National Academy for Social Prescribing

Evidence briefing

Sustainable funding models for social prescribing

The National Academy for Social Prescribing (NASP) commissioned its Academic Partners to review and summarise the evidence on funding models for social prescribing, and any insights into their financial sustainability. This NASP briefing captures the headline findings.

The Academic Partners' review of the academic literature, and other reports and evaluations, found that no studies had included financial sustainability in their design or evaluation, so the evidence summary was not able to report on this aspect. This is thought to reflect the fact that many delivery models are still relatively new and/or are not yet set up to allow reporting on financial sustainability in either the short or long term.

All the findings and examples referred to in this briefing are drawn from individual high-quality studies that met the criteria for inclusion in the evidence summary. In total the evidence summary drew on 13 studies, reports or evaluations. See summary for full list of references.

What we know

The evidence shows a range of different funding models for social prescribing, which include a diversity of funding sources such as private, public and charitable.

None of the funding models included in the evidence summary set out to deliver or to report on sustainability, so currently there is no evidence on whether models are or are not sustainable.

Newer models, such as Integrated Care Services (ICS), are currently being implemented and the literature review did not find any information from them to include in the current summary. However, moving forward, evidence from collaborative commissioning models, including via ICS, will be important to study.

However, the evidence summary does offer a way to group some of the different social prescribing funding models and going forward these could each be evaluated for their financial sustainability.

The different types of funding model highlighted by the summary are:

- **Single commissioner:** A Clinical Commissioning Group (CCG), Local Authority (LA), Housing Association, or Primary Care Network (PCN) mostly

commissioning a Voluntary, Community, Faith and Social Enterprise (VCFSE) sector organisation to manage and deliver social prescribing.
- **Collaborative commissioning of complementary services**: CCG and LA together commissioning a VCFSE organisation for management and delivery.
- **Fully integrated commissioning**: Chief Executive Officer (CEO) of CCG and LA. e.g. a CEO leading both LA and CCG (pooling of funding).
- **In-house delivery**: CCG and LAs jointly delivering social prescribing.
- **Direct funding of VCFSE sector**: CCG providing block grants for VCFSE sector organisations to deliver social prescribing.
- **Using Personal Health Budgets** (PHBs) or integrated PHBs.

Regardless of funding model used, the evidence suggests that **the most effective models and approaches are those where a range of local partners work together**, and that it is important to recognise the challenges in doing this.

Benefits and challenges of the co-commissioning approaches included:

- Bringing complementary perspectives and expertise, promoting collaborative working and cooperation between services, and reducing overlap and duplication.
- A very local focus on ill health prevention and experience of working with local communities.
- Generating real time local knowledge and information that can be used for effective service design and investment.
- Promoting use of appropriate outcomes and measurement tools to create a more rounded understanding of impact.
- When private investment such as Social Impact Bonds (SIB) (whereby an organisation is contracted to design and deliver a welfare or social project and is subsequently paid based on achieving specific milestones or outcomes) are part of the delivery model time there are concerns that should be addressed. In one example, front-line Link Workers had mixed feelings towards the SIB that underpinned the work as they were suspicious of a model perceived as offering a financial gain to investors on the back of vulnerable members of society who are affected by homelessness, but fundamentally valued the work that this funding made possible.

The evidence highlights that **the VCFSE sector is central to all the different social prescribing funding models, and that small VCFSE providers are particularly at-risk.**

- Whichever model is adopted, it is important to consider the capacity of the voluntary sector to deliver social prescribing activities. This can be the key limiting factor and it is only unlocked if enough funding is directed to the

VCFSE sector. Direct commissioning rarely covers full-cost recovery for small providers.

- In most cases, grants to deliver social prescribing are allocated by local and unitary authorities. Co-commissioning or co-ordination between local authorities and CCGs or PCNs may help support the VCFSE sector more effectively through a more integrated approach to account for budgetary cuts to services.

- Evaluation of the Rotherham Social Prescribing Service (RSPS) suggests that all the key stakeholders in social prescribing have a role to play in ensuring social prescribing is sustainable. Stakeholders include: the NHS, funders of the RSPS, and small activity providers themselves.

- One study of the RSPS highlighted that small providers questioned whether their true value was fully understood by commissioners of health and social care services. There was concern that, without this recognition, small providers may be gradually 'crowded out' by larger providers who may offer greater economies of scale but were less likely to be embedded in, and properly understand, local communities.

The gaps - what we still need to understand

There is little evidence that explicitly focuses on the VCFSE experience of social prescribing, especially in relation to funding delivery of VCFSE services. The current evidence summary focused on social prescribing; however, there is a much wider literature to learn from on the involvement of VCFSEs within different public service fields, which could provide insights on factors such as capacity, funding and financial sustainability.

The evidence summary raises a fundamental question about whose responsibility it is to ensure the ongoing existence of a healthy and thriving ecosystem of small VCFSE providers. Finding ways to answer this question may be fundamental to successful and sustainable social prescribing in the longer term.

Priority should be given to identifying the cost-benefits of different funding models and potential sources of funding, as well as a specific need to evidence the value of delivery of small-scale local services that are key to successful social prescribing. Moving forward, evidence from collaborative commissioning models, including ICS, will be important to study.

We are committed to working with partners to continue to identify and address priority evidence needs.