This is a '**platform**' evidence summary commissioned by the National Academy for Social Prescribing (NASP) from their Academic Partners (AP). The AP has a research track record in the review question or topic and were able to provide an expert commentary on the evidence base, together with an indication of the limitations of that evidence base. Their commentary represents the 'platform', from which they undertook further literature searches. They worked with an information specialist to design and conduct database and grey literature searches relevant to the review question or topic (see appendix 1 & 2). They screened references located from these searches against inclusion/exclusion criteria. Included studies were added to the commentary provided by their topic expert(s) to update, broaden, or otherwise add to the existing 'platform'.

(Sustainable) funding models for social prescribing

Context

This evidence summary is one of a suite commissioned by the National Academy for Social Prescribing from their Academic Partners in 2021 https://socialprescribingacademy.org.uk/evidence-on-social-prescribing/our-academic-partners/).The topics included in this suite were identified through a robust prioritisation process with individuals representing the breadth of the social prescribing landscape. The summaries were produced by researchers from the NASP Academic Partnership; specific teams are listed on each document.

Four of these topics had significant work conducted previously by members of our group, and so we report that work then build out using new database searches and broader grey searches; to produce synthesised conclusions about what is known (we term these 'platform' reviews, see above). The remaining summaries are 'fresh' reviews of the evidence base as it stands.

The summaries are intended for a broad readership but have a policy and practice focus; bringing together what is known on specific areas relating to social prescribing and summarising the findings, limitations, and gaps in that field. Each summary contains a detailed bibliography, and we would encourage readers to follow these links for further, more detailed, reading on each topic.

Recommended Citation

Kimberlee R, Bertotti M, Dayson C, Elston J, Polley M, Burns L, Husk K. [On behalf of the NASP Academic Partners Collaborative]. (2022). *'(Sustainable) funding models for social prescribing*'. London: National Academy for Social Prescribing

Question description

What range of funding models exist for social prescribing? How has service sustainability been considered, if at all, within these models?

Methodological approach, plus additions for this summary

Platform element

As with our other platform reviews, the current evidence was summarised by the core members of the NASP Academic Partnership most aligned with this topic. This was a summary of their teams' work on the area and was brought together into synthesised paragraphs along with a summary of the limitations, key gaps, and areas to strengthen as detailed below.

Additional evidence element

We undertook a systematic search for both peer reviewed literature and grey literature. The literature searches comprised terms for the concepts of social prescribing and funding (see Appendix 1). The databases Scopus and Web of Science were searched for peer reviewed literature. Grey literature such as reports, and evaluations were obtained by searching Social Care Online and Google.co.uk. In addition, evaluation reports of social prescribing services were screened for relevance. After screening 9 sources were identified for inclusion in the additional evidence element.

Data were extracted into a bespoke data extraction template for this review, and studies were not critically appraised as it was details of specific funding models which were of interest, which we would not expect to have greater or lesser confidence in depending on methodological robustness.

These two components, 'what was known' in the platform and 'what is added' in the additional evidence, are brought together to assess what we can say overall in the Conclusions section at the end of this document.

Summary of evidence by experts ('Platform')

Overall funding models

Models for funding social prescribing fall into distinct categories (adapted from Bromley by Bow, 2019):

- 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) organisation to manage social prescribing.
- Collaborative commissioning of complementary services: CCG and LA together commissioning to VCFSE organisation for implementation.
- 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 local authorities jointly deliver social prescribing.
- Direct funding of VCFSE sector: CCG provided block grants for VCFSE sector organisations to deliver SP.
- The possibility of using Personal Health Budgets (PHBs) or integrated PHBs.

Whichever model is adopted there is an important issue around the capacity of the voluntary sector to delivery social prescribing. The ability of the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to deliver social prescribing depends primarily on grants other than those received through the delivery of social prescribing. In most cases, grants to deliver social prescribing are allocated by local authorities (or county councils). Funding of social prescribing needs to account for budgetary cuts to provide services to their clients. Co-commissioning between local authorities and CCGs or PCNs or a level of coordination through the Integrated Care Systems (ICS) may be an answer to this significant problem.

The Rotherham Model

To add detail to the overall models, there are four main studies presented below relating to social prescribing funding models, three are peer-reviewed papers and one is a thematic evaluation report. All are based on research undertaken in Rotherham and their micro-commissioning model. We first summarise that model, then each report:

Rotherham Social Prescribing Service (RSPS) has two linked services: the 'Long-Term Conditions' component, which is embedded in General Practitioner (GP) led Integrated Case Management; and the community mental health service component, which is delivered in partnership with Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH). Both components are commissioned by NHS Rotherham Clinical Commissioning Group (CCG) and delivered by Voluntary Action Rotherham (VAR) in partnership with more than 20 local voluntary and community organisations.

The service aims to increase the capacity of GPs to meet the non-clinical needs of patients with complex long-term conditions (LTCs) who are the most intensive users of health and care resources; and to enable Community Mental Health Teams (CMHTs) to help users of secondary mental health services build and direct their own packages of support. The Long-Term Conditions component was first commissioned as a two-year Pilot in 2012. In 2014-15 it was re-commissioned for a further year as part of Rotherham's multi-agency proposal to the Better Care Fund, with an additional three years of service provision commissioned in April 2015 and then again in April 2018. The Mental Health component was initially commissioned

as a 12-month pilot in 2015 but was soon extended to March 2018. Both components of RSPS are currently fully funded by the CCG up to March 2022.

The annual funding agreement covers the core cost of delivering RSPS alongside a ‘micro-commissioning’ budget to ‘micro-commission’ a 'menu' of VCFSE activities that have been specifically developed to meet the needs of service users. The programme budget is split roughly 50:50 between the service team and micro-commissioning.

Overall, the evaluation of the RSPS suggests that key stakeholders in social prescribing – the NHS, their funders, local infrastructure, and small providers themselves – each has a role to play in ensuring social prescribing is sustainable. Ultimately, the ingredients for a successful and sustainable model of social prescribing lie in a range of local partners working together equitably in the interests of individuals and communities facing multiple forms of disadvantage.

Paper 1

A qualitative study into the outcomes associated with the Rotherham Mental Health service and found that social prescribing makes a positive contribution to emotional, psychological, and social wellbeing for patients of secondary mental health services. A key enabling mechanism of the social prescribing model was the supportive discharge pathway which provided opportunities for sustained engagement in community activities, including participation in peer-to-peer support networks and volunteering.

Paper 2

A comparative study of two approaches to commissioning social prescribing: the micro-commissioning model in Rotherham and the social impact bond (SIB) operating in Newcastle. It finds that a SIB approach tends towards New Public Management during programme design and implementation and that this creates challenges for social prescribing programmes, whereas the complexity of social prescribing appears better suited to the more relational commissioning approach employed in Rotherham.

Paper 3

Introduces the idea of ‘social prescribing 'plus'’ by drawing together two emergent theoretical concepts: asset-based approaches to health and care; and collaborative innovation, to reframe social prescribing in the context of broader debates and competing paradigms of public administration. This study considers whether social prescribing represents a more substantive step-change in the way policymakers think about the design and delivery of health and social care policy. It suggests cautious optimism is merited: through social prescribing 'plus' in particular policymakers in several localities have embraced the principles of asset-based working and collaborative innovation but whether this amounts to a genuine step-change in their approach will need to be assessed over the longer term.

Paper 4

This report discusses the role and contribution of small providers of social prescribing services and activities that support the delivery of the Rotherham Social Prescribing Service. Despite the micro-commissioning model identifies challenges for small providers have been relating to funding and sustainability. Although small providers were able to access funding to support RSPS referrals through the 'micro-commissioning' approach, this rarely covered the 'full-cost' of provision. As a result, many were cross-subsidising services and activities through other funds but had concerns about their sustainability in the longer term. Increasingly more is being expected of small providers by public sector commissioners in health and social care, but without sufficient investment in their ability to operate sustainably, and cross-subsidy is proving increasingly challenging in the current economic climate.

Importantly, this study highlights that small provider's 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. We suggest that the real value of social prescribing is the way it connects patients with complex health conditions to small local providers, and then on to a diverse range of community activities and opportunities. However, there is a risk that without more sustainable models of investment many small providers, and the value they create, could be lost. Overall, this raises a fundamental question about whose responsibility it is to ensure the ongoing existence of a healthy and thriving ecosystem of small providers in a locality and how this can be achieved in practice? Finding common agreement to the answer to this question may hold the key to successful and sustainable social prescribing in the longer term.

Limitations

We included the word 'sustainable' in parentheses for this review as, arguably, we don't know yet whether the funding models are sustainable as social prescribing is still relatively new in most places. As such, we argue that future work should focus on 'funding models for social prescribing', as this can tell us what an inequitable and unsustainable model might look like.

Overall, this subject remains under-researched and there is little evidence that explicitly engages with the VCFSE experience around social prescribing, especially relating to funding. The evidence we present related only to social prescribing, however there is a much wider literature on the involvement of VCFSEs within different public service fields. This tends to focus on issues around capacity, funding, and sustainability; their purported distinctiveness, or position, within a mixed economy of welfare relative to other types of providers; the implications of public service commissioning; and the evolving nature of their partnership with the state.

Summary of additional evidence located:

In order to build on the above expert platform, we conducted a literature search across both bibliographic and grey literature. Our searches resulted in 108 located items and following screening 9 sources of new information were included; of which 5 were journal articles and 4 were evaluation reports (see Appendix 2).

Funding models

These nine new sources included detail on the specific funding models for social prescribing already described, as well as providing a general overview of models that were being used. Below we describe the main findings of these sources as they relate to: 'standard' co-commissioning models; social impact bond approaches; and 'general' descriptions of models.

Co-commissioning: Firstly, five sources (Elston 2019, Foster 2020, Bromley by Bow 2019, Health Foundation 2014, and Healthy London 2018) all describe the ways in which standard (or, more accurately, most common, and as described above) commissioning for social prescribing has been adopted.

Often between LA and CCG, co-commissioning encompasses multiple forms, but brings potential co-working benefits (Bromley by Bow 2019). This Bromley by Bow report expands on modes and aspects of co-commissioning, identifying three main forms: (1) Single commissioner with collaborative working, (2) Collaborative commissioning of complementary services, (3) Fully integrated co-commissioning. The reported benefits of co-commissioning include: bringing a complementary perspective, local authority focus on prevention, local authority experience of working in the community space, expertise on effective ways of working, generating real time local knowledge and data and utilising it for effective service design and investment, reducing silo working and enabling discussion on overlap, duplication and cooperation between services, promoting use of diverse outcomes and measurement tools to create a more rounded understanding of the schemes, and broadening scope for social prescribing approaches.

Extending this work and providing case studies were the reported evaluations by Health Foundation 2014, and Healthy London 2018, who also identified a need for integration with the VCFSE through coherent umbrella organisations.

Social impact bonds: Two of the included sources (George 2020, and Ways to Wellness 2021) report on the ways in which social impact bonds (SIBs) have been used to finance social prescribing. As George (2020) reports, SIBs are a variant of 'payment by result' whereby a government contracts an organisation to design and deliver a welfare or social project and is subsequently paid based on achieving specific milestones or outcomes. In their study, George (2020) also reports that, in an innovative homelessness project, front-line link workers had mixed feelings towards the SIB that underpins it. The workers 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. The workers were also concerned about inappropriate outcome measures; but fundamentally valued the work that this funding made possible.

The Ways to Wellness (2021) model is reported as the first health service to use Social Impact Bond (SIB) investment paired with outcomes-based, multi-year NHS contract. The programme brought together cross-sector partners with differing perspectives, cultures, and priorities creates an opportunity for partners to learn from one another and draw on each other's strengths. However, the team find that this was paired with inherent tensions between partners from differing organisational and cultural perspectives.

Financially, the Ways to Wellness programme was successful, with the outcomes meaning that the final SIB capital was re-paid at the end of year six (March 2021). Additional costs of finance and returns on investment were paid to the investor, linked to performance.

Overviews: Both Jani 2020, and Scott 2021 provide overviews of the myriad ways in which social prescribing has been financed over recent years. From Jani (2020):

Table 1. Different funding models that could be used to support the social prescribing ecosystem.

		Social Px providers	Social Px prescribers
Funding sources			
Public	Combo: Public, private and/or philanthropic e.g. Social Impact Bond	– CCG funded social Px providers – Local Authority-funded social Px providers – Combo CCG + LA co-funded – Personal health budgets[a]	– CCG-funded link workers – Local Authority-funded link workers
Private		– Individual out of pocket – Crowdfunding[a]	– GP practice-funded link workers
Philanthropic		– Charities providing social Px to patients – Foundations/philanthropies sponsoring social Px providers	– Foundations/philanthropies sponsoring link workers

Social Px: social prescriptions; CCG: Clinical Commissioning Group.
[a]Models which could theoretically be used to support the social prescribing ecosystem.

PROGRESS Plus:

Almost all included reports did not report differential outcomes for specific populations within cohorts, including those identified by the PROGRESS Plus framework https://methods.cochrane.org/equity/projects/evidence-equity/progress-plus. Given that these are descriptions of funding models in the main, this is to be expected. Those that did include populations included in the framework, reported that (a) there were no differences seen across age, gender, ethnicity, living arrangement and work status (Health Foundation 2014), and (b) evidence of more positive change for younger service users, prompting discussion about whether it would be more appropriate to focus the service on younger users and how outcomes for older service users could be better understood.

CONCLUSIONS

Social prescribing remains relatively new, and we do not yet know whether the funding models being adopted are sustainable. Whichever model is adopted in particular contexts, it is important to recognise and be sensitive to the capacity of the voluntary sector in delivering social prescribing. Future research should engage with the VCFSE experience around social prescribing funding approaches, and link to the developing literature on commissioning this sector through health systems.

To re-state, ultimately the ingredients for a successful and sustainable model of social prescribing lie in a range of local partners working together equitably, whilst recognising the inherent tensions between partners from differing organisational and cultural perspectives.

References

Platform element

I. Paper 1

Dayson, C., Painter, J., & Bennett, E (2020). Social prescribing for patients of secondary mental health services: emotional, psychological and social wellbeing outcomes. Journal of Public Mental Health

II. Paper 2

Dayson, C., Fraser, A., & Lowe, T. (2019). A comparative analysis of Social Impact Bond and conventional financing approaches to health service commissioning in England: the case of social prescribing. Journal of Comparative Policy Analysis.

III. Paper 3

Dayson, C (2017) Social prescribing 'plus': a new model of asset-based collaborative innovation? People, Place and Policy, 11 (2), pp 90-104

IV. Paper 4

Dayson, C. and Batty, E. (2020) Social Prescribing and the Value of Small Providers - Evidence from the Evaluation of the Rotherham Social Prescribing Service. Sheffield: CRESR, Sheffield Hallam University.

Additional element

1. Bromley by Bow (2019). “An exploration of co-commissioning approaches to social prescribing services.” London: Bromley by Bow Insights

2. Elston, J., F. Gradinger, S. Asthana, C. Lilley-Woolnough, S. Wroe, H. Harman and R. Byng (2019). "Does a social prescribing 'holistic' link-worker for older people with complex, multimorbidity improve well-being and frailty and reduce health and social care use and costs? A 12-month before-and-after evaluation." Primary Health Care Research and Development 20.

3. Foster, A., J. Thompson, E. Holding, S. Ariss, C. Mukuria, R. Jacques, R. Akparido and A. Haywood (2020). "Impact of social prescribing to address

loneliness: A mixed methods evaluation of a national social prescribing programme." Health and Social Care in the Community 29(5): 1439-1449.

4. George, T., J. Rogers and A. Roberts (2020). "Social impact bonds in the UK homeless sector: perspectives of front-line link workers." Housing, Care and Support 23(3): 123-134.

5. Health Foundation (2014). "Shine 2014 final report Social Prescribing: integrating GP and Community Assets for Health." London: The Health Foundation

6. Healthy London (2018). "Deliverable 2 - VCSE Sector Engagement and Social Prescribing." London: Greater London Authority

7. Jani, A., M. Bertotti, A. Lazzari, C. Drinkwater, F. Addarii, J. Conibear and M. Gray (2020). "Investing resources to address social factors affecting health: the essential role of social prescribing." Journal of the Royal Society of Medicine 113(1): 24-27.

8. Scott, J., G. Fidler, D. Monk, D. Flynn and E. Heavey (2021). "Exploring the potential for social prescribing in pre-hospital emergency and urgent care: A qualitative study." Health & Social Care in the Community 29(3): 654-663.

9. Ways to Wellness (2021). "The First Six Years Approach, Findings and Learning." Newcastle upon Tyne: Ways to Wellness

Appendix 1 – Additional searches, search strategy

Funding models

Experts say question should be around types of funding models (not on sustainability)
No date limit.
+ google searches
+ ethos search

Scopus

(TITLE-ABS-KEY ("social* prescrib*") OR TITLE-ABS-KEY ("social prescription*") OR TITLE-ABS-KEY ("community referral*") OR TITLE-ABS-KEY ("social referral*") OR TITLE-ABS-KEY ("non-medical referral*") OR TITLE-ABS-KEY ("link worker*") OR TITLE-ABS-KEY ("care navigator*")) AND TITLE-ABS-KEY (commission* OR fund* OR investment* OR grant* OR budget* OR "private sector") AND (LIMIT-TO (AFFILCOUNTRY , "United Kingdom"))
=74

Web of Science

TS=("social* prescrib*" OR "social prescription*" OR "community referral*" OR "social referral*" OR "non-medical referral*" OR "link worker*" OR "care navigator*")

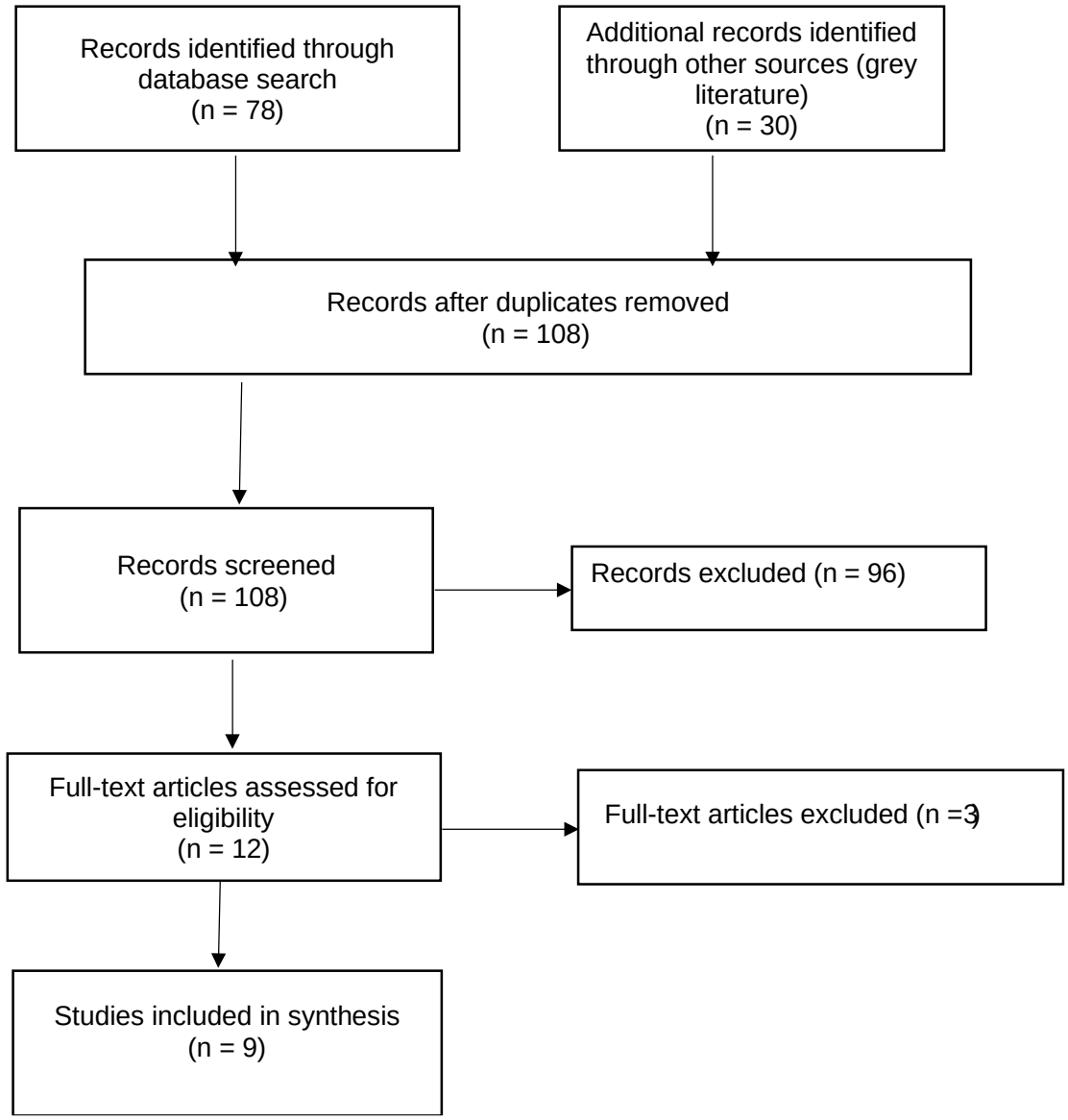
AND
TS=(commission* OR fund* OR investment* OR grant* OR budget* OR "private sector")
Refine by: Countries England and Wales
=58
Total = 132
After de-dup - 78

Google

allintitle: (""social prescribing"" OR ""social prescription"" OR ""link worker"") AND (commission* OR fund* OR investment* OR grant* OR budget* OR "private sector")
= 29

Appendix 2

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram for additional search element. This diagram depicts the flow of information through the different phases of this review. It shows the number of records identified, included and excluded, and the reasons for exclusions.



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