

Enabling the potential of social prescribing



A summary of the issues affecting longer-term VCSE funding including views from before and during the COVID-19 pandemic



Operating context

We conducted the first survey component of this report before the outbreak of COVID-19, and the second not long after the first peak had passed. This summary reflects the fact that the extent of the pandemic's effects on social structure, the economy, public wellbeing and the Voluntary, Community and Social Enterprise (VCSE) sector is just starting to emerge.

Before COVID-19:

“I have serious concerns that the VCSE are usually where people are sent; they cannot sustain the service without funding. We cannot keep burdening them just to get the pressure off the NHS.”

Social Prescribing Provider

Since COVID-19:

“...We do talk a lot about patient-centred care, but, I think community-centred care ... has been lost somewhat in recent years. But... small organisations ... can help the formal system to make that leap forward into reconnecting with communities again and improving the health of our population. So, [social prescribing is] every bit as significant and important as the Nightingale hospitals or GP COVID centres...”

Social Prescribing Commissioner from an ICS

Acknowledgements

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Disclaimer

The views expressed in this report are those of the authors and do not necessarily represent those of TNLCF.

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Executive summary

Social prescribing relies on the Voluntary, Community and Social Enterprise sector (VCSE) to enable personalised, place-based care. The increase in demand for VCSE services has led to growing concern about VCSE's capacity to deliver against the recent developments in social prescribing. COVID-19 has put a further strain on this situation.

Method

We conducted two online surveys to understand the breadth of concerns across social prescribing schemes in the UK. Phase 1 (pre-COVID-19, n=508) collected responses during January and February of 2020, and Phase 2 (post-COVID-19, n = 237) during May and June 2020.

Results

Both surveys achieved a strong geographical response from across the UK, with both providers and referrers of social prescribing services well represented.

Phase 1 data showed that the VCSE funding infrastructure for social prescribing was fragile and piecemeal before the pandemic. Twenty social prescribing schemes (10% of the total) reported being unfunded. Over half of the respondents had seen an increase in referrals (up 62% on average) and self-referrals (up 51% on average) over the past 12 months.

Respondents reported that on average, current funding leaves social prescribing providers with only 18% of their capacity left for further referrals; almost 40% reported no further capacity.

Four open-ended questions from Phase 1 identified key themes:

- Lack of equity in the relationship between the VCSE sector and the commissioners of social prescribing
- The need for long-term funding arrangements to enable consistent, reliable service provision
- The need for core funding for providers of activities for service users referred via link workers
- Lack of money moving across sectors; most specifically towards activities that take place after referral by a link worker
- The need for a range of different income streams to allow more inclusive access to social prescribing, beyond service users referred by healthcare professionals

Phase 2 data identified ways in which the pandemic has forced social prescribing schemes to operate differently, including:

- Remote working and the increased support needed by providers when working virtually
- The broadening of referral pathways, with an increase in collaborative working between the VCSE sector, local authorities and Primary Care Networks (PCNs), to

reach new groups of people needing support

- Link workers taking on more flexibility in their roles, depending on localities; they often had higher caseloads, and addressed a different range of key needs
- A different mix of key needs to be addressed:
 - Rising emotional and mental health problems
 - An increase in need for support around benefits
 - Welfare advice
 - Employment advice
 - Housing issues
 - Digital access and digital poverty
- Link workers generally spending more time with each service user, due to their greater need for support following the severe decrease in VCSE services left for referrals; furthermore, the need to continually remap local provision to keep track of the support available.
- The VCSE sector temporarily closing services, redesigning them to allow online provision, or revising working arrangements to introduce protective measures
- Increased numbers of volunteers (drawn from furloughed workers) to support local responses; some were integrated with link worker responses, some not

Despite the expansion of social prescribing around the UK, key aspects of funding for the VCSE sector are failing. This is not true for every scheme, but for many – particularly small organisations and individual practitioners.

Our recommendations to ensure a future for social prescribing:

- 1. Any organisations or services that take referrals from social prescribing link workers must receive financial investment for this**
- 2. Long-term (e.g. five years) core funding for the provision of activities and services in response to referrals must enable appropriate payment for providers of all sizes**
- 3. All stakeholders must collaborate in a way that increases community capital**
- 4. Link workers must have the appropriate equipment, support, caseload size and skills to work remotely and support a wider group of people being referred into social prescribing**
- 5. Everyone should be able to access social prescribing, whether face-to-face or via digital channels**

Suggestions for implementation of our recommendations are in section 4.

1. Introduction

Social prescribing has evolved significantly across the UK in the past four years, perhaps more than any of us could have imagined. It's a vital element of the UK Government's move towards universal personalised care, which involves local agencies referring service users with socioeconomic and/or psychosocial needs to a link worker.

Link workers are non-clinical workers with a variety of job titles. They help service users to assess their needs, co-producing solutions that use appropriate local resources. They connect service users to community groups and statutory services for practical and emotional support. These include a range of groups or services, including social services, social care, public health funded health behaviour programmes and self-management programmes, weight management programmes, children's centres, libraries, museums, leisure centres, and employability programmes. They work collaboratively with local partners to help community groups remain accessible and sustainable, and help people start new groups.

1.1 The original aim of our report

In early 2020 TNLCF commissioned a report to consider the new operating landscape for social prescribing. As the VCSE sector provides the majority of services, there was a particular focus on sustainable VCSE funding to ensure the longevity of social prescribing.

TNLCF was a central player in the development of social prescribing; it funds and supports the programme development of many small and medium-size VCSE providers. TNLCF funding for The Conservation Volunteers (TCV) has: enabled development of the Social Prescribing Quality Assurance Framework¹; supported development of the Allied Health Professionals Social Prescribing Framework²; supported one conference for research and two for the International Social Prescribing Network; and allowed significant dissemination of learning to over 1,000 conference participants across the UK.

Social prescribing has evolved from being just a GP referral; many sectors are now involved³. The increases in referrals due to increased link worker funding from NHS England, in social prescribing schemes, and in demand for VCSE services, has led to growing concern whether the VCSE sector will maintain the capacity to deliver.

Phase 1 used a neutral 'fact-finding' survey to provide a snapshot of a representative sample of stakeholders within the social prescribing system, with strong VCSE representation.

¹ https://42b7de07-529d-4774-b3e1-225090d531bd.filesusr.com/ugd/14f499_a5e3a40ac260401a80e01853bb7ef8b9.pdf

² www.rsph.org.uk/about-us/news/launch-of-new-social-prescribing-framework-for-allied-health-professionals.html

³ Polley et al (2020) *What does successful social prescribing look like? - mapping meaningful outcomes.*

1.2 Impact of the COVID-19 pandemic - March 2020 onwards

The COVID-19 pandemic is a once-in-a-lifetime event that is imparting significant change across society.^{4,5,6,7} This includes huge numbers volunteering through the NHS responder's portal (managed by the Royal Voluntary Service)⁸, local area volunteering providing food and medicines to those most at need, and a wonderful response from link workers, often repurposing themselves to work outside of their original remit. The value of the VCSE is recognised through the formation of Volunteer Cells within the emergency response system.

Phase 2 demonstrates the agility and responsiveness of social prescribing schemes during the pandemic. Clearly social prescribing schemes are more important than ever.

Both phases highlight the many challenges that lie ahead for the VCSE sector, particularly in gaining equitable and sustainable funding. There is a unique opportunity for the devolved UK governments to recognise this by focusing sustainable funds to the VCSE sector. Sustainable, shared funding sources will bring stability and resilience to a very fragile sector, while still allowing VCSE organisations to use additional funding sources for their services.

We hope that senior decision makers will use this summary, and the full report⁹, to guide their thoughts on how to support all VCSE social prescribing activity providers long into the future, as they are the greatest source of support within local communities and represent a strong return on investment.



⁴ UK Data service - ONS data: www.ukdataservice.ac.uk/get-data/themes/covid-19/covid-19-data.aspx

⁵ Mentalhealth.org: www.mentalhealth.org.uk/news/almost-quarter-adults-living-under-lockdown-uk-have-felt-loneliness

⁶ Covid-19 social study, UCL: www.covidsocialstudy.org/results

⁷ Wright L, Steptoe A, Fancourt D. Are we all in this together? Longitudinal assessment of cumulative adversities by socioeconomic position in the first 3 weeks of lockdown in the UK [published online ahead of print, 2020 Jun 5]. *J Epidemiol Community Health*. 2020;jech-2020-214475. doi:10.1136/jech-2020-214475

⁸ volunteering.royalvoluntaryservice.org.uk/nhs-volunteer-responders-portal

⁹ www.tcv.org.uk

2. The surveys

2.1 Design and analysis

We conducted two surveys. Phase 1, intended to understand the financial landscape of social prescribing, ran from 13 January to 24 February 2020. Phase 2 was conducted during the pandemic (29 May - 12 June 2020) to capture the changing role of social prescribing and the impact upon all involved. The surveys were both short online questionnaires¹⁰ co-designed by members of the Social Prescribing Network¹¹.

The respondents were self-selecting (with respondents from Phase 1 contacted for Phase 2), invited by email and Twitter. The organisations listed in Appendix A were asked to solicit responses from employees and members. Respondents were asked to pass the survey on to colleagues or expert contacts in the field.

We undertook content analysis on Phase 1's shorter qualitative data using Excel. We used a thematic analysis approach for the longer qualitative responses from Phase 2, using Quirkos software to code and organise the data.

2.2 Demographics

There were 508 responses in Phase 1; 45 respondents answered only one question and opted out at the start, 463 responses were analysed. There were 237 responses in Phase 2.

2.2.1 Phase 1

Phase 1 respondents represented a wide range of roles and organisations both within and outside of the UK social prescribing pathway.

- 60% provided services or made referrals to the pathway
- 40% didn't directly work in social prescribing but were familiar with the sector

Of those working in social prescribing services¹²:

- 70% were providers (e.g. green social prescribing, singing groups)
- 23% were referrers (e.g. GPs, Allied Health Professionals)
- 9% worked in roles related to social prescribing (e.g. commissioners, national coordination of social prescribing, NHS managers, private organisations and VCSE organisations that facilitate social prescribing)

The 276 respondents who gave location information were from all around the UK. The greatest percentage were from Central England (Midlands) (19%), followed

by London and North East England (both 16%). Other regions represented were: South East (13%), South West (11%) and North West (7%), Wales (9%), Scotland (6%), NI (3%) and "national" (1%).

Of the 276 who gave information about their role, 38.5% described themselves as "CEO/senior manager" from within the VCSE sector providing support services, 24% as referrers, 14.5% as providers, and 22.9% as "other"¹³.

2.2.2 Phase 2

We received 237 responses in Phase 2. Of those working directly in social prescribing services:

- 52% were providers (e.g. nature-based wellbeing)
- 38% were referrers (e.g. GPs)
- 3% were referrer and prescriber combined (e.g. a VCSE service supporting social prescribers)
- 7% stated they were "other" (e.g. funders, managers within health service)

There was representation from all parts of the UK. The greatest percentage were from the Midlands (21%), followed by Wales (17%). Other regions were: London (14%), South East (11%) South West (8%) North East & North West (both 7%), East (4%), Scotland and NI (both 3%), "all over UK" (3%) and Ireland (1%).

- 63% were from the VCSE sector
- 32% were from the NHS
- 3% were from local councils
- 2% were from "other" places (e.g. Fire service, Welsh Government)



¹⁰ Copies of the questionnaires can be found at www.tcv.org.uk

¹¹ www.socialprescribingnetwork.com

¹² Some respondents fitted more than one category; figures may add up to more than 100%.

¹³ Examples include: VCSE services not within the social prescribing referral directory (30%), GPs (7%), Allied Health Professionals (8%), with the remaining 55% being other assorted roles.

3. Results

3.1 Social prescribing: cost, capacity and demand

To understand the funding landscape for social prescribing services, we needed a broad idea of the cost of delivery, attendance levels, funding sources, and to what extent funding is earmarked for social prescribing.

Referrers' costs relate to providing link worker or social prescribing services. Providers' costs relate to providing the actual services (e.g. a gardening club or weight loss group).

Table 1: Cost of delivering a social prescribing service for one year (n=148)

Type of respondent	Number of responses	Mean cost to deliver services for 1 year	% replying "don't know"
Referrers	35	£147,569	0%
Service providers	59	£201,489	0%
Other SP services	54	£92,925	52%

Table 2: Number of users each year (n=147)

Type of respondent	Number of responses	Mean number of service users in 1 year	% replying "don't know"
Referrers	26	3,534	15%
Service providers	104	1,171	13%
Other SP services	17	1,330	18%

Table 3: Frequency of use over one year (n=135)

Type of respondent	Number of responses	Mean number of times a year	% replying "don't know"
Referrers	24	17.5	29%
Service providers	94	55	15%
Other SP services	17	25	18%

Referrers reported much higher figures per year than providers or other professionals. This may reflect the level of drop-off that occurs through social prescribing pathways – further research would be needed to confirm this.

Although most of the literature refers to GPs, a wide range of professionals and sectors now make referrals into social prescribing. 24% of Phase 1 respondents (65/276) identified as service providers, receiving referrals from:

- GP practices (33%)
- Allied Health Professionals (20%)
- Community work (10%)
- VCSE (7%)
- Adult Social care (95%)
- Other (24%) including CICs, DWP, Police, social workers

3.1.1 What is the perceived demand for social prescribing services?

Increased uptake of social prescribing services is part of NHS England’s universal personalised care strategy¹⁴, yet concern is growing about the capacity available within the VCSE sector to meet this increased demand within existing budgets.

We asked respondents to comment on their perception of the demand for social prescribing services.

Organisations making referrals and self-referrals reported an average increase in perceived demand of 62% and 51% respectively.

Table 4: Perceived demand for social prescribing services (n=189)

Referral route	Perceived increase in demand	No increase	Don't know
Referral via system	62%	16%	22%
Self-referral	51%	27%	22%

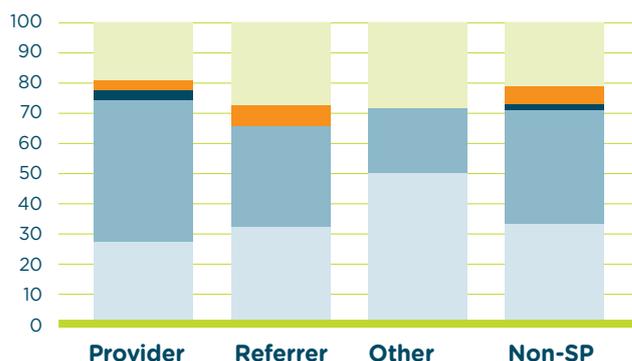
Providers reported having only 18% capacity for further increase in demand. The targets set by NHS England are for 900,000 additional referrals in year one, rising to 2.5 million in 2023-24¹⁴. These should be reviewed against the remaining capacity. We anticipate that demand has risen further during the pandemic, and that many VCSE organisations are now in an economically precarious situation due to inability to fundraise. This is likely to have a serious knock-on effect on the level of provision remaining.

Table 5: Reported capacity for an increase in demand (n=147)

Type of respondent	Number of responses	Mean possible % service capacity increase
Referrers	18	16%
Service providers	77	18%
Other SP services	14	5%
Not directly in SP	38	18%

- Between 32% and 50% of respondents reported no capacity for further referrals
- A further 20 to 40% of respondents had from 1 to 50% capacity available
- 20 to 25% were unsure what capacity they had available
- Only 5% reported having 100% capacity available (likely to be services just starting up)

Figure 3: Level of increase in demand that could be met within pre-pandemic budgets



Key: Level of capacity before COVID-19

- No capacity
- 1%-50%
- 51%-99%
- 100%
- Don't know

57% of respondents were either unable to meet an increase in demand or unsure of capacity.

Approximately 20% of those answering that they had capacity available said that they could only meet an increase in demand if additional funding was provided. Of those who said they had no capacity, some commented that current funding conditions were not sustainable.

During the pandemic many providers have increased their capacity to respond to immediate and urgent needs. There has, however, been no mention of how the organisations can afford this increase.

¹⁴ www.england.nhs.uk/personalisedcare/upc/comprehensive-model

3.2 Views about the future of funding for social prescribing

The last three years has seen the PCN link worker referral process improve formal connections between the health sector and local community groups, increasing adoption of social prescribing. But disappointingly, many VCSE organisations (particularly very small ones) still do not receive payment for their services, or are commissioned on a short-term basis.

3.2.1 What is your current source of funding?

199 respondents answered this question in Phase 1.

They showed great variation in funding sources, with no single sector predominating. In effect the picture remains largely the same as it was four years ago, where many were sourcing funding from wherever they could find it¹⁵.

10% of social prescribing services were unfunded. 38% reported funding from some part of the NHS, predominantly primary care. PCNs are increasingly becoming the main source of funding, although they only accounted for 9% in this survey.

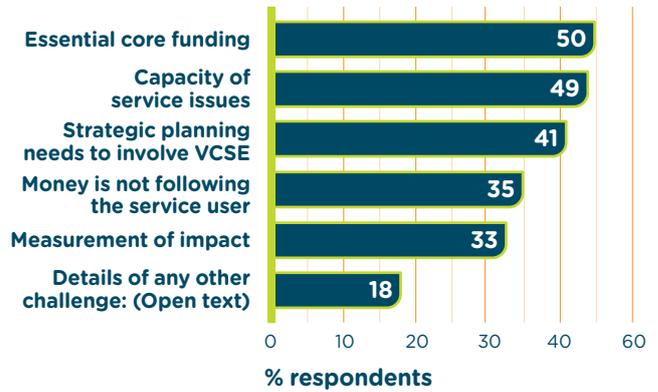
- No funding (10%)
- Clinical Commissioning Group (26%)
- Primary Care Networks (9%)
- NHS (3%)
- Local Authority (19%)
- Lottery (13%)
- VCSE (7%)
- Privately funded (3%)
- Other (12%)

In Phase 1 we asked participants what their funding challenges were. They identified five overarching, interconnected themes:

1. Lack of equity in the relationship between the VCSE sector and commissioners of social prescribing (the public bodies who plan, procure, deliver and evaluate services for local residents)
2. The need for long-term funding arrangements to enable consistent, reliable service provision
3. The need for core funding for activity providers
4. Lack of money moving across sectors; most specifically towards activities that take place after referral by a link worker
5. Using a range of approaches to generating income to enable activities to be available to a wider group of people than just those who were referred through social prescribing

We asked Phase 2 respondents about these issues again to see if they were still relevant. Responses showed that core funding, capacity to accept more referrals, and strategic planning within existing budgets are still the top issues.

Figure 4: The main funding challenges post COVID-19



The increase of referrals from PCNs and local authorities has increased demand in the VCSE sector. Funding arrangements are mixed. The VCSE sector has always been self-sufficient to manage service users who access their organisations independently (i.e. self-referral, green in figure 5).

As demand from social prescribing increases, some VCSE organisations are commissioned to provide services for service users referred by a link worker (blue). But commissioners do not always cover the full costs of running the service.

In the final scenario, some VCSE organisations are expected to provide activities for those referred to them, without additional commissioning to cover the costs. This appears inequitable as a tariff would typically be paid if referral were to another NHS/health provider. Frequently these are small organisations and practitioners (red).

Figure 5: VCSE funding challenges within the context of social prescribing



[CCG: clinical commissioning groups, ICS: integrated care system SPV: special purpose vehicles]

¹⁵ Polley et al (2016) Report of the Inaugural Social Prescribing Network Conference

SOCIAL PRESCRIBING IN THE WAKE OF COVID-19

CASE STUDY 1: DEVON

The University of Plymouth carried out a rapid evaluation of social prescribing in Devon in May 2020¹⁶.

This aimed to identify the needs and challenges of front-line social prescribers during the COVID-19 crisis to advise services on how best to continue to deliver a high-quality, equitable service. There were 52 respondents, representing PCNs, the NHS and VCSE.

Changes and adaptations included: developing repositories of activities, and collating local knowledge of existing and developing networks. Services moved to being phone-based rather than face-to-face. Some services used volunteers but there was some overlap and duplication. Local health professionals saw social prescribing as merely signposting (directing service users to services without a formal referral) rather than giving specific prescriptions for holistic remedies.

Changes in service users: Some services experienced a drop in referrals, while others experienced an increase that related to supporting the shielding population.

Challenges included: working from home for social prescribers, away from their usual management support; moving to non-face-to-face services; a lack of services for link workers to make referrals to; dealing with the impact of isolation on mental health needs in the service user population, leading to more service users with complex needs.

Moving forward

Social prescribers (including healthcare professionals, link workers and job centres) need: appropriate management support and supervision to enable remote work; appropriate IT support and equipment; and a wide range of appropriate, high quality services for them to signpost or make referrals to.

3.2.2 Relationships with the VCSE sector

Respondents identified a fair relationship between the NHS, local government and the VCSE sector as the key to achieving universal good practice in funding social prescribing schemes. Prior to the pandemic, VCSE organisations were becoming more involved in the planning phase of schemes, but this is still far from standard practice. Suggestions from both referrers and providers included the need for the VCSE sector to be integrated more systematically.

“I would like to see funders looking at the VCSE as a part of the health and social care sector – this way the outcomes of VCSE interventions would be recognised and resources would be a priority. If all the funders in a locality or across a type of outcome worked with the VCSE strategically we would have a more integrated approach to funding the sector. Currently one funder can destabilise the sector by removing funding that has a domino effect on other parts of the sector.”

Social Prescribing Provider

Disjointed strategies may benefit one organisation or sector but often disadvantage and destabilise other organisations in the same area, through duplication of effort and wasted resources.

VCSE infrastructure organisations, which support other VCSE organisations by helping them to influence, connect and develop, have been long recognised within this sector as a way to enable hyperlocal response. They have a wealth of local knowledge and trust. During the pandemic, hyperlocal activities have been crucial for rapid support and message dissemination. Several respondents highlighted successful VCSE schemes being defunded, only for similar schemes to be set up ‘in-house’ in PCNs, along with the destabilising effect this can have.

3.2.3 Funding arrangements

Many providers highlighted the need for a long-term funding solution, as opposed to short-term arrangements that run out quickly and damage relationships with service users. Long-term funding would be a key enabler of social prescribing. This view was shared by some referrers.

“I have serious concerns that VCSE are usually where people are sent, they cannot sustain the service without funding. We cannot keep burdening them just to get the pressure off the NHS”

Referrer into Social Prescribing

Many respondents felt that the activities being prescribed by link workers need core funding to ensure that VCSE organisations are appropriately funded, cover running and training costs, and keep activities available.

¹⁶ <https://bit.ly/37gbzeF>

A good proportion of referrers suggested a range of mixed-sector funding solutions, showing an increased willingness to collaborate across sectors and a strong theme of shared funding and shared responsibilities. They also often outlined the need for combined funding to be locally held, for local services and activities to access.

Some respondents identified a specific sector that they thought should be providing all the funding. Providers were more likely to mention combined funding from a combination of two or three of the following sectors:

- Local government
- NHS and CCGs
- Public health
- Social care
- Grants
- Private sector

Many Phase 2 respondents expressed concern that without investment into long-term core funding in the VCSE sector there will soon be no social prescribing to speak of, or it will become something only the wealthy can afford.

Referrers and providers from both phases highlighted the lack of money moving from the health sector to the social prescribing sector as a key funding issue. Both felt that money should follow the service user where a referral has been made by the healthcare system.

In Wales there has already been a move to review VCSE sector funding in a more integrated fashion via regional and programme-specific boards. Along with a minimum specified investment level, this provides a helpful benchmark for all stakeholders to work with.

“For Regional Programme Boards and Programme Specific Boards to be required to include, and be accountable for, measures within their Area and Wellbeing Plans they will take to support the VCSE sector, including setting a minimum investment level (of 20%) of Welsh Government programme funding in the VCSE”

Referrer into Social Prescribing

3.2.4 Addressing inequalities through additional income generation

Social prescribing is intended as a holistic service to support social health determinants (such as debt, poor housing, inactivity) as well as lifestyle and mental health conditions. Respondents pointed out that to be inclusive, there must be funding that allows vulnerable people to access activities. These service users may enter the pathway via self-referral, which is not always included in social prescribing funding.

Respondents described how they had raised additional funding. Some providers reported activities being kept going by donations and payments from participants – but they acknowledged that this excludes the most vulnerable people who need support.

Some groups suggested selling products made during activities. But not all activities can do this. Other providers suggested top-up grant funding as additional

income, which could be used to extend services to vulnerable people.

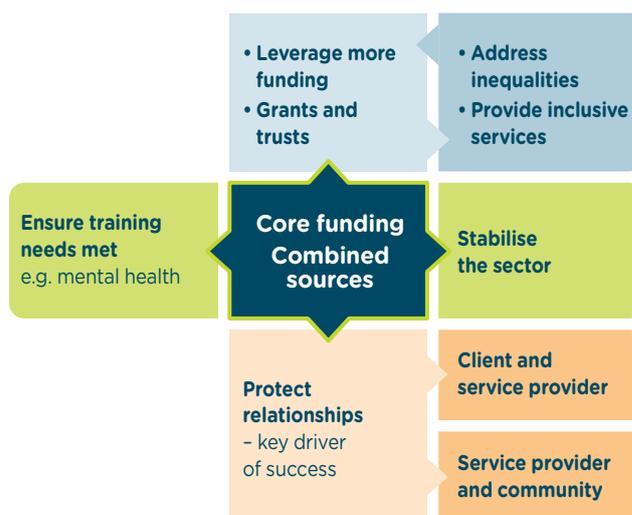
3.2.5 Core funding

There have been persistent calls for government to invest in the VCSE sector in a way that will provide stability and allow capacity development in local communities. Respondents felt their cries are largely ignored.

“What would be beneficial would be to have recognition of the impact made by local community charities and be officially recognised by Governments with an allocated funding stream to enable sustainable developments.”

Social Prescribing Provider

Figure 6: Potential positive impact of core funding



Guaranteed core funding is needed to match the stated desire for social prescribing schemes to be holistic, and able to support everyone who needs them, as opposed to a nominated group with a particular condition. Furthermore, guaranteed funding provides a lever to solicit matched or additional funding from grant bodies. This could open up services to self-referred service users.

As we come out of the crisis phase of the pandemic, it's essential that core long-term funding for social prescribing activities is given urgent prioritisation. 12% of charities say they may cease operating altogether before December 2020. Furthermore, UK charities are facing a £10.1 billion funding gap due to the pandemic: they expect their incomes to drop by £6.7 billion while demand for their support rises by the equivalent of £3.4 billion¹⁷. Without a vibrant, stable local VCSE sector, social prescribing cannot exist.

¹⁷ www.probonoeconomics.com/news/charities-facing-%C2%A3101-billion-funding-gap-over-next-six-months

3.3 How have social prescribing schemes adapted during the pandemic?

The sudden lockdown in March 2020 meant an instant change to provision. All face-to-face contact stopped. In a matter of days link workers moved to phone working; many providers started using phone, paper, and digital channels to support their service users.

But the changes have been much broader and deeper than just communication formats. They also affected: the role of the link worker; eligibility for referral, how service users were referred to link workers, and the partnerships between the VCSE sector, local authorities, GPs, PCNs and CCGs.

Most importantly the role of voluntary organisations, local communities, and the VCSE sector as a whole changed, as they stepped in to provide the support that friends, families, and other services were unable to provide.

3.3.1 How did the referral process adapt?

Referrals changed very quickly. Most respondents appeared to be widening their referral criteria and the number of service users contacted. Whereas referrals previously came predominantly from GPs, there was a reduction in 'normal' referrals; link workers were often tasked with contacting people on the vulnerable and shielding lists.

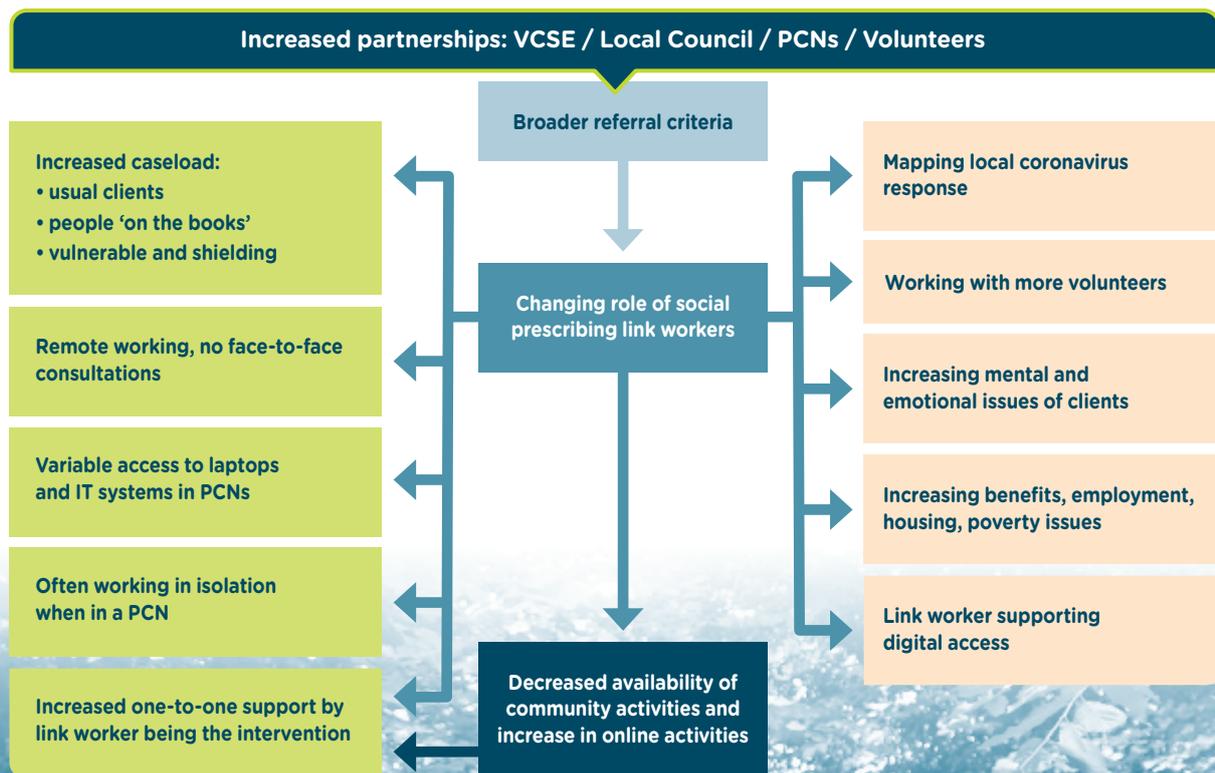
Referrals to link workers (both PCN and non-PCN-based) also came from community hubs or local council initiatives. The referral routes in some schemes also adapted to allow more self-referrals or direct referrals to link workers instead of going via a GP.

Several respondents also noted that this included a younger demographic, people with families, and those struggling with the impact of lockdown.

3.3.2 How have link workers adapted?

Link workers have needed to connect with new and existing local groups and organisations. Some have been following up on people identified during welfare checks by volunteers. Others have carried out welfare checks, then made referrals to support their service users.

Figure 7: Impact of COVID-19 on the role of the link worker



Topics discussed with service users extended much further into wider determinants of health, as opposed to the health domain. Many link workers switched to supporting immediate needs.

Service users also needed support with financial and employment issues raised by being unable to work during lockdown, or from furloughing and redundancies. Some schemes broadened their remit to take on referrals relating to benefits and housing. Others added organising transport to and from hospital and supporting end of life care.

Many link workers explained that they were spending more time with each service user and becoming part of the supportive intervention themselves, as opposed to referring and signposting service users as normal. This required them to draw on counselling skills more, as they noted an increase in need for mental health support. They reported providing emotional support during lockdown, especially for older people, and for those needing support with grief, increased levels of anxiety, and simply human contact while in lockdown.

3.3.3 Caseload changes

Some link workers highlighted how their caseload had changed. As well as responding to immediate needs, many schemes continued to see existing service users in different formats, as well as contacting all past service users, as they could become vulnerable quickly. Some also reported spending more time with service users, and a greater number of consultations.

If not monitored carefully, the combination of increased caseload, increased complexity of provision, and the additional emotional support needed could increase burnout in the workforce.

Link workers have also had to rethink where they refer service users to and how they support those unable to leave their homes. This has involved creating local databases of new groups and organisations that have emerged to provide coronavirus related support, and anticipating needs as the coronavirus pandemic progresses.

SOCIAL PRESCRIBING IN THE WAKE OF COVID-19

CASE STUDY 2: Project ECHO, Northern Ireland and Ireland

Project ECHO¹⁸ NI held a webinar in June 2020, facilitated by the Directorate of Integrated Care, Health and Social Care Board in Northern Ireland. The webinar aimed to explore the social prescribing response and adaptation in the Northern Ireland and Ireland networks. 59 people attended; there were presentations from five social prescribing services.

Changes and adaptations to services included: changing from face-to-face to remote services from mid-March onwards, due to COVID-19. Staff were redeployed or recruited to community phone helplines to assist with psychological first aid, as well as groceries and prescriptions. Phone calls could be weekly or daily depending on support needs. Services included socially distanced “garden chats”, a large variety of online Zoom groups, doorstep bingo and deliveries of activity packs. Support with technology was offered, for example help with using Alexa, WhatsApp, or iPads, to enable interaction with outside world.

Changes in service users: Services were offered to everyone listed in all link worker casebooks, past and present, to see if the pandemic had triggered a need for support. Some service users may have

been brought back to “square one” due to the pandemic. Services disseminated public health information through the existing social prescribing system (via council-funded texts or flyers).

Challenges included: High levels of digital poverty due to age, finances and attitude to technology; this was estimated at 20-80% of the population by different participants. Where digital/online support was not provided, services offered telephone support. Staff wellbeing and development was supported by digital platforms.

Moving forward

Support for staff wellbeing will continue to be necessary for staff to meet, train and find supervision and wellbeing support, to enable them to continue supporting their service users. Some service users are now more ready to engage with digital offers which could signal a new, permanent digital route into services for them.

¹⁸ Project ECHO is committed to addressing the needs of the most vulnerable populations by equipping communities with the right knowledge, at the right place, at the right time. See: echo.unm.edu

3.4 Partnerships between sectors and organisations during the critical phase

Local communities and volunteers have arguably been the backbone of a hyperlocal community-based response to the pandemic. In some cases, the only way to cope with capacity has been through partnerships with other sectors and existing organisations.

Despite the tensions, many respondents reported greater collaboration between local stakeholders and organisations, which was seen as a very positive outcome. Where existing schemes were running well, they forged partnerships with the wider system as part of a local response. In particular many respondents reported increased interest in social prescribing schemes from local councils and statutory services.

3.4.1 Activity formats

Some service providers have temporarily closed, while others have rapidly changed how they provide activities; these changes can be classified into broad groups:

Access to services: Every possibility avoiding direct contact has been tried by at least some respondents. Many online platforms have brought service users together in groups or for one-to-one discussions. One-to-one discussions were also held by phone. Paper information was sent out by post, and some groups made DVDs with wellbeing information and advice – these were often used when a service user could not access the internet.

Home-based services: Providers were incredibly creative in motivating service users to look after their own wellbeing at home. Many delivered activity packs that included arts, crafts, cards, seeds to grow, puzzles, competitions or packs of cards.

Adaptations to in-person services: Some organisations made “garden visits” to maintain social distancing. A range of adaptations are still being made. Many respondents reported they will no longer provide refreshments or food, difficulties with extra bureaucracy and safety guidelines, and providing handwashing stations. Social distancing is being maintained, with the use of small breakout rooms decreasing. Group sizes are being reduced, and many organisations are looking at how they can make more use of outdoor space.



3.4.2 Sustaining new volunteers

Many respondents reported an influx of volunteers during lockdown, which was welcomed. Volunteers worked with link workers on tasks such as delivering food, medicine and activity parcels, as well as acting as befrienders. Alongside responses coordinated with local authorities and PCNs, other volunteers were recruited through the GoodSAM app. These activities were not always coordinated with existing local community infrastructure. New mutual aid groups were immensely helpful to meet hyperlocal need but often unintegrated into existing strategic responses, causing quality assurance concerns.

Many respondents were delighted by this increase, recognising the benefits it brings to volunteers as well as providers and service users. Many see this as a great opportunity to build on the outpouring of compassion within local communities. They see opportunities to connect volunteers with organisations and providers that need help to survive post-COVID-19.

However, there is a fear that a return to working life will mean a large drop in volunteers, already witnessed within the emergency planning system. Other concerns were for lack of strategic oversight to ensure integration.

3.4.3 The role of digital

Razai et al.¹⁹ (2020) have published a paper about social prescribing in primary care since the COVID-19 outbreak. They state that remote video consultation has a clear role to play in supporting those suffering with anxiety and loneliness due to the pandemic.

Through digital channels, including social media, many providers have developed aspects of their service not previously considered. Some have already reported they are reaching service users that they could not before.

Many respondents also reported that some service users have had to use digital channels due to a lack of face-to-face options, many with support from link workers and volunteers. Again, the benefits of reaching audiences not previously reached was highlighted e.g. in rural areas.

Organisations that make referrals to link workers have also highlighted the benefits of digital infrastructure. But with new link workers having been mainly prepared for face-to-face working, in some cases they did not have access to medical records or even the right equipment to work remotely.

Respondents mentioned many challenges to adopting a more digital approach. Some service users do not have computer or internet access, and are used to face-to-face support. The digitally disadvantaged need financial support to get this, as well as coaching to become IT literate. Similarly, some providers and referrers will need to upskill to enable high quality digital provision and support service users in accessing it.

¹⁹ Razai MS, Oakeshott P, Kankam H, Galea S, Stokes-Lampard H. Mitigating the psychological effects of social isolation during the covid-19 pandemic. *BMJ*. 2020;369:m1904. Published 2020 May 21. doi:10.1136/bmj.m1904

4. Recommendations

Social prescribing has more than proved its worth during the pandemic. Enabling communities to be at the heart of recovery from COVID-19^{20,21} has real potential. The greater number of local partnerships, changes to referral criteria and processes, increased volunteering, and the move to digital make this an agile architecture to support the vulnerable population.

This report has highlighted the fact that the pandemic has caused new groups to need support from social prescribing, such as those of working age and people with families. This is especially relevant when considering Michael Marmot's findings on health inequalities, which raise concern that underlying inequality will be made worse by the pandemic.²²

We will need to support recovery from COVID-19 for many years. Key needs include a rise in emotional and mental health problems, and a need for increased support relating to benefits, welfare advice, employment advice, housing issues, digital access and digital poverty. Social prescribing will have a key role in addressing this.

There are still key aspects of how we move funding out to the VCSE sector that are failing. This is not true for every scheme, but it is for many, particularly for small organisations and individual practitioners, who often support the most disenfranchised.



To ensure that social prescribing has a future this report recommends that:

- 1. Any organisations or services that take referrals from social prescribing link workers must receive financial investment for this**
- 2. Long-term (e.g. five years) core funding for the provision of activities and service in response to referrals must enable appropriate payment for providers of all sizes**
 - Local VCSE organisations, local authorities and PCNs must continue to build on the fantastic collaborative working achieved during the crisis phase of the pandemic
 - We must develop collaborative funding arrangements between PCNs, local authorities, health boards and other relevant sectors where they do not currently exist
 - Where Integrative Care Schemes exist, they must ensure long-term funding, recognising the breadth of impact of social prescribing, is embedded within their current and future commissioning plans, to ensure stability and continuity of service provision
 - VCSE infrastructure organisations must be used as they are crucial to enabling the hyperlocal response which can enable small provider organisations and practitioners
 - It is the responsibility of the different bodies that fund social prescribing in each locality to commission schemes with long-term funding (e.g. 5 years) to support stability
- 3. All stakeholders must collaborate in a way that increases community capital**
 - It is critical that the VCSE sector have equal input into strategic planning and delivery of social prescribing schemes at local levels, particularly as VCSE provision has substantially changed and reduced during the pandemic
 - VCSE infrastructure organisations must be used, as they are crucial for detailed knowledge of smaller organisations in the locality
 - PCNs must review existing local provision before employing new link workers, to avoid duplication of work and creating competition instead of collaboration
 - All social prescribing schemes and stakeholders must plan how to support rising and changing needs relating to COVID-19
 - New volunteers must be integrated into existing social prescribing schemes to avoid duplicating the

²⁰ democracycollaborative.org/learn/publication/owning-future-after-covid-19-new-era-community-wealth-building

²¹ www.bma.org.uk/media/2570/bma-sustainable-and-environmentally-friendly-general-practice-report-june-2020.pdf

²² www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

work of link workers, and to build more capacity for support, activities, and services

4. Link workers must have the appropriate equipment, support, caseload size and skills to work remotely and support a wider group of people being referred into social prescribing

- The correct equipment (mobile phones and laptops) must be provided when a link worker starts their job; this is especially relevant to link workers employed by PCNs
- There must be clear definition of what they are and are not expected to do, especially as referral criteria into existing schemes have changed
- There must be clearer documentation of the training required to safely support service user needs, ideally as a competence framework
- Caseloads must be carefully considered, as more link workers are spending time supporting service users due to a reduction in VCSE activities and services to refer to

5. Everyone should be able to access social prescribing, whether face-to-face or via digital channels

- Service users without computer or internet access need support to find funding or schemes to enable this
- Scheme commissioning must include funding for the equipment to enable VCSE organisations and link workers to provide some digital social prescribing
- All stakeholders must invest in training to become more digitally fluent
- The digitally disadvantaged need support and coaching to access online support groups and activities



The Conservation Volunteers

Sedum House, Mallard Way, Doncaster DN4 8DB
www.tcv.org.uk



The Conservation Volunteers



@TCVtweets

Appendix A

List of organisations contacted to distribute surveys in Phases 1 and 2

- **Social Prescribing Network**
www.socialprescribingnetwork.com
- **MARCH network (UCL)**
www.marchnetwork.org
- **National Academy for Social Prescribing**
www.socialprescribingacademy.org.uk
- **Elemental Ltd**
elementalsoftware.co
- **National Association of Link Workers**
www.nalw.org.uk
- **Arts Council England**
www.artscouncil.org.uk
- **SPRING Social Prescribing**
www.springsp.org
- **College of Medicine**
collegeofmedicine.org.uk
- **Health Foundation**
www.health.org.uk
- **Royal Society for Public Health**
www.rsph.org.uk
- **Natural England**
www.gov.uk/government/organisations/natural-england
- **National Outdoor for all Working Group**
outdoorsforallweb.wordpress.com/about
- **DEFRA**
www.gov.uk/government/organisations/department-for-environment-food-rural-affairs
- **The social prescribing discussion group**
- **StreetGames**
www.streetgames.org
- **Bromley By Bow Centre**
www.bbbc.org.uk
- **Nesta (Health Lab)**
www.nesta.org.uk/archive-pages/health-lab
- **Thrive.org**
www.thrive.org.uk
- **Social Farms and Gardens**
www.farmgarden.org.uk
- **University of Salford**
www.salford.ac.uk
- **University of East London**
www.uel.ac.uk
- **University of the West of England**
www.uwe.ac.uk