stakeholder buy-in, particularly with independent funders and local government colleagues. Without understanding of the extent to which social prescribing is baked

Figure 4: Social prescribing’s impact on the NHS long term plan



in to the long-term plans for system change, many are not assured that there is a long-term commitment in the NHS to social prescribing, further preventing engagement.

There is a need for clear, targeted communication setting out the intent of social prescribing, how the NHS is investing, and its implications for others working in communities – both in terms of the practical links that are needed with other organisations and the outcomes it seeks to achieve.

- **Social prescribing leaders should make clear how social prescribing fits with wider strategy:**

Communications should emphasise the strategic importance of social prescribing and how it supports the long-term shifts envisaged for the health and care systems and the core purposes of ICSs around improving population health, tackling inequalities, enhancing productivity and value for money and supporting broader social and economic development across communities

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