National Association of Link Workers

citizens advice

Exploring social prescribing referrals & impact on information, advice and guidance services

Research report
May 2023

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Executive Summary

The impact of social and wider determinants of health on health outcomes is well established. As a result, health systems have recognised a more personalised approach is needed to tackle those determinants that lead to poor health and to reduce pressure on the healthcare system. Social Prescribing is one of the first formalised interventions to meet patients' unmet social needs, impacting their health and wellbeing to enable holistic healthcare delivery. The NHS rollout of social prescribing has mainly been resourced by recruiting link workers.

Critical components of Social Prescribing are the social prescribing link worker and community based support, of which social welfare law advice plays a significant role. Citizens Advice (CA) is England and Wales's largest provider of free social welfare law advice. As a result, it has seen unprecedented demand for their service due to the social prescribing schemes referring to their local services for issues. Demand has been further exacerbated by the cost of living crisis and the aftermath of Covid-19. As a result, patients who need an urgent resolution to their socio-economic issues have a significant wait for this vital support and therefore risk the non-clinical issue exacerbating the clinical one.

Social prescribing is grounded in equity and community development. To effectively develop local communities (and the VCSE provision within them) ethically and equitably, social prescribing services and commissioners require insight that demonstrates patients' pathway through the system and reveals the impact of social prescribing services on all stakeholders involved, including CA.

Citizens Advice (CA) commissioned the National Association of Link Workers (NALW) to research the scale and nature of social prescribing referrals on its stakeholders and what the data tells us about referral and demand for social welfare law advice. At a time when patient satisfaction in the NHS is the lowest since the record began, the main reason being NHS waiting times for GP and hospital appointments, it is important to uphold patient confidence in social prescribing service by ensuring waiting lists are at the barest minimum if not eliminated to improve the patient experience.

Our research found some implementation challenges in service delivery that must be addressed.

- Commissioners, academics, and social prescribing service managers must consider the entire service user/patient journey, including social prescribing link workers and community based support services, such as Citizens Advice, in their service design or research.
- Social prescribing key performance indicators must include the entire patient/service user pathway (including social prescribing link workers and community based support).
- Resources should be made available to enable data to be captured in the whole patient journey, including funding for the entire patient/service user journey and recruiting more social prescribing link workers to reduce or eliminate overwhelm.
- Views from Scotland, Wales, and England are included in this report; therefore, the recommendation will be helpful to all nations.

Introduction

Our understanding of what a healthy life looks and feels like has changed considerably over the past two decades. First, the recognition that mental health should receive parity of esteem with physical health being enshrined in law by the Health and Social Care Act 2012 (Baker & Gheera, 2020) and now, the importance of our social environment and experiences (also called the social determinants of health) on both our physical and Mental Health committed to in national policy (NHS England, 2019). A core strategic aim of NHS organisations is to reduce health inequalities, which are systematic differences in health experienced by particular groups or communities who share characteristics (e.g., race, sex), have geographical proximity (e.g., those in the same town or borough) or live with shared experiences (e.g., low-income groups) (The King's Fund, 2022).

Addressing Health Inequalities

Our understanding of health inequalities has grown considerably over the past decade, and it is now agreed the principle contributing factor to health inequalities is an individual's broader social, economic, cultural, and environmental context (Lovell & Bibby, 2018). This context is more commonly called the 'wider determinants of health' (some-times the social determinants of health), and includes income, education, access to green space, availability of healthy food, the types of work people do, and the environ-ments they live and socialise in (figure 1).

Figure 1: The wider determinants of health (King's Fund, 2022, adapted from Dahlgren & Whitehead, 1993)

Income

Those with low incomes have their choices significantly reduced, often priced out of healthier food, living and travel options. This can lead to health issues such as obesity, with adults in the most deprived regions having almost double the prevalence of obesity compared to their counterparts in the least deprived **(36% compared with 20%) (Batterham, 2020).**

Housing

Poor quality, overcrowded, or unstable housing can cause a range of physical and psychological health issue, including cardiovascular and respiratory diseases, depression, and anxiety **(Centre for Ageing Better, 2020).**

Environment

People from ethnic minority communities, or low income households have lower access to green spaces **(e.g., parks)** and increased exposure to harmful pollutants. Those who live closer to green spaces have been found to take part in more physical activity than those who are deprived of this and are therefore seen to utilise health services less **(Public Health England, 2020).**

Education

Education levels can impact life expectancy, with those graduating from university by the age of 30 living five years longer than those with lower levels of education **(OECD, 2019).** Despite this, the type of degree chosen can impacts the likelihood of entering stable employment and future earning potential. This can be seen in graduate unemployment rates, which range from 15% to 0% dependent on degree course completed **(Rasheed, 2022).**

Information, advice, and guidance

One of the key service types that support individuals with the wider determinants of health are those who provide information, advice, and guidance (IAG). Many IAG providers will offer self-help information via their website (e.g., the types of welfare you may be able to access) and will also offer advice and guidance on how to act either via the telephone or face to face, where self-help is no longer appropriate (e.g., what to do once you're behind on your bills). There are a wide range of information, advice, and guidance providers, who deliver different forms of IAG in different ways. Some offer generic advice to particular communities of people (e.g., those with distinct conditions, such as cancer or dementia), whereas others offer more specialist advice to all those who require it (e.g., debt advice to the general public). All IAG services however work to empower people to improve, and sustain improvements in, their context.

Citizens Advice

Citizens Advice (CA) is a national network of charities that offer confidential, impartial information, advice, and guidance to members of the public across England and Wales. It is the largest provider of IAG services in the country, and during 2021-2022, supported 1.96 million people over their telephone services, 624,000 people by email, 183,000 in a face-to-face setting and 176,000 via webchat. The organisation has a high success rate, with 3 in 4 people who contacted the service in 21/22 and nearly 9 in 10 people who contact the service would recommend their services to a friend **(Citizens Advice, 2022a).**

The three main issues CA advisers supported these individuals with were consumer issues (including energy), welfare and debt. Their support generated £14 of public value for every £1 invested, totalling £4.6bn during the year. This includes direct income generation or debt relief for clients, for whom CA services have been found to generate £6,614 in income on average, and indirect benefits due to the prevention of health deterioration **(Citizens Advice, 2022a).**

Anna's Story (Citizens Advice, 2021)

Anna was made redundant during the pandemic and was unable to keep up with debt repayments. The CA adviser supported them to apply for Universal Credit and Personal Independence Payment—securing Anna £404 per month in additional income — and writing off a total of £11,696 through a debt relief order, significantly supporting Anna to manage their debts.

One of the most immediate and widely reported benefits of receiving support from CA services is a reduction in mental health issues including anxiety and depression, with 6/10 clients reporting improvements in wellbeing following engagement with a CA service **(Citizens Advice, 2022a)**. By improving the wider determinants of health, CA services also support their clients to become more physically well.

Robert's Story (Citizens Advice, 2022b)

Robert contacted CA after his mental health worsened due to ongoing issues in relation to a faulty boiler. The CA adviser liaised with the local council to get an engineer out urgently advising a possible oil leak due to Robert's mental and physical symptoms, which was later confirmed by healthcare professionals. The leak was identified, and boiler replaced, ensuring no further hazards to Robert's health existed. Robert explained:

> *"If it wasn't for Citizens Advice I believe I would be extremely unwell and this issue would not be resolved… if I did not go to Citizens Advice there wouldn't have been anyone else who could have helped me".*

The COVID19 pandemic saw a significant number of the population become reliant on welfare, or debt to support themselves and CA services reported a change in the socio-demographic make-up of those seeking support in response to this, with a much broader client group, who were experiencing more complex issues **(Citizens Advice, 2021)**. The COVID19 recovery period did not appear to alleviate these issues, with CA services experiencing a 72% increase in the number of contacts related to fuel and the number of contacts for food banks more than doubling between 2021-2022 **(Citizens Advice, 2022a)**. The cost-of-living crisis is expected to further exacerbate these issues and staff have reported, with recent data demonstrating a growing upward trend in the numbers of cost-of-living related issues clients are reaching out with **(Citizens Advice, 2022c)**.

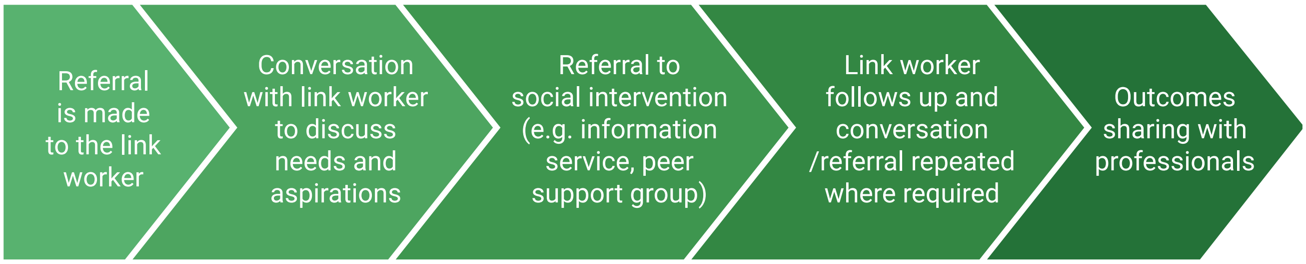
Not only have the numbers of those who require access to community based support grown over the past three years, service users are coming from a broader range of socio-demographic backgrounds with more complex needs **(Citizens Advice, 2022b)**. This means professionals in IAG services are required to spend longer with service users to explore their issues, reducing caseload turnover and the numbers of people supported over a time period, and require additional skills and expertise to support them, reducing the range of professionals that can work with clients **(Brown et al., 2021)**.

During October 2021 – October 2022, CA supported nearly 1.5 million clients nationally. Just less than 1% of these clients (nearly 13,000) were recorded as being referred to the organisation by social prescribing link workers. However, not all clients tell CA that they have been referred; different local CA services have different categories for recording clinical referrals, and the categories for recording social prescribing referrals are not always suitable. Despite the small percentage, this is a 14% increase on the year before **(Citizen's Advice, 2022d),** demonstrating a significant rise in demand related to social prescribing services.

Social prescribing

Social prescribing is an umbrella term used to describe the process of referring service users to non-medical forms of support (e.g., information about benefits, peer support groups, healthy living activities) in order to address the social determinants of health and alleviate pressures experienced in primary care (White et al, 2020). Social prescribing is facilitated in the National Health Service (NHS) by Social Prescribing Link Workers (SPLWs), whose role is to spend time with service users, understand what their core needs are and connect them to local voluntary and community sector enterprises VCSEs that deliver the social interventions that will address these needs **(NHS England, 2020a).** Figure 2 below demonstrates the core stages a service user will go through when engaging with a SPLW.

Figure 2: User journey through social prescribing services (Professional Record Standards Body, 2022)



While evidence of social prescribing efficacy is mixed, it is agreed within the literature that for social prescribing services to be effective, they require a strong voluntary and community sector (VCS) presence as onward referral destinations and the organisation who will deliver the social interventions that benefit the patient **(Veasey et al, 2018; Pescheny et al., 2018; Wildman et al., 2019; NHS England, 2019).** The socioeconomic impact of COVID19 and the cost-of-living crisis, however, have pushed VCS capacity to its limits and the sector's sustainability is in doubt **(Cole et al., 2020; Polley et al., 2020).** Commissioners across statutory services are expected to support community development through the provision of resources and funding, ensuring the organisations that accept onward referrals have the capacity to manage **(NHS England, 2020a).** Existing literature demonstrates that community development work undertaken as part of Social Prescribing Services (SPSs) is limited and any related funding allocation inconsistent and inequitable **(Polley et al., 2020).**

National Association of Link Workers

The only professional body and collective voice for Social Prescribing Link Workers in the UK. We are committed to upholding confidence and integrity of the profession by ensuring patients and communities receive high quality social prescribing link worker model services.

Project background

To effectively develop local communities (and the VCSE provision within them) in ethical and equitable ways, SPLWs and commissioners require insight that clearly demonstrates the movement of users through the system and reveals the impact of Social Prescribing Services (SPSs) on all stakeholders involved. CA commissioned the National Association of Link Workers to undertake research to explore the scale and nature of social prescribing referrals to their services and the impact of these referrals on their capacity and within the current economic climate. CA is a national network of charities that offer confidential, impartial information, advice, and guidance (IAG) to members of the public. It is the largest provider of IAG services in the country, directly supporting over two and a half million people from over 2000 locations across England and Wales **(Citizens Advice, 2022a).**

1. **What impact does social prescribing have on its stakeholders?**
2. **What does the Social Prescribing Observatory and the CA datasets tell us about onward referrals made by SPSs and the demand for services provided by CA?**
3. **What are social prescribing link workers' experiences of making onward referrals to services provided by CA and what impact do they perceive these referrals make on the service user and CA?**

NALW will seek to answer these questions by meeting the following objectives:

- Undertake a literature review, to assess the impact of social prescribing on service user outcomes, health service use, social determinants of health and VCSE capacity.
- Conduct secondary data analysis using the Social Prescribing Observatory data and the CA data to explore social prescribing demand and the demographic drivers for service demand;
- Undertake an online survey to explore how SPLWs' refer to services, specifically those provided by CA, and determine their views on how these referrals can be officially recorded to

Methodology

A two stage process was undertaken in line with the objectives outlined above. Phase one consisted of a evidence review in order to explore the impact of social prescribing to date and secondary data analysis to explore the ways in which demand for services are measured and the scale and nature of onward SPS referrals. Phase two consisted of a stakeholder validation meeting that supported the development of a later online questionnaire to be completed by NALW's network to gain a further understanding of the experiences of social prescribing link workers and their perceptions of their impact and its measurement. A detailed description of the methods utilised, and data accessed can be found below.

Phase one: secondary research

Phase one of the research consisted of review of the literature to explore the impact of social prescribing to date and secondary data analysis to explore the ways in which demand for services are measured and the scale and nature of onward SPS referrals.

Review of the extant literature

An evidence review was undertaken in order to assess the impact of social prescribing on service user outcomes, health service use, socio-economic goals, and VCS capacity. Keyword searches were entered into grey literature databases and snowball searching was undertaken to identify suitable evidence within the reference lists of existing sources. To be included, studies must have been published between 2017-2022, focus on social prescribing services delivered in England and Wales and be publicly available. A total of 34 papers were reviewed. The majority of studies sourced were primary research (evaluations), however secondary desk studies (including literature reviews) were also included. Framework analysis **(Ritchie & Spencer, 1994)** was conducted, due to its transparency and the scope it offered for collaboration between multiple researchers.

Analysis of secondary data

Secondary analysis of Social Prescribing Observatory data (box 3) and Citizens Advice (box 4) data were undertaken to assess the consistency in the patterns in the two data sources so as to better understand trends and patterns in social prescribing, as well as quality of existing data used to monitor social prescribing activity.

Box 3: Social Prescribing Observatory Data

The Oxford Royal College of General Practitioners Research & Surveillance Centre **(RCGP RSC)** has a current membership of over 1800 general practices in England covering approximately 8 million patients. To support the rollout of social prescribing, the Royal College of General Practitioners (RCGP), in partnership with the University of Oxford, created a Social Prescribing Observatory that is updated weekly, providing up to date information about social prescribing nationally. This data is collected using two SNOMED codes, which can be entered into clinical systems used in primary care to enable an overview of activity happening in any one area **(NHS England, 2020a).** This data is key to national commissioning of services and allocation of resources as it can be used by NHS England and others to measure the uptake of social prescribing and inform decisions as to how the healthcare system can adapt to meet the needs of those it serves. Local funding arrangements are also determined by the number of SNOMED codes recorded in each area and it is therefore a key data source in relation to understanding demand and being able to address local need **(Bromley by Bow Centre, 2022).**

Population and referrals data was manually extracted from the SPO data **(Oxford RCGP RSC Tableau Dashboard)** on issues related to Housing and Money for the period October 2020 to September 2022 by gender, age, and selected geographies. Quarterly rates were calculated per 10,000 population separately for issues related to money and housing. Trends were analysed using a Joinpoint regression model and the total numbers for the English population were estimated by applying the crude rates to the total English population (Table 1).

Table 1: Demographic representation within the SPO data (2022)

	ENGLAND POPULATION	SPO
Population	56.5m*	4.87m**
% Female	51%	49%
% in least deprived quintile	20%	21%
% over 65 years	18.6%	39%
% under 17 years	49%	25%

*ENGLAND POPULATION (2021 CENSUS) **AVERAGE POPULATION IN OXFORD-RCGP RSC PRACTICES Q4 2020 – Q3 2022

Box 4: Citizens Advice data

Clients visiting a Citizens Advice, following a Social Prescribing referral, are captured under a social prescribing subject code. Allocation to this code is dependent upon the client reporting the referral. CA provided the NALW with a summary statistical report for the period Quarter 1, 2020 to Quarter 3, 2022. Statistics were presented by issue and included multiple visits from the same client. Similar to the SPO data, quarterly rates per 10,000 population were calculated for comparison, drawing population and sub-population data from publicly available sources. Analysis of trends, demographic and geographic patterns was performed in the same manner as that of the SPO data.

Phase two: primary research

Phase two of the research consisted of a stakeholder validation meeting that supported the development of a later online questionnaire to be completed by NALW's network to gain a further understanding of the experiences of Social Prescribing Link Workers (SPLW) and their perceptions of their impact and its measurement.

Stakeholder validation meeting

In order to inform the development of the SPLW survey, an online stakeholder validation meeting was held, which sought to explore findings of phase one of the research, and sense checking proposed questionnaire content.

Design

A one hour validation meeting was designed incorporating group work to determine consensus on the proposed questions for the survey for phase two. This group work consisted of a questionnaire validation activity. The questionnaire validation activity was guided by the principles of the Consensus Group Technique **(List, 2001).** In consensus groups a criterion level of agreement is set **(usually around 75%)** and statements are modified to determine whether the criterion level can be met. The method includes steps where participants vote on statements and those statements that do not produce clear cut majorities are clarified, reworded, or split.

For this group work, participants were asked to vote "Yes" or "No" to inclusion of the question. There were 21 questions in total and those questions that did not receive more than 70% consensus in the voting round were discussed in the group to determine exclusion or rewording.

Procedure

An invitation email was sent to 16 independent stakeholders stating the purpose of the meeting. A pre-meeting report was distributed before the meeting along with the link for joining the meeting. The report described the findings of phase one and the aim of the stakeholder meeting **(Appendix 1).** The meeting took place via Microsoft Teams, was facilitated by the CEO of the National Association of Link Workers and commenced with an introduction to the meeting along with a presentation on the findings from phase one **(Appendix 2).** The questionnaire validation group work then took place using Slido for voting. The meeting was recorded for analysis purposes.

Descriptive demographic information was collected from the participants, then the questionnaire validation activity took place:

- The moderator shared each suggested question and asked for a vote for inclusion (Yes/No)
- Discussion at the end for questions that receive less than 70% of the vote

Analysis

Voting data was extracted from Slido and indicated which questions were included in the final SPLW survey. The recording was transcribed and verbal feedback was examined.

Results are described in full on page 21 and informed the development of the Social Prescribing Link Workers survey questionnaire, Appendix 3.

SPLW online survey

Design

The SPLW survey **(appendix 3)**, finalised after the stakeholder validation meeting included open and closed questions to enable the collection of quantitative and qualitative data. The aim was to ask respondents what they are doing and how in a quantifiable manner, while the qualitative data offers deeper insight and explanations. Thematic analysis was utilised for the qualitative data analysis, guided by Braun and Clarke (2006).

Procedure

The survey was developed using SurveyMonkey and distributed electronically to NALW's networks to gain a further understanding of onward referrals and their impact. Those who were either individual social prescribing link workers/link workers or social prescribing service managers/leads with a caseload were asked to complete the survey.

It was promoted through NALW networks, included mailing list, social media, online platform, and partner channels. It remained open for four weeks.

Analysis

Quantitative data was analysed in Microsoft Excel and thematic analysis (Braun and Clarke (2006) was utilised for the qualitative data.

Results are described on page 26.

Findings: Secondary Desk Research

Phase one of this research consisted of evidence review to explore the impact of social prescribing to date on its stakeholders and secondary data analysis to explore the ways in which demand for services are measured and the scale and nature of onward SPS referrals. The findings of these activities were themed in line with the research questions and can be found below.

Impact on stakeholders

Impact on service users

The majority of social prescribing services described within the literature resulted in improvements in measures of wellbeing, mental health, and social connection (loneliness/isolation) for a large proportion of those who engage with SPLWs **(Ferguson & Hogarth, 2018; Elton et al., 2019; Bertotti et al., 2020; Bickerdike et al., 2017; Dayson et al., 2017; York CVS, 2019; Dayson et al., 2021; Polley et al., 2021; Mead, 2019; Reinhardt et al., 2021; Woodall et al., 2018)**. Whether these improvements can be directly attributed to SPSs, are statistically significant, and can be sustained over the longterm for all communities is not yet clear **(Carnes et al., 2017; Bickerdike et al., 2017; Kiely et al., 2022; Pescheny et al., 2020; Polley et al., 2017)**.

The SPO and CA data do demonstrate however that particular demographics of service users benefit from social prescribing and onward services at a higher rate than others. SPO referrals related to housing for example were 70% higher among males compared to females over the period and highest for people aged 40-64 years followed by those over 65 years and lowest in the 18-39 age group. Similarly, for money issues, rates were also lowest in the 18-39 age group, though rates were highest in the >65 group, 14% higher than those in the 40-64 age group. In addition, for money issues, rates were 38% higher among women compared to men. Within the CA data, referral rates were almost 50% higher for females compared to males and activity related social prescribing was higher with increasing age group.

Impact on health services

Studies exploring the impact of social prescribing services on capacity in primary care, with some demonstrating reductions of up to 68% **(Carnes et al., 2017; Bickerdike et al., 2017; Ferguson & Hogarth, 2018; York CVS, 2019; Reinhardt et al., 2021; Bertotti et al., 2020; Polley et al., 2021)**, and others increases in use, particularly for older cohorts **(Elston et al., 2019; Woodall et al, 2018)**. Findings of studies exploring the impact on capacity in other areas of the health and care sector (urgent, secondary, and social care) were in some cases similarly mixed **(Reinhardt et al., 2021)**, but on the whole, positive **(Bickerdike et al., 2017; Carnes et al., 2017; Polley et al., 2017; Elston et al., 2019; Bertotti et al., 2020; Munoz et al., 2020; Case et al., 2021; Kiely et al., 2022)**. While general practitioners were reported to perceive social prescribing positively, their views as to whether it had reduced their workload were not as positive **(Bertotti et al., 2020)**. A general practitioner, quoted as part of an evaluation undertake by White et al. (2020), provided some explanation as to why this may be:

> *"Sometimes it can just be because, if that patient is no longer coming to see you as often, it's just somebody else who's coming to see you".*

The social return on investment of SPSs is again, contested, with every £1 spent returning between £1:£1.84 **(Dayson et al., 2017)** to £1:£5.16 **(York CVS, 2019)**. There is general agreement within the literature that the average SROI for an SPS is £1:£2.30 **(Polley et al., 2017; Bertotti et al, 2021; Ferguson & Hogarth, 2018)**, reinforced by the SPS evaluation conducted by Mead (2019) which demonstrated an SROI of £1:£2.27 and an evaluation conducted by Kensington & Chelsea Social Council (2018) which demonstrated an SRO of £1:£2.80. While the efficacy and value for money of SPSs remains under debate, evaluations have consistently demonstrated the requirement for social prescribing services to be underpinned by a well-resourced and resilient voluntary and community sector **(VCS)** to be successful **(Pescheny et al., 2018; Wildman et al., 2019; Dayson et al., 2017; Woodall et al., 2018; Veasey et al., 2018; Holding et al., 2019)**. Despite this, much less research has been undertaken exploring the impact on the VCS.

Impact on voluntary, community and social enterprise sector

Within the literature, the number of onward referrals reported was often higher than the number of inward referrals **(Dayson & Batty et al., 2017; Family Action, 2018; Social Prescribing Torfaen, 2018; Together Co, 2020)**, sometimes considerably, with each member of one SPS being referred onto an average of five VCSEs **(Family Action, 2018)** and in another, some people being referred onto ten VCSEs **(White et al, 2020)**. This demonstrates that in some cases SPSs generate a considerable amount of work for organisations in the VCS. Two studies provided the number of onward referrals and the number of organisations that were referred onto. Across these SPSs, on average, 8 referrals for each VCSEs involved in the programme would be generated. Bertotti et al., (2018) however identified that in their study, the bulk of onward referrals were to 10% of the total VCSEs, and SPLWs have recognised the inequitable distribution of onward referrals across VCSEs **(Ferguson & Hogarth, 2018)**, indicating an average measure of onward referral would not be appropriate to support equitable funding allocation.

When asked, VCSEs have consistently explained that capacity was one of the most significant issues in relation to their ability to support those coming out of social prescribing services **(Ferguson & Hogarth, 2018; Cole et al., 2020; Polley et al., 2020).** Due to the fact the push for social prescribing has coincided with the COVID19 pandemic and the ‘cost-of-living’ crisis, it is difficult to distinguish exactly what role SPSs have played in the current capacity issues in the VCS, however it is widely recognised that these events have pushed an already struggling sector to its limits. Prior to the COVID19 pandemic, VCSEs reported receiving higher rates of referrals from the NHS and issues relating to waiting lists for services were identified in early social prescribing evaluations **(Wildman et al., 2019; Pescheny et al., 2018).** During the COVID19 pandemic, between 32 and 50% of VCSEs surveyed reported having no further capacity to support service users, and those who did have capacity, were limited to an average of 18% remaining capacity **(Polley et al., 2020; Cole et al, 2020).** Over half of the same respondents were not positive they would be able to meet the additional demands of SPSs **(Polley et al., 2020).**

NHS England have committed to having 900,000 people referred into social prescribing services by 2023/24 **(NHS England, 2019).** While this push to grow social prescribing within the sector is widely welcomed, concerns have been raised as to the further impact this may have on the already struggling VCS. Calls for an increased focus on community development as a core role of SPLWs and key goal of commissioners are recurring in the literature **(Elemental, 2020; Polley et al., 2020; Cole et al., 2020; Wallace et al., 2020).**

Onward referrals and the demand for services

Both datasets analysed demonstrate an increase in social prescribing activity and trends in activity by geography or demographic group are broadly consistent. While it does not allow for exploration of impact on health services directly, both the SPO and Citizens Advice data demonstrate that geographically, social prescribing activity is concentrated in particular areas. The SPO data demonstrates that rates of referrals for money related issues are 3.6 times higher in the most deprived communities compared to the least deprived (chart 1). Regarding housing issues (chart 2, there was approaching an eight-fold variation between the highest and lowest deprivation quintiles.

Chart 1: Social Prescribing Referrals by selected geography (rate/10,000 population) England Q4 2020 - Q3 2022 - Money

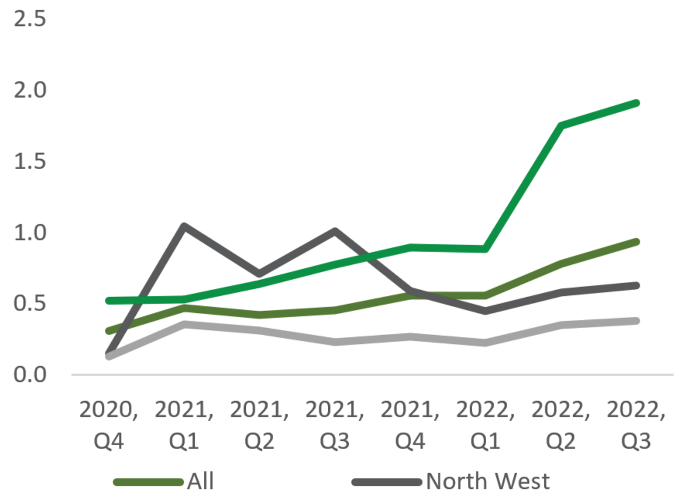
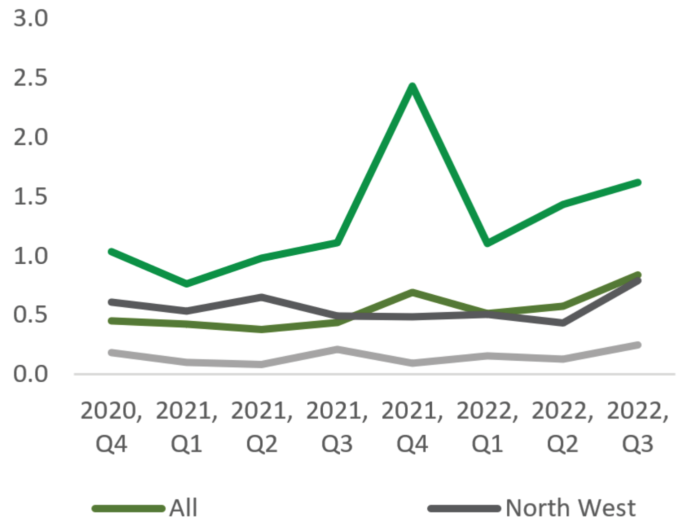
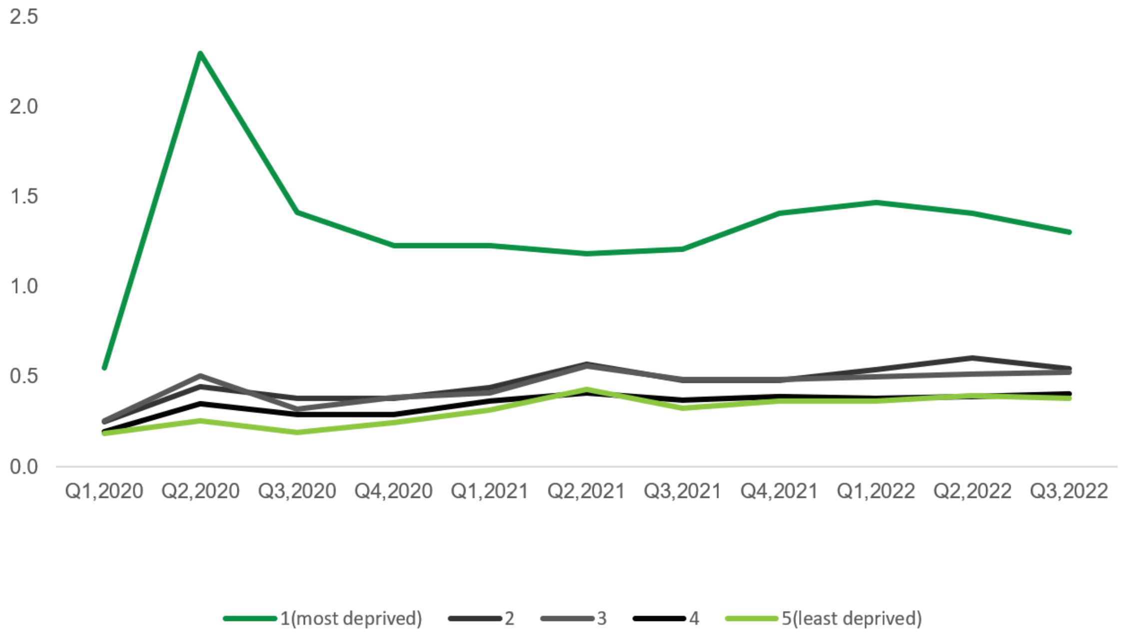


Chart 2: Social Prescribing Referrals by selected geography (rate/10,000 population) England Q4 2020 - Q3 2022 - Housing



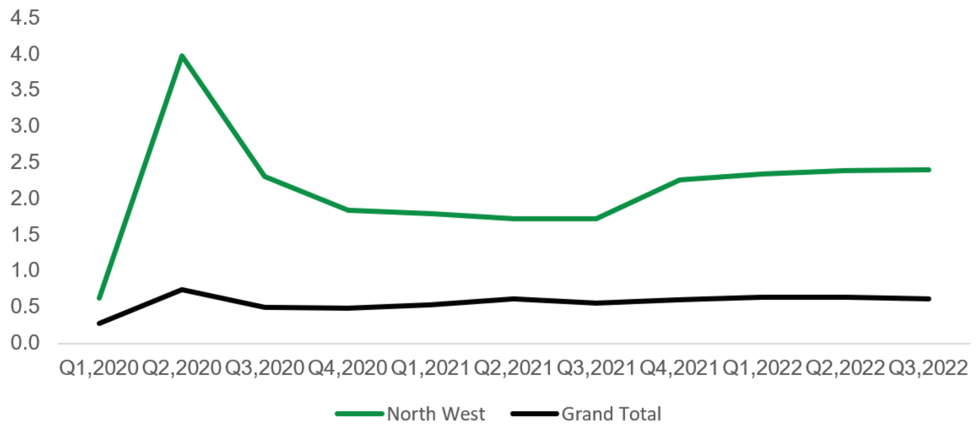
With regard to community deprivation, as expected, there was a strong deprivation gradient with rates of referrals to CA services 4.3 times higher in the most deprived compared to the least deprived communities (Chart 3).

Chart 3: All social prescribing issues in CA (rate/10,000 population) England Q1 2020 - Q3 2022 (by IMD)



Over the two-year period SPO data shows referrals in the North-West for money issues were 13% higher than the UK Average, while housing issues were similar to the national rate. This is reflected in the CA data that shows rates in the North West were more than three times higher than the next highest region (East of England) and 3.75 times the England average (chart 4).

Chart 4: All social prescribing issues in CA (rate/10,000 population) England Q1 2020 - Q3 2022 (by Government Office Region)



The SPO data demonstrates how these issues may impact particular VCSEs, including IAG services: during October 2020 to September 2022, the rate of GP referrals to social prescribing services tripled in relation to money issues (from 0.31 to 0.94) (chart 5) and nearly doubled for those related to housing issues (from 0.45 to 0.84) (chart 6).

Chart 5: Social prescribing referrals (rate/10,000 population) England Q4 2020 - Q3 2022 – Money

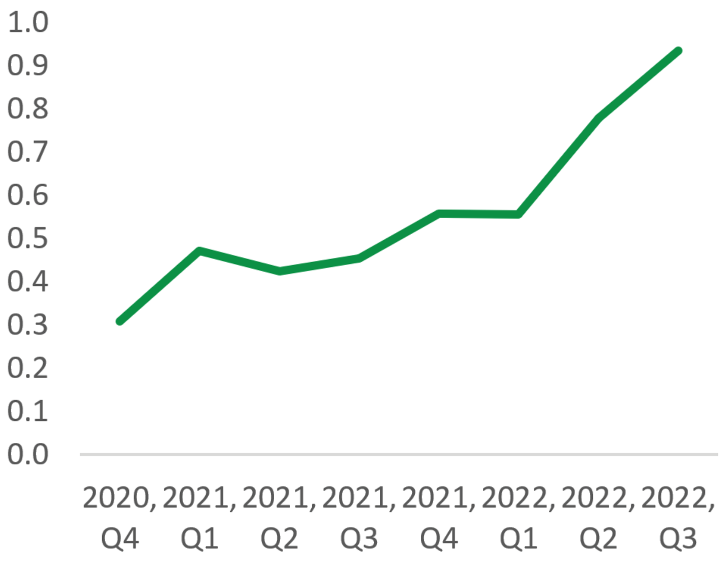
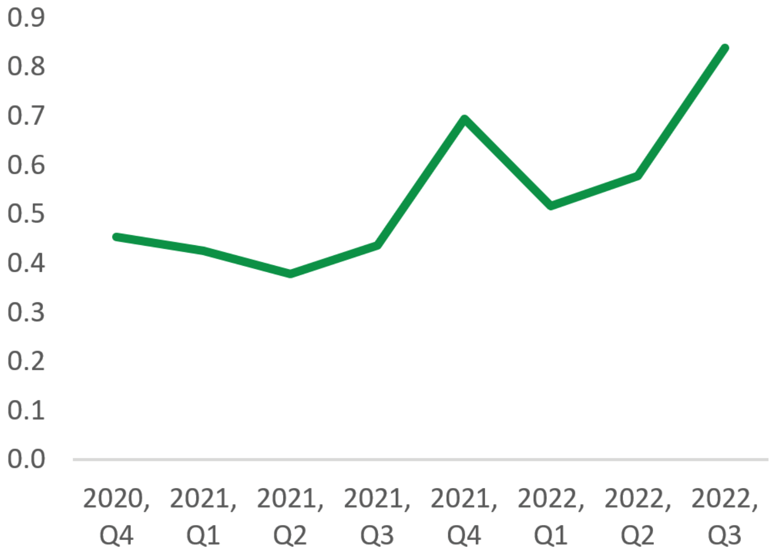
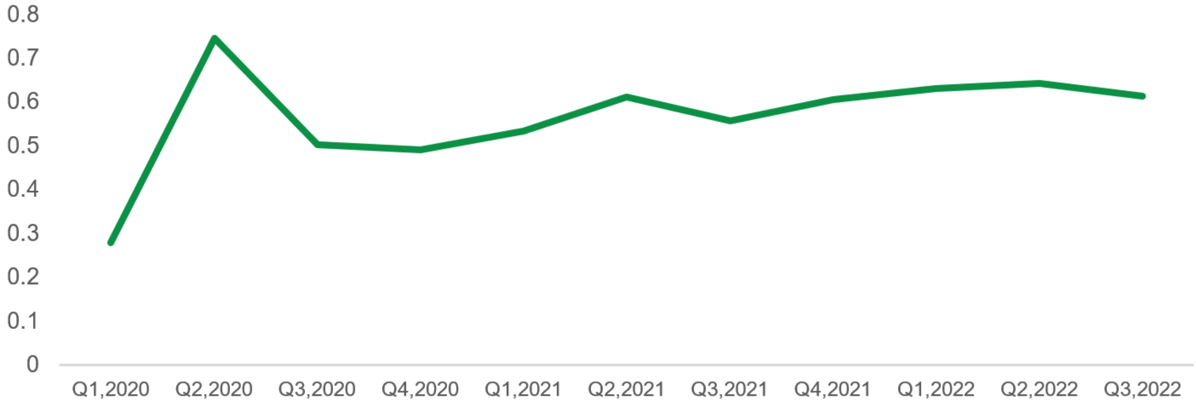


Chart 6: Social prescribing referrals (rate/10,000 population) England Q4 2020 - Q3 2022 - Housing



This increase in referrals to SPLWs appears to be having impact. While the increase in rates of those referred to Citizens Advice from social prescribing services is somewhat lower than those recorded by the Royal College of General Practitioners (SPO data) (increasing from 0.46 to 0.58), this increase does represent a statistically significant trend, with an average annual quarterly percentage increase of 3.26% ($p<0.05$) (chart 7).

Chart 7: All CA social prescribing issues (rate/10,000 population) England Q1 2020 - Q3 2022



The role of community development

While not an explicit topic addressed in the research questions, throughout the review of the existing literature in this area, community development was a consistent theme. Community development in the context of social prescribing is work undertaken by those in the health sector (more specifically SPLWs or commissioners) to identify gaps in provision within the VCS and fill these gaps through resource coordination and funding allocation **(NHS England, 2020a).** Examples include micro-commissioning new groups to meet user needs, commissioning established VCSEs to deliver social prescribing, and exploring payment-by-results contracts. Best practice guidance states VCSEs should play a key role in not only delivering contracts, but also the development of the specifications that sit behind them and the funding models that support them; this ensures services work for all parties involved. The literature demonstrates however that this approach to service development is still in its infancy, with VCSEs representatives continuing to call for the increase in this type of activity **(Veasey et al., 2018).**

While some examples of community development work that redistributed funding and resources from statutory sector enterprises to VCSEs were identified within the literature **(e.g., Rotherham (Dayson & Batty, 2017)),** the majority of SPSs engaged with in research noted receiving no or little funding beyond the cost of a salaried SPLW **(Polley et al., 2019; Bertotti et al., 2020; Dayson & Batty, 2020).** These SPSs' inability to mitigate their impact on the VCS is of particular concern, considering VCSEs have reported already bolstering SPS referral requirements by expanding voluntary programmes and cross-subsidising from other funding sources **(Cole et al., 2020; Dayson & Batty, 2020).**

Box 5: Funding (Citizens Advice, 2022e; Citizens Advice, 2022f)

Some CA services reported receiving no funding as part of the social prescribing service, which only covered the funding for social prescribing staff. It was also highlighted that short-term funding meant the work of community development was not embedded into the responsibilities of SPLWs, leaving them no capacity to undertake this form of work. The service suggested that funding cover the costs of the advice provided to those referred as part of social prescribing and funding should be put in place for two years or longer, with SPLWs given the space and time to support community development.

It has also been suggested that funding approaches such as micro-grants, which are seen to exacerbate issues of short-termism in the sector and encourage inconsistent and unstable service user experience should be replaced by more strategic, long-term funding streams **(Veasey et al., 2018; Davison et al., 2019; Dayson & Batty, 2020; Polley et al., 2020).** Considering these issues are more likely to impact those VCSEs serving deprived and minoritised communities **(Cole et al., 2020),** ill-informed funding allocation could exacerbate population inequalities, rather than alleviate them **(Veasey et al., 2018; Brown et al., 2021).** For decision-makers to undertake their work effectively, they require robust data that demonstrates the user journey, not just the activity of SPLWs. Questions have been raised in the literature as to what extent data regarding VCS impact is currently a) being recorded, b) being collected and collated in a consistent and centralised way, and c) being made available to decision-makers **(Polley et al., 2020; Cole et al, 2020).**

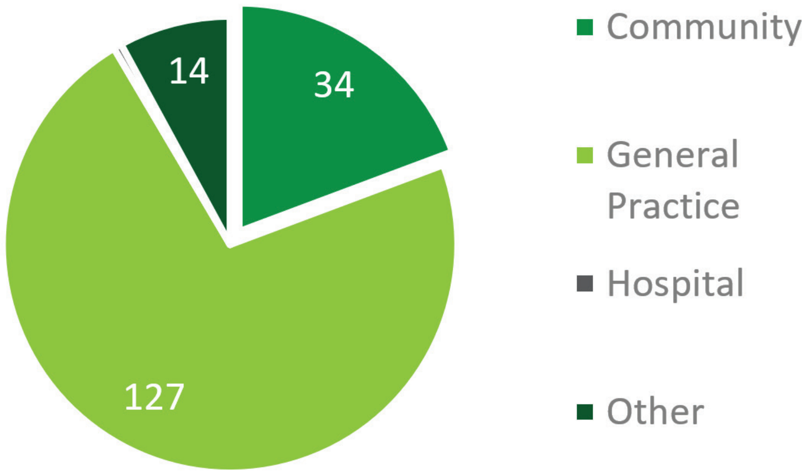
Box 6: Inequalities (Citizens Advice, 2022g)

In one CA service, outreach services were delivered as part of the local social prescribing service, which funded two CA advisers that supported 6 separate GP surgeries across the geography. All the GP practices were located in socially deprived areas, where there is a high level of client need and a high level of dependency on local services. Over a period of 12 months, 430 people with complex, high need, and high dependency cases were supported, most of whom were supported face-to-face. This demonstrates that in some cases, not only are the numbers of people referred to CA services significant, dependent on existing inequalities, their issues can be much more complex than in other geographies or in other communities. Funding should reflect these inequalities and ensure programmes specifically targeted at more complex communities recognise this complexity.

Findings:
Primary Research

Social Prescribing Link Worker Survey

Chart 8: Where is your work based?



First, respondents were asked what types of organisation they work within (chart 8). The majority of respondents work at a general practice (n=127) with only 1 respondent working at a hospital. 34 work in the community and 14 indicated **"Other",** with responses including VCSEs, criminal justice services and some respondents working from home or online.

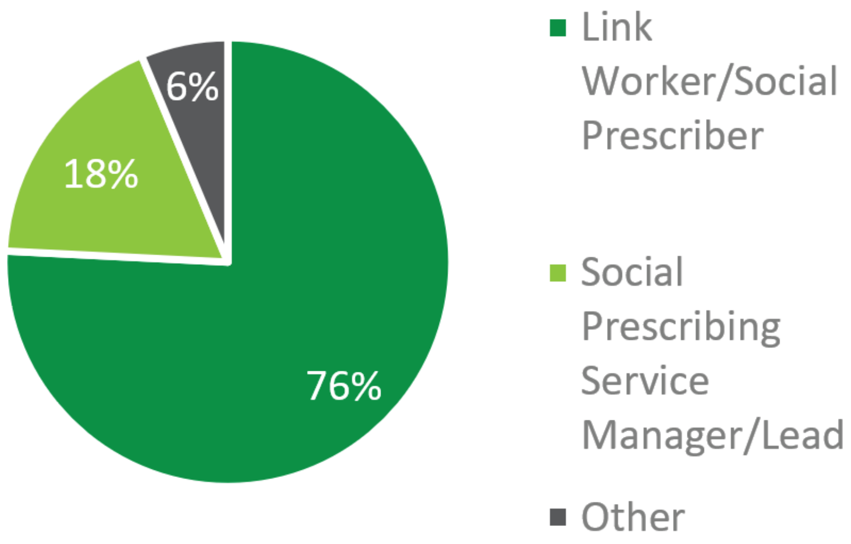
Within the **"Other"** category that 14 respondents chose, some respondents stated that they were placed in more than one place of work e.g.,

> *"Agile, surgery, community, homes, online"; "General Practice, Community and Remote"; "Community & GP practice".*

Other descriptions included:

- Charities (children, homeless)
- VCSE / IAG organization (e.g., Citizen's Advice)
- Police service
- Long Covid Clinic
- Dentist
- Local Health Board
- CVS (PCN funded)

Chart 9: How would you describe your role?

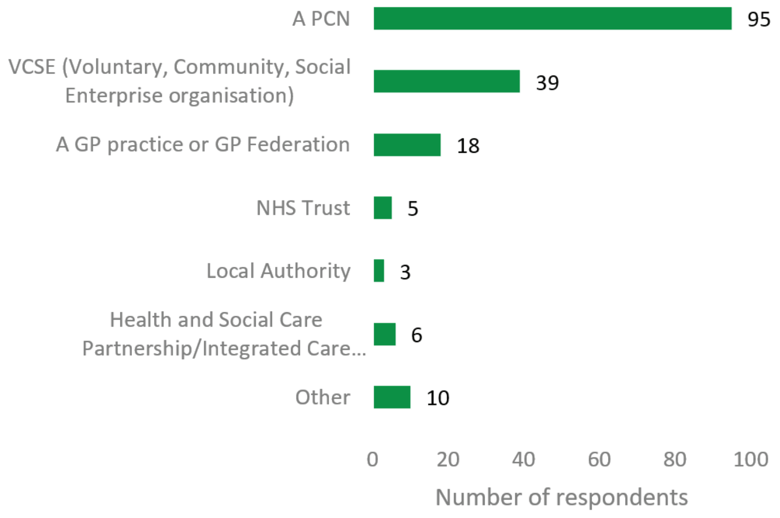


The majority of respondents work at a general practice (n=127) with only 1 respondent working at a hospital. 34 work in the community and 14 indicated “**Other**”.

The ”**Other**” roles included:

- Adviser for disability benefits
- Allied Health Professionals
- Business manager
- GP/supervisor of SV&V PCN Social Prescribing Team
- SNT Police Officer
- Wellbeing Coordinator
- Similar role for a community project called Chat Central

Chart 10: Are you employed by?

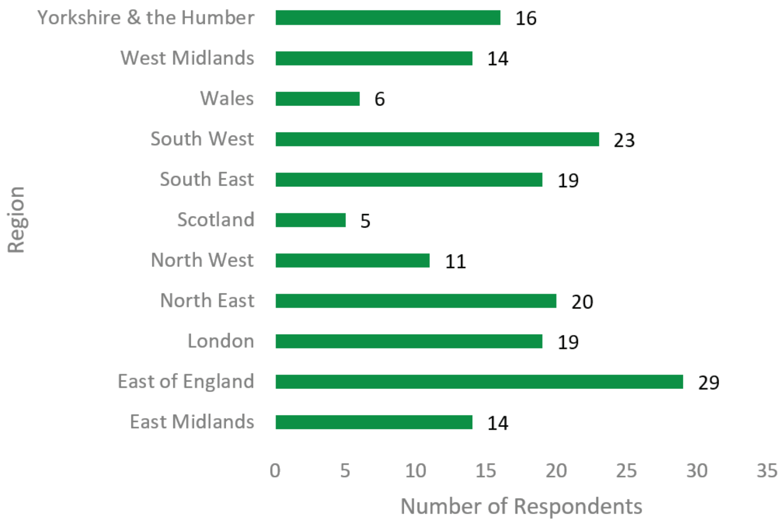


The majority of respondents were employed by a PCN (n=95), followed by VCSE organization (n=39) and a GP practice or GP Federation (n=18). 5 were employed by an NHS Trust, 6 by an HSC partnership/ICS/Health Board, and 3 by a Local Authority.

The majority of respondents were employed by a PCN (n=95), followed by VCSE organization (n=39) and a GP practice or GP Federation (n=19). 5 were employed by an NHS Trust, 6 by an HSC partnership/ICS/Health Board, and 3 by a Local Authority. Ten respondents indicated **"Other."** Other employers include:

- Charity (e.g., Mind)
- Employed by a CIC seconded NHS Long Covid
- Org contracted by a PCN
- CA working with a PCN
- Police
- Social Prescribing Consortium
- Taurus health care

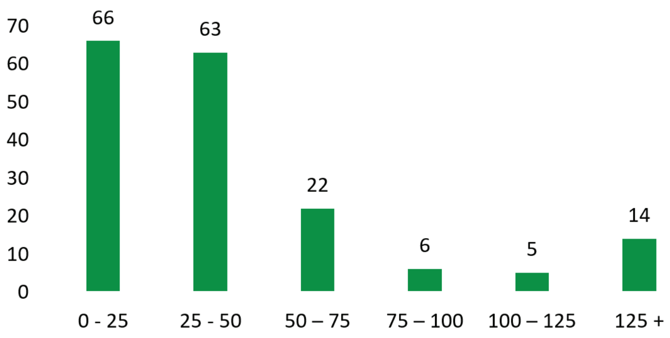
Chart 11: What region or nation are you based in?



There was good representation across England, ranging from 29 respondents from the East of England to 11 in the North West. There were six respondents from Wales and 5 from Scotland. There were no respondents from Northern Ireland.

Respondents were asked how many referrals they personally receive on average per month over the last 12 months.

Chart 12: How many referrals have you personally received on average per month in the past 12 months?

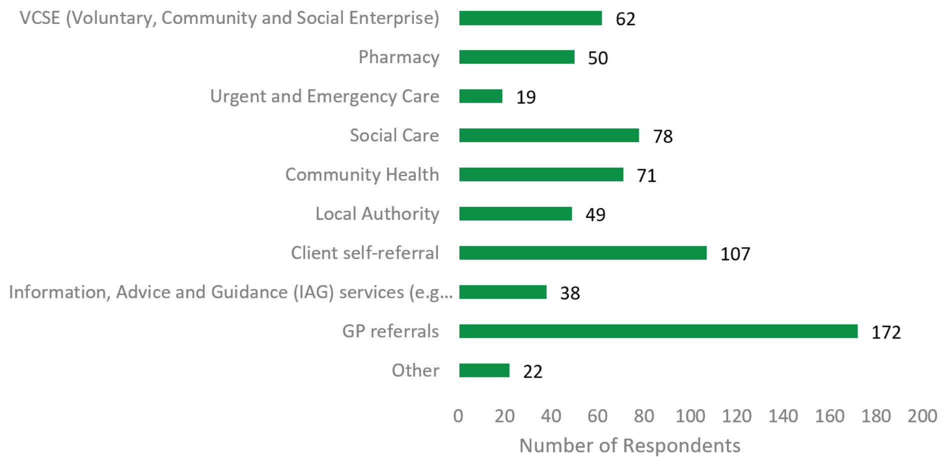


The majority of respondents were in the 0-50 referrals received on average per month range (n=129; 73%), however a total of 19 (11%) reported receiving over 100 referrals on average per month.

Respondents were asked if they experienced an increase in referrals over the last 12 months. The vast majority of respondents (n=157; 89%) reported an increase while the remaining respondents (n=19; 11%) reported no increase.

Respondents were asked where their referrals came from (chart 13).

Chart 13: Where do you receive referrals from? (please tick all that apply)



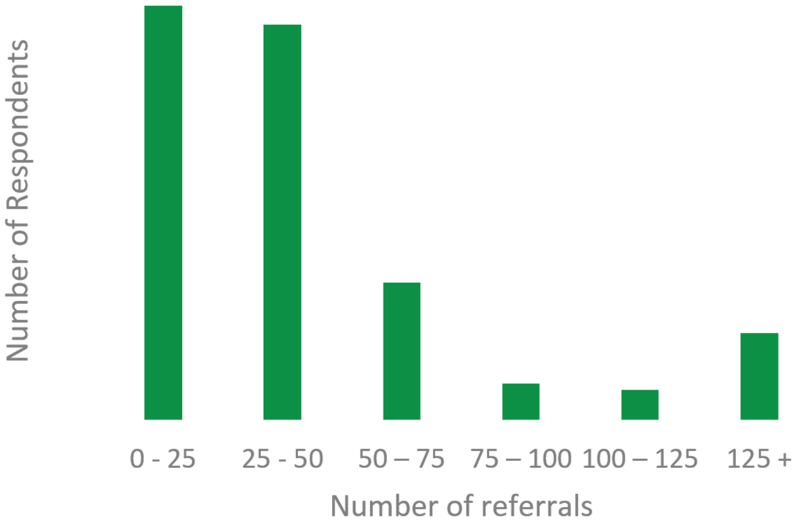
Only 19 respondents indicated that they receive referrals from Urgent and Emergency Care.

Other referring organisations included:

- Community events/ community leaders
- Mental health services
- Council/elected members
- Police / Non-SNT Police departments
- Parish Nurse
- Family Members/Friends/Neighbours with consent
- Churches and volunteer groups
- Fires service
- PCN
- Local School (community hub)
- Any professional
- Disability Employment Advisors for UC
- Integrated Care team
- Local University
- Housing Association
- Cancer Care Wellbeing Centre
- Dementia services
- DWP
- Secondary care
- Physiotherapist
- IAPT services
- Additional Roles Reimbursement Scheme

Respondents were asked how many clients they have supported with signposting to services (i.e., supporting them with contacting the service themselves) or referring to services (i.e., contacting the service on behalf of the client) on average per month in the past 12 months. Chart 14 shows the results.

Chart 14: How many for clients have you personally supported with signposting to services (i.e., supporting them with contacting the service themselves) or referring to services (i.e. contacting the service on behalf of the client) on average per month in the past 12 months?

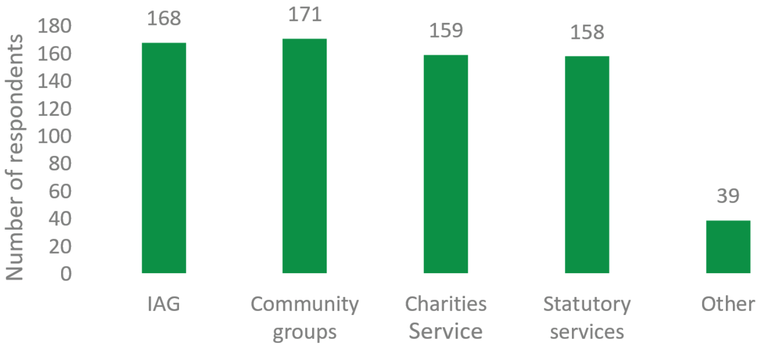


Just over half of respondents were in the 0-50 clients supported on average per month range (n=104; 59%), leaving 71 (41%) respondents reporting supporting over 50 clients per month, with nearly a quarter (n=41; 23%) reporting supporting over 100 client's on average per month.

The vast majority of respondents (n=159; 90%) reported an increase in the referrals and supported signposting they made in the past 12 months, compared to 17 10%) respondents who have not seen an increase.

Respondents were asked what services they support clients to contact/refer to, choosing all options that apply to them. Results are seen in chart 15.

Chart 15: What services do you support clients to contact / refer to? Please choose all that apply



Almost all respondents reported supporting clients to contact/refer to IAG (n=168) and community groups (n=171), followed very closely by Charities (n=159) and Statutory services (n=158). 39 respondents added "Other" services.

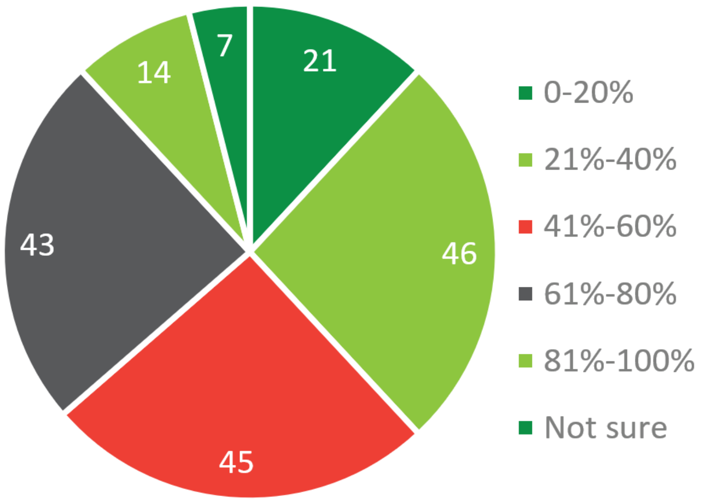
Other services included:

- Specific to long covid
- Fitness, exercise classes, local gym, exercise options
- Own groups
- Support groups and information
- Weight management
- Charities (e.g., Mind, Macmillan)
- Mental Health Services (emotional support, counselling services)
- Bereavement
- Finance (benefit advice, debts)
- Housing
- Church's (hot meals, free furniture)
- Private sector (e.g., legal, judicial, solicitors or employers)
- Social care and homelessness
- Cleaners
- Community hubs
- Drug and alcohol
- Domestic abuse
- Hobbies/interests/lifestyle
- Fire home safety check
- Carers
- Green Activities
- Mutual aid
- IAPT
- Employment support
- Peer support
- Non-NHS counselling
- Holistic forms of therapy
- Training
- Volunteer Organisation (e.g., warm hubs)

Respondents were asked if they record what services they refer / support signposting to. The majority stated "Yes" (n-=170; 97%), with a small number reporting "No" (n=6; 3%).

Respondents were asked what percentage of their supported signposting / referrals to services related to housing or money issues. This is presented in chart 16 below.

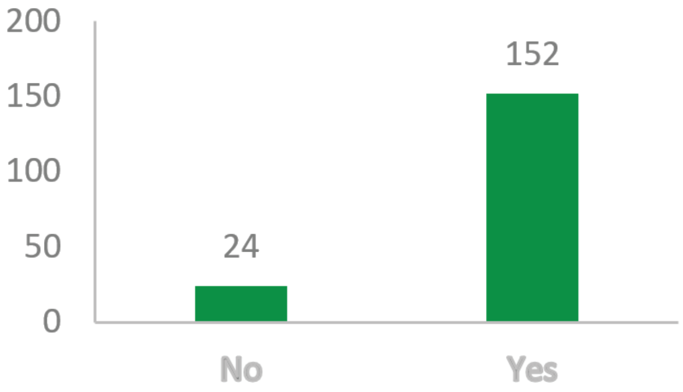
Chart 16: What percentage of your signposting to services / referrals to services are related to housing or money issues?



The chart shows that approximately 12% (n=21) of respondents answered in the 0-20% range, 26% (n=46) in the 21-40% range, 26% (n=45) in the 41-60% range, 24% (n=43) in the 61-80% range, 8% (n=14) n the 81-100% range. 4% (n=7) were not sure.

Respondents were asked if they use an electronic coded system/Clinical System to record referrals. Chart 17 shows the responses.

Chart 17: Do you use an electronic coded system/Clinical System to record your referrals?



The vast majority do use an electronic coded system/Clinical System (n=152; 86%).

Respondents who indicated that they did have an electronic coded system were asked if they have a code for VCSE or IAG services. 74 (49%) reported that they do have a code for VCSE or IAG services. Those that responded no, they don't have a code, were asked to describe how they record referrals to VCSEs or IAG services. Answers included:

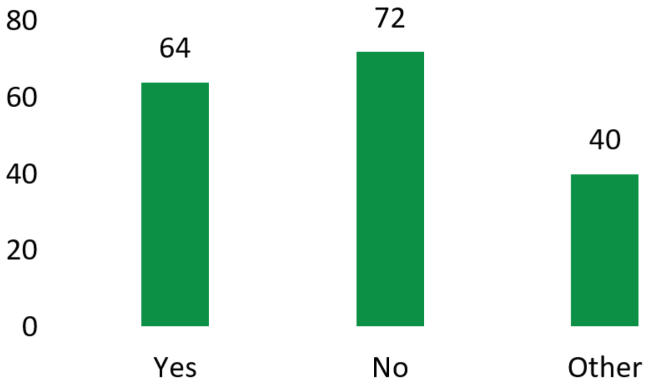
Other services included:

- Manager records the referrals
- Saved on patient records (written (**"other"** & description; free text in the patient notes/medical record/ casebook; recorded as referral to voluntary service)
- Care navigation
- Case management systems/Frontline/own database system/Excel spreadsheet
- I don't know/unsure
- Referrals to CA have their own form
- Use 2 different systems, medical: social prescribing code. SP system
- Tick box option within a care planning template which is connected with the person's medical record.

Many stated that they record a code, such as **"social prescribing"/ "Other"** and then add the detail in a free text/notes section of the system.

Respondents were asked if they felt that SNOMED codes accurately reflect social prescribing referral numbers (chart 18).

Chart 18: Do you think SNOMED codes accurately reflect social prescribing referral numbers?



64 respondents felt that SNOMED codes accurately reflect social prescribing referral numbers compared to 72 who felt that they do not. 40 respondents chose "Other".

Respondents who indicated that they did have an electronic coded system were asked if they have a code for VCSE or IAG services. 74 (49%) reported that they do have a code for VCSE or IAG services. Those that responded no, they don't have a code, were asked to describe how they record referrals to VCSEs or IAG services. Answers included:

"Other" explanations included:

- Did not use/know what SNOMED is
- Didn't know/Not sure
- Does not capture:
    - Multiple referrals for one patient (patient referrals can be more than once)
    - Who referred patient to SPLW
    - What service SPLW referred client to
    - If referral declined by patient or social prescriber
- Coding issues:
    - Not enough codes
    - Some codes are difficult to find
    - Clearer guidance required about using codes / training

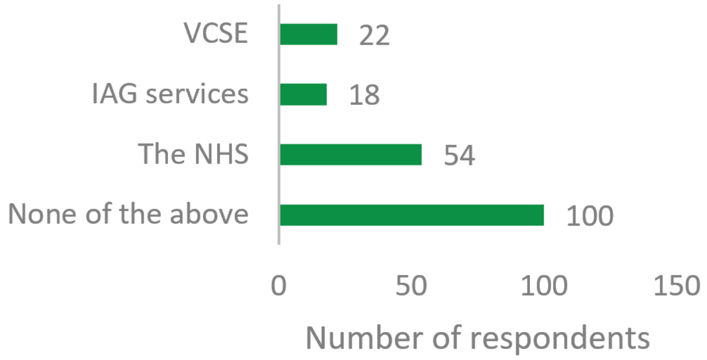
> *"Nobody trained me as a new social prescriber, and it took me 10 months to find SNOMED codes. A lot are present within the template I use but it was so useful to discover SNOMED and search because I found some not within my template, but which are definitely relevant."*

Another suggested that

> *"It depends who is coding, when and why - clearer guidance is needed around the use of this code. It's important that anyone in GP practice /NHS roles understands their role in social prescribing, so it isn't seen as only the preserve of one/a small number of professionals".*

Respondents were asked if they think SNOMED codes accurately reflect the impact social prescribing has on IAG Services, VCSE services, the NHS or none, they were asked to choose all that apply. Results are seen in Chart 19.

Chart 19: Do you think that SNOMED codes accurately reflect the impact social pre-scribing has on the following? Please tick all that apply



22 respondents felt that SNOMED codes accurately reflect the impact the impact social prescribing has on VCSE, 18 for IAG services and 54 for the NHS. The highest proportion of respondents felt that SNOMED codes do not accurately reflect the impact social prescribing has these services (n=100).

Respondents were asked what would be useful to help record referrals to IAG services/VCSEs? What is good practice? Respondents highlighted the issues they face when recording referrals to IAG services/VCSEs, along with suggestions on how to improve this. Themes are discussed below.

IT systems not capturing relevant data

The IT systems SPLWs use to record referral could be improved as recording detailed information can be very ad hoc and different for different systems. Respondents highlighted that they record extra referral information in a variety of ways, including in the patients notes; referral letter section, own spreadsheet systems/spreadsheets. Many use more than one system and it was suggested that one system is used where they can enter and retrieve data for statistics with one respondent stating that

> *"Data recording methods are System one and SocialRX. Good practice would be to use one to collect information accurately."*

Respondents that work for charities highlighted that they have basic systems in place (better than previously using many spreadsheets) but it would be more beneficial to use a system similar to health professionals. Another stated that

> *"We have developed our own database with the aim of meeting the funders requirements, unfortunately this data set is all hard indicators, we use GP Practice system EMIS to record more soft indicators including the patients journey and staged progress improvements, detailing what really matters to the person."*

How to capture relevant SP referral/signposting data

The current system does not capture the breadth of referrals/signposts that they make, and the coding list is insufficient. Increasing codes (e.g., SNOMED) on the IT systems would be very useful. This would allow for accurate reporting and provide valuable information. A set up in place to truly reflect the client journey/impact of services would be useful. Suggestions included:

- Ability to add codes:
  - That allow for a greater variety of scenarios (e.g., “"Signposting to outdoor activity" or "digital self-management resource" rather than a specific service)
  - For specific services/community partners (e.g., external referral codes for VCSEs and other organisations)
  - Ability to code multiple referrals from one consultation
  - That capture time spent with patients / follow ups / waiting times
- Standardised coding
- Ensure training in data entry
- Case studies
- Connecting the systems between services

One respondent highlighted that

> *“We have some excellent community services locally and all I can do is record them under a generic referral to voluntary group and then name the group. It might be good to be able to break this down in each area to indicate the specialism of the service. Some will specialise in parenting, some in mental health and others in finance for example.”*

It was highlighted that in order for accurate coding to be developed, conversations need to happen between PCN's, General Practices and NHS to capture hidden work. That social prescribing link workers need to be part of the decision process because they all work differently.

One respondent summarised many issues with the current systems for capturing data:

> *“On the Social Prescribing templates including the Ardens template, the 'signposting' and 'referral' drop down boxes where you capture referrals that have been made needs to be catergorised much better, for example, currently 'signposted to Citizens Advice' comes under the heading 'Signposted to mental wellbeing service' which is not a correct categorization and therefore link workers may struggle to find this. You also can't tick more than one box per category so if you have signposted to Citizens Advice, Forward Leeds alcohol service and IAPT, you can only tick one from the drop down box on Ardens so the others are disregarded.”*

Having a social prescribing referral pathway recorded

A clear outline of referral pathways was also suggested to help, for example one respondent suggested it would be helpful to

> *"Record number of referrals to each service with separate codes for each services separately."*

Another provided an example of a service who records the pathway

> *"Frontline Northumberland records each step of the referral".*

Recording referrals themselves was common, with one respondent stating that

> *"We keep a separate spreadsheet that our line manager collates, part of this records where we are referring/signposting to"*

and collate monthly reports from this data to share.

Service coordination / communication

Some kind of system/service co-ordination would be useful with one respondent suggesting that

> *"Information from IAG services which feeds back into the patient record (i.e. for LCVS Social RX links into the notes and we can see and access it)"*

could help.

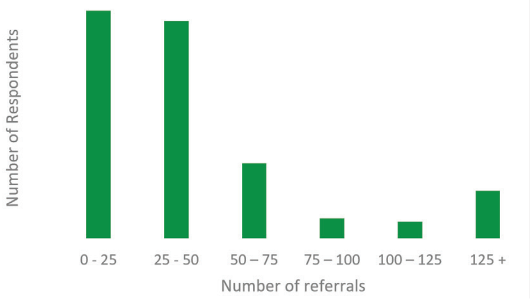
The experience of one respondent highlights that there are steps in the referral process that can be problematic and a system allowing direct referrals to services electronically could help

> *"A robust system set up between the local Citizen's Advice Services and Social prescribing link workers to make referrals to and from. I signpost patients but very often can't get through to CA on the phone or make an appointment for them. The CA service set up to help people apply for the first time for Universal Credit is completely unreachable, the phones aren't answered so can't access or signpost to this service at all!".*

Respondents suggested that conducting Inter Agency Collaborative meetings / briefings could help improve communication.

Respondents were asked if they had any way of knowing if clients followed through with engaging with the IAG services/VCSEs after supported signposting (chart 20).

Chart 20: Do you have any way of knowing if clients followed through with engaging with the IAG service/VCSE after supported signposting?



125 (71%) respondents reported Yes, and 51 (29%) had no way of knowing if clients followed through with engaging with the IAG service/VCSE after supported signposting.

Those respondents who do know if their client followed through with advice to engage with IAG service/VCSE were asked to tell us how they know if a client followed through with advice to engage with IAG Services/VCSEs. Responses included usually a follow up call or appointment with the client or follow up with service. It was generally agreed that there was no formal process for doing this.

Follow-up call with/feedback from clients

Follow up calls ranged from during the time waiting for a service (every few weeks during this time), to 6 months post discharge (and some do not follow up post discharge). Many do not have a process for follow- up with clients, however it was suggested that if respondents did not follow up themselves, they would not know. It was also noted that it is not always possible to follow-up with all patients.

One respondent stated:

> *“I always book follow up calls with the patient's agreement and consent to try to establish if they need any more help or whether what I signposted them to was effective in helping them.”*

Another shared:

> “I try to follow up but depending on cases and input, this doesn’t always happen.”

Follow-up appointments with clients

Some respondents conduct follow-up appointments with clients, sometimes made at initial assessment. One respondent stated that they arrange

> *“Follow on appts after referral. This is not always consistent as people may be discharged before they have a chance to engage.”*

Another respondent stated that

> *“In most cases follow up appointments are also scheduled to provide further support but also to assess if the service met the person's needs. In the main I have already built up a partnership-based relationship with staff at the referral agency and encourage the person I've signposted to agree and sign to information sharing so the agency and I can provide a more wrap around service.”*

Follow up with/feedback from service provider

Another way of finding out this information is to get feedback/follow up with the service provider, including updates from some organisations. Generally this information has to be requested by the respondent. One respondent shared that there are

> *“Not really the channels or data sharing arrangements to make this happen”.*

However another respondent shared that

> *“We have an SLA with a local charity who provides us with a monthly report”*

and another shared that

> *“We have a refer pathway and most of the places we refer to they tell us how well the patient has got on”.*

Other ways of knowing

Some clients are referred to groups ran by the respondents organisation so they will see them there/engaging in projects they run. Others have good links with local community and see clients there also.

Respondents who do not know if their client followed through with advice to engage with IAG services/VCSEs were asked to tell us why they do not know if a client followed through with advice to engage with IAG Services/VCSEs. Responses included that there is no clear communication with services, feedback has to be requested from the service, no capacity to follow up with clients, and cannot follow up with clients after a certain timeframe.

No communication between social prescribing link workers and services / service feedback only provided if requested

Respondents highlighted that there is no pathway/communication between themselves and the services they refer/signpost to. One respondent shared

> *“Again no pathway or lines of communication open between Citizens Advice and Social prescribing link workers working in the PCN in my local area.”*

Feedback from services regarding clients tends to only be provided if requested. One respondent shared that there is

> *“No feedback from service unless asked for or followed up with client”.*

Another highlighted that

> *“Services never follow back and I don't have time to chase”.*

No capacity to follow up clients

Many respondents do not have the capacity or time to follow up clients. One respondent shared

“Because I didn't the capacity to follow them up anymore”.

Another respondent summarized the issue:

“Due to the high volume of caseload it is impossible to keep track of the signposted services that client follow through. Some services have the capacity to feedback if a patient is engaged whilst others don't. The only way to confirm is to contact the patient directly but it can be hard as some services can take weeks for the patient to be engaged in. e.g. high demand so it does not make sense to keep the patient on caseload until there is space available. Again, for issues relating to housing and benefits - there can be a long wait for outcome.”

Another shared that

“I don't have time to follow up. I have up to 30 referrals a week.”

Not always a need to follow-up

Some respondents suggested that they do not need to follow up, sharing that

“Depending on patients need and their preference I do not always follow up on signposting/referrals, but I always ask to follow up - they then choose to engage further or not. I always say to self-refer back if any difficulties.”

Can only follow-up within timeframe

Some respondents shared that there is only a certain timeframe that they can follow-up clients and therefore do not know if they followed through with contacting the IAG services/VCSE.

One respondent highlighted that

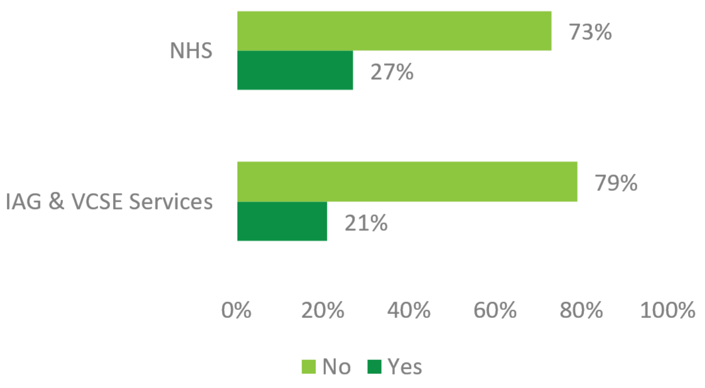
“We only have 12 weeks max to work with clients.
If discharged before contact is made then we cannot follow up”.

Another shared that it is

“Difficult if service has long waiting list and client
has been discharged before contact attempted”.

Respondents were asked if they think that the full impact of social prescribing referrals on IAG services and VCSEs, and the NHS is being successfully measured. Results are shown in chart 21.

Chart 21: Do you think the full impact of social prescribing referrals on IAG services and VCSEs is being successfully measured?



The majority of respondents felt that this impact is not currently successfully measured for IAG & VCSE Services (79%; n=139) and the NHS (73%; n=129).

Respondents who answered “No” to this question for the impact on the NHS were asked what they thought could be done to improve this. Respondents felt that improving IT systems and increasing codes, staff training in data entry, looking at the impact on services, capturing qualitative information, collating data for strategic planning and ensuring buy in from health services and GPs would help measure the full impact of social prescribing referrals on the NHS.

Improving IT systems and increasing codes

Similarly to Q17 and Q24, there was a general consensus that whilst current systems are used, they do not capture the complex nature of social prescribing referrals. Another issue is that IT systems do not talk to each other (and different systems use different codes). Suggestions included a specific SP recording system that is used across the UK so there is standardized recording and monitoring.

It was felt that systems should collect more data, be consistent, include standardized measures, recognize what needs to be collected, and capture:

- More outcomes relevant to the service/ better outcome measures
- SP impact on services (e.g., NHS; reduction in GP appointments, ambulance call outs etc.)
- SP impact for clients
- Time spent with a client
- Multiple referrals to services (e.g., can only make one NHS referral in system but could be making multiple referrals e.g., GP, physiotherapist).
- SNOMED codes that reflect the service being offered rather than clinical observation
- Activities undertaken (e.g., signposts, referrals and supported activity such as taking people to groups initially)
- More data that is relevant with SP (e.g., social determinants of health)

Recording on two systems can be confusing and time consuming. It was felt that the way referrals and interactions are recorded are not adequately reflected in the templates used. Connecting/linking IT systems to accurately collect data would be useful.

Staff trained in data entry

It is important to ensure that staff are trained in entering data and that data is recorded accurately. One respondent shared that

> *"In our organisation they are recording non SPLW referrals incorrectly and are recording things such as bowel screening phone calls as a SPLW referral."*

Regular measurement of impact on services

Regularly measuring the impact on other teams/services, e.g., reduction in attendances to see the GP could help with measuring the impact of social prescribing on the NHS. Feedback on impact from GPs could be measured, however it was also highlighted that there are difficulties in recording this impact, one respondent noted:

> *"At the moment the demand on the NHS, and the ongoing health and social care needs are so high that it is hard to truly measure the benefit of services such as social prescribing. For example, we cannot measure aspects such as 'saving GP time' as there will always be people waiting for those appointments at the moment."*

Another noted:

> *"I don't think the input from Social prescribing and the weight it takes off the NHS is fully understood. Time that frees up clinicians and the help it provides to patients. There needs to be some way each service within the NHS can monitor this".*

Capture qualitative information

It was felt that funders want quantitative outcomes but more needs to be done to capture all the soft improvements that would allow social prescribing link workers/GPs/other practice staff to build on. Some respondents are collecting this data as case stories. More data could be collected, surveys, qualitative and quantitative data such as case studies to show impact / outcomes. One example was shared by a respondent

> *"We have just started implementing the wellbeing star to show the journey as opposed to just number of referrals."*

Buy in from health services and GPs

Some felt that more buy in from health services and GPs would help. One respondent shared that

> *"Our database is meant to tie in with GP surgeries but they are not taking it up - if they did this could be measured".*

Respondents who answered "No" to this question for the impact on the IAG services/VCSEs were asked what they thought could be done to improve this. Many respondents highlighted that IT systems could be improved, more coding options, client feedback, improving communication between social prescribing link workers and the organisations they refer to and collecting more in-depth qualitative data.

More coding options to reflect referrals in current IT systems

The coding options in the current IT systems do not include all relevant referral reasons. Including these reasons could better reflect the work being undertaken and help monitor impact and need. Referrals being coded/recorded accurately would enable the impact to be measured, this could be done by including:

- Extra codes for required information (e.g., list local organisations, IAG, VCSE; ability to record number of meetings)
- Relevant qualitative and quantitative outcomes (a lot of these are not captured).

These could be built into SP IT system, allowing for

> *"effective and efficient if the template allowed for all aspects of recording as this can then be pulled from the run reports within system one and easily captured."*

On respondent suggested

> *"Developing and implementing a meaningful and user-friendly measurement of impact - currently the system and process we use in my borough does not measure impact, though we are working on a pilot measure this year"*

Capture client feedback (e.g., Client feedback forms)

Feedback from clients could help explore the impact social prescribing has on IAG services / VCSE however it was noted by one respondent that

> *"impact is difficult to evidence when work is with vulnerable, elderly, EOL or those with complex mental health, these patients are not in position to feedback on service."*

Services: Two-way communication and referral processes / feedback

Two-way communication and referral processes between social prescribing link workers and services / feedback from services was suggested to help. Feedback/follow-up/updates from VCSE, and other agencies the respondents refer clients to could help, however respondents were conscious that they may not have the time also.

Having direct referral forms to services on systems could also help measure this impact, one respondent highlighted that there are

> *"No direct referral forms for CAB on our system".*

A suggestion was provided on how to do this:

> *"Introduce collaborative meetings to encourage a collective understanding of the scope of services that IAG's, VCSE's and Social prescribing link workers can offer to patients."*

Example:

> *"A feedback loop from the organisations to the social prescribing link workers making the referrals will be helpful. Our team meets regularly (quarterly) with core service providers to find out the impact on their services. We commissioned a service provider and have feedback from the organisation about the money saved on behalf of patients. Useful and important way to recognise impact of the service."*

Another respondent highlighted that

> *"Relationship building opportunities to understand each others work and models of how to work together. It is maddening that as a SPLW I have no access to CA to make an appointment with a vulnerable client, other than very impenetrable Advice Line. See projects like Bromley By Bow and other successful welfare Co-productions and seems little willingness to make something like that a reality. The benefits landscape is a very hard place to navigate and applications like PIP and AA are daunting".*

Collecting qualitative data such as case studies and sharing

Qualitative data could be collected such as case studies to help show the impact SP has on IAG/CSE services. Sharing this information with GPs and the public would be useful. One respondent highlighted that

> *"I think it's difficult to measure all outcomes. some are very soft and subtle. I keep case studies where I can as well as looking at statistical data. I think when working on a personalised level it is hard to make all outcomes and data fit boxes"*

Another suggests that

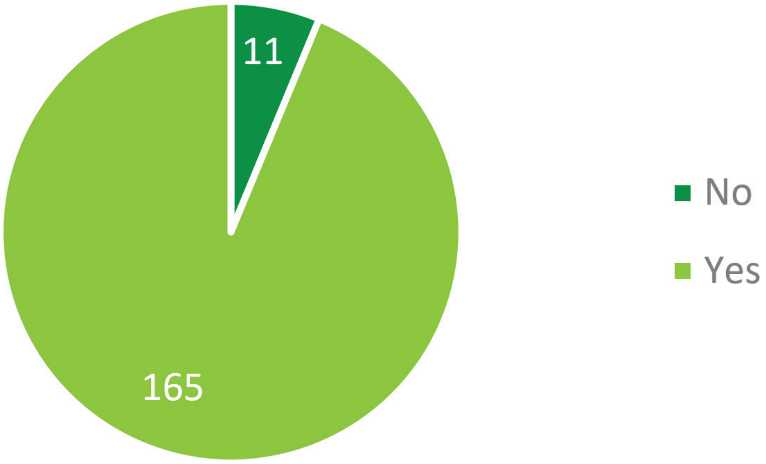
> *"Social prescribing is about outcomes, and small sustainable change that snowballs into something bigger - it cannot ever truly be represented by numbers alone."*

An example of attempting to measure this was shared:

> *"Small research projects set up by the Integrated Care System and Care Boards - e.g. one could be done in Peterborough over 12 months to establish an understanding of how things are working."*

Respondents were asked if they think the IAG services and VCSEs they are referring /signposting clients to are contributing to improving health outcomes for their clients and improving the social determinants of health. Chart 22 shows their answers.

Chart 22: Do you think the IAGs and VCSEs you are referring /signposting clients to are contributing to improving health outcomes for your clients and improving the social determinants of health?



The vast majority (n=165; 94%) felt that the IAGs and VCSEs they are referring /signposting clients to are contributing to improving health outcomes for their clients and improving the social determinants of health.

Those who did feel the IAG services and VCSEs they are referring /signposting clients to are contributing to improving health outcomes for their clients and improving the social determinants of health. Many themes emerged, including the very positive impact for client's health and well-being (that can be seen in feedback from clients), types of support provided by VCSEs and IAG services, in particular support with housing and debt, and addressing Isolation and connectedness, including through community groups. Two final themes highlighted that these services can be overwhelmed however they do have positive impact on other services such as the NHS.

Very positive impact for clients health and well-being

The positive impact of VCSEs and IAG services on client outcomes and the social determinants of health was widely agreed by respondents. It was agreed that these services definitely improve clients' overall health and well-being, they are helping to resolve the issues impacting health. It was highlighted that having help to access services that can support wider issues helps to reduce stress, anxiety and worry for clients, which then in turn improves their health and well-being.

It was felt that they are doing incredible work and that without these services social prescribing link workers have nowhere to turn to improve the health and well-being of their clients. These organizations provide essential information and help people,

> *"Especially now more than ever with cost-of-living crisis and how to tackle it."*

It was suggested that SPLW rely heavily on these agencies to fill in the gaps that the NHS can't

"Mainly because Social Prescribing is nonclinical and therefore concentrates on what is going on inside the home and in a person's environment".

Feedback from clients shows the impact

Feedback to SPLWs from clients shows the impact IAG services/VCSEs have on health outcomes of clients. One respondent shared

"Verbal feedback from patients in follow ups often emphasises this for me.,"

another highlighted that

"We do see the results and clients give positive feedback."

Similarly, another shared that

"I have had a lot of positive feedback from patients following referrals/signposting."

Another respondent shared that

"I know a lot of patients that have had good outcomes because of organisations I have referred in to, for example socially isolated elderly people into Age UK for social groups and people struggling with debt in to CAB."

Another highlighted that they know they make an impact because of

"The feedback from the patient for a start. The fact that the patient does not come back to us for the same reason."

Types of support provided by VCSEs and IAG services

People referred onto VCSEs and IAG services have had some very good outcomes. Offering the appropriate / practical / person centred support. Many different types of support were highlighted, included:

- Building independence
- Improved mental health (reducing stress, anxiety, loneliness, feelings of isolation)
- Employment
- Access to care support/peer support
- Financial support (e.g., debt)
- Housing
- Improved physical health (reduced hospital appointments)
- Improved social engagement/community connections

One respondent highlighted specific examples of success referring to these. organisations

"A married lady I have helped to reduce trauma by linking her with counselling for rape victims, linking someone with MS who is bedbound and socially isolated with an online befriending group from the MS Society and the person seeming happy with the outcome of my help."

Specific support with housing and debt

These organisations provide support with challenges like housing and debt, and this in turn helps reduce stress and improve mental health, reduce GP admissions, and improve overall health outcomes for clients.

One respondent shared that

> *“Problematic challenges such as housing and debt has shown signs of improvement when IAG and VCSE involvement takes place bringing about a sense of hope and respite to vulnerable patients living with mental illness whose lives are often restricted and blighted by homelessness and poverty.”*

Another shared that

> *“Yes, practical support such as housing/benefits advice has been vital for people currently when they are confused and anxious about the rise in cost of living.”*

The overall health benefits for clients can be seen in this response

> *“Increase benefit claims, which supports with inequalities and ensures clients have support with housing, energy, which will help reduce GP appointments and hospital admissions.”*

Another respondent also shows the clear overall well-being benefit of the help these services provide

> *“If the client whose mental health is being affected by their financial situation which is being solved by Citizens Advice by either supporting them to claim benefits or with debt then it will improving their mental health.”*

Addressing Isolation and connectedness

These services provide support with isolation and loneliness. One respondent highlighted that

> *“For many GP attendees, the issue is non-medical. The extended conversation with the SP addresses these needs and Co produces the appropriate non-medical outcome. Sometimes a GP visit is just to get out of the house and have a chat. It is about connecting people with appropriate services.”*

Another respondent shared that

> *“Similarly for someone who is lonely and isolated, being able to connect with other people by attending social groups run by a local VCSE will also have positive impact in their mental health and wellbeing.”*

Services overwhelmed

A theme that emerged was the fact that these services can be overwhelmed and that can impact their capacity to help. One respondent shared that these services help

> *“Where demand for service has capacity to help. Some have little resources or have long waiting times (e.g., greater than 6 months).”*

Another shared that

> *"People usually receive good support once they find it although there is still a lack of services, and most are full or have long waiting times which prevents some people receiving help."*

One respondent highlighted that

> *"There is very little offered by statutory services re mental health, social care so VSCE sector fill gaps, but funding and capacity are issues."*

Another respondent shared an example of the impact of services being overwhelmed

> *"I hope so otherwise what is the point! We are being told by CAB in our area that they are very busy, and this has led to our social prescribing link workers directly supporting patients with things like benefit forms (which technically we are not trained or insured to do)".*

Positive impact on other services

These services have a positive impact on other services like the NHS with one respondent stating that

> *"Clients use less NHS services" and another sharing that " …they use GP and A&E services less."*

The small number of respondents who did not feel the IAGs and VCSEs they are referring /signposting clients to are contributing to improving health outcomes for their clients and improving the social determinants of health, felt so for a range of reasons discussed below.

Level of demand

One respondent felt that clients still face inequality, and this does not change, stating that it

> *"Doesn't change the inequality clients experience nothing more than a sticking plaster."*

Another felt that there are not enough options to refer to. Another respondent felt they are conducting reactive social prescribing rather than proactive sharing that

> *"We are mostly dealing with reactive social prescribing rather than proactive. Many of the people we speak to are in financial crisis which has a knock effect. We cannot adequately make a difference as we are firefighting most of the time to help people try to meet their very basic needs."*

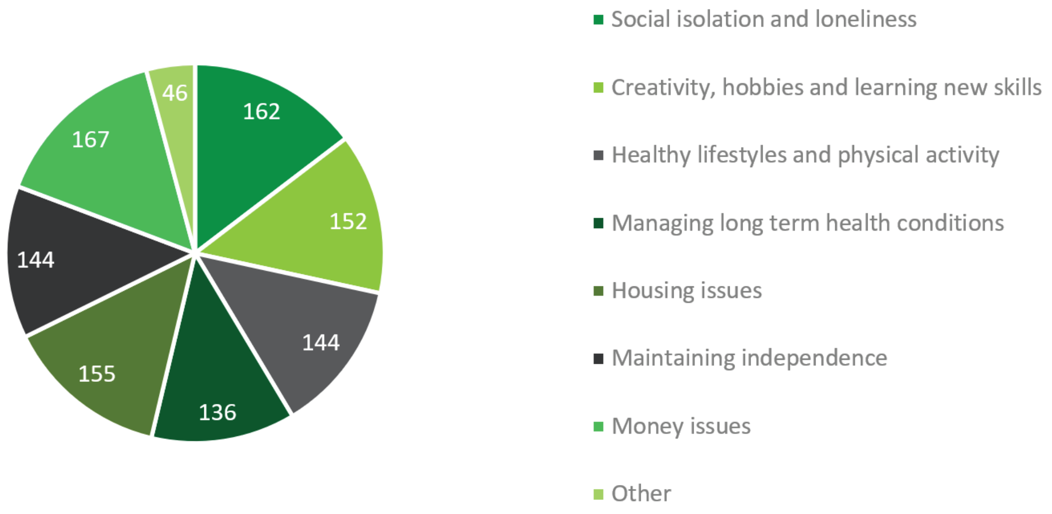
Structure

Another respondent felt that the social prescribing model is very unstructured, whilst the focus of SPLWs is correct, it is becoming swallowed by the NHS (Primary care) business model. They also highlight that

> *"There is a risk "social prescribing" setting up health outcome groups will monopolise over community assets instead of supporting or working with the VCSE, IAGs already there and battling for funding. Transport is a huge issue for people and no investment on local level."*

Respondents were asked to choose reasons they refer/signpost clients to IAG services and/or VCSEs. They were asked to choose all reasons that applied.

Chart 23: What are the reasons you refer/signpost clients to IAG and/or VCSE services? Please choose all that apply



Other referral reasons:

Mental health difficulties/challenges, emotional well-being. Support people/groups:

- Vulnerable people/ people with learning disabilities and ASD
- Refugee support
- New groups/funding/connect
- Unemployed
- Volunteering
- Carers
- New parents, particularly mothers
- Families (children, relationships)
- Bereaved
- Palliative care

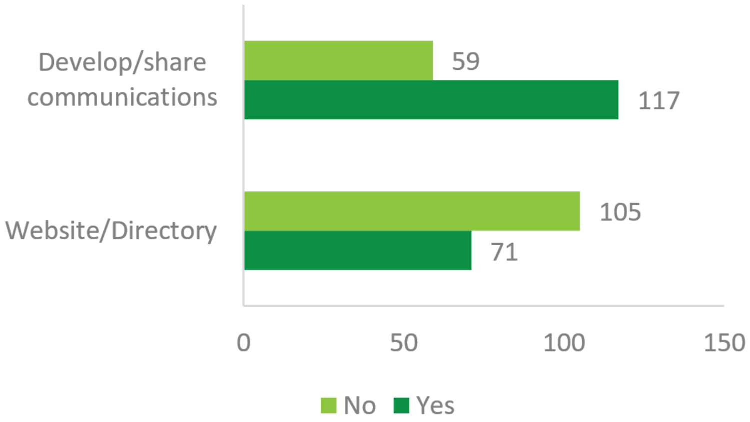
Advice:

- Health (pain management, long covid)
- Employment
- Asylum processes and appeals
- Benefits
- Immigration
- Legal matters/disputes
- Home environment (incl. DIY, fire safety)
- Education and training
- Domestic abuse/violence
- Sexual abuse
- Judicial issues
- Addictions (drugs, alcohol)
- Transport

Respondents were asked if their organisation develops or share communications regarding self-help (e.g., leaflets) that may encourage users to self-refer to an IAG service or VCSE. They were also asked if their organisation has, or signposts to, a website/directory that people can access without being referred to by a link worker. Chart 24 shows the responses.

Chart 24: Does your organisation develop or share communications regarding self-help (e.g., leaflets) that may encourage users to self-refer to an IAG service or VCSE?

Does your organisation have, or signpost to, a website/directory that people can access without being referred to a link worker?

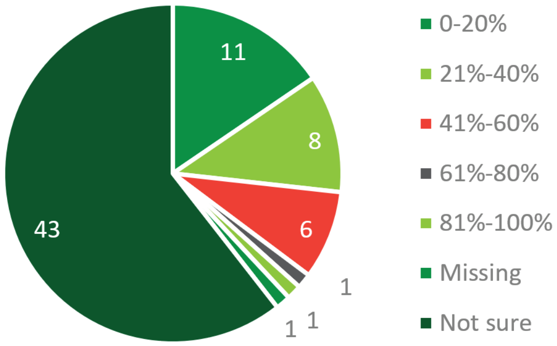


The majority stated Yes they do develop/share communications (n=117) and 59 stated No. The majority stated that No, their or-ganisation does not have a website/directory, nor signposts to one that people can access without being referred to by a link worker (n=105) and 71 stated Yes they do.

Respondents who stated their organisation has, or signposts to, a website/directory that people can access without being referred to a link worker were asked what percentage of traffic that reaches the IAG service / VCSE pages of the website (chart 25).

Chart 25: If you answered "Yes" to Q30, can you tell us approximately what % of traffic reaches the IAG service / VCSE pages of the website?

Does your organisation have, or signpost to, a website/directory that people can access without being referred to a link worker?



The majority of respondents (n=43; 61%) did not know how much traffic reaches the IAG services/VCSEs pages of the website. 11 (16%) respondents indicated 0-20%, 8 (11%) indicated 21-40% & 6 (8%) indicated 41-60%. 1 (2%) respondent indicated that 61-80% and 1 (2%) more indicated 81-100% of traffic reaches the IAG services/VCSEs pages of the website. 1 respondent did not answer.

* Based on 71 respondents

Respondents that answered Yes, their organisation develops or shares communications regarding self-help (e.g., leaflets) that may encourage users to self-refer to an IAG service or VCSE were asked to tell us more tell us more about the content of them and where they are made available. Respondents highlighted the types of information they/their organisations provide to clients and within their workplace. These are categorised as “Clients” and “Staff.”

Information available for clients included:

- Leaflets/booklets from local and national organisations they refer to (IAG, VCSE promotional material):
  - Citizens Advice; Money Worries leaflet by Teignbridge CVS; Healthy You; Dementia centre booklets covering all topics; Carer leaflets; domestic abuse; City Council Staying Independent, no smoking campaign, holistic mental health resources, local groups such as Evergreen, Mindspace, Wellbeing Lincs; Samaritans, Nightlight; Hertfordshire Network; NHS Hert-fordshire; University partnership; HHFS; The Recovery Academy for psycho education.
- Websites:
  - Organisations they refer to - provide links (e.g., Citizens Advice; Livewell North Lincolnshire, Healthconnectionsmendip.org directory and resources pages; Northumberland Frontline directory; NHS Local council Directory of services within the community)
- A directory
- Social Media (e.g., Facebook page)
- Online Self-help group details
- Newsletter for patients (content varies, but usually a theme covering five steps to wellbeing)

This information was available through the following avenues:

- In appointments / home visits
- Email
- Text/WhatsApp
- Post
- Websites
- GP surgeries (on notice boards, waiting areas, websites)
- Schools / Churches
- Charities
- Liaise with other groups and organisations
- Community groups/events / coffee mornings / walk in clinics
- Networking & networking events
- Promoted on social media
- SP cards with details of agencies that are useful

One respondent highlighted how they try to make the information fully accessible “They are made available in paper or digital form, or on Facebook, the WWW. They can be found in directories such as the Leeds Directory, & Mindwell. There is a lack of paper based self-help for people who do not use the internet, or do not wish to or don't have the means to download apps.”

Many respondents highlighted they created their own resources including:

- Social Prescribing leaflets –

> *"In-house generated SP leaflet which is on display in all GP practices and available electronically."*

- Information packs/booklets –

> *"Currently producing a booklet to leave with patients full of useful resources including VCSE organisations and IAG."*

> *" Devised our own booklets for information on various topics such as communicating with someone with dementia, blue badge applications, how to claim certain benefits, safety in the home, mobility aids etc., sent directly to those who we are supporting with these issues".*

- Posters – display at community events; through the platform of Thriving Streatham

- Supported

> *"GP practice to develop leaflets. These are handed out at the point of assessment, i.e., social prescribing for mental health and many others such as lists of foodbanks and housing associations."*

- Newsletter "Wellbeing News"/ Team bulletins for PCNs

Information available for staff included:

- Newsletter for staff and patients (shares anonymized case studies to show the impact of SPLW work, new groups, and services locally and key signposting information)
- Information from manager via email and during team meetings
- Information shared within the team
- Have regular 'guest speakers' at team meetings to share information and an opportunity to ask questions
- WhatsApp group to share information
- The ALISS e-community database for community resources is managed and maintained by their organisation. Each practice base social prescribing link worker has the opportunity to add resources to the Practice Website, their social prescribing link workers also attend many local network meetings

Discussion

The following section summarises the findings of the research and is themed in line with the previous two chapters.

Impact of social prescribing on stakeholders

Impact on service users

The literature would suggest the process of social prescribing has a positive impact on service users' wider determinants of health, however the research that underpins these assumptions remains immature and evidence is, in some places, contradictory (**Carnes et al., 2017; Bickerdike et al., 2017; Ferguson & Hogarth, 2018; York CVS, 2019; Reinhardt et al., 2021; Bertotti et al., 2020; Polley et al., 2021; Elston et al., 2019; Woodall et al, 2018; Munoz et al., 2020; Case et al., 2021; Kiely et al., 2022**). It is, at this point, also unclear where in the user journey positive impacts are realised and which service users benefit from the service in which ways. It is, for example, unclear whether positive impacts are experienced by users simply by connecting with an SPLW, or only once engagement with VCSE services has been completed. The vast majority of SPLWs who took part in this research felt that the process of social prescribing, and engagement with the VCSEs they are referring / signposting clients to, are contributing to improving health outcomes for their clients and improving the social determinants of health. Despite this, almost a third of respondents claimed that while they held these perceptions, they had no way of knowing if clients followed through with engaging with the VCSE services signposted to or achieved the intended outcomes from those services. The core reason provided for this was capacity, and our SPLWs indicated that as the number of referrals rises, the rate of follow up is likely to fall as it becomes less feasible with increasing caseloads. Equally, the need for a flexible approach in engaging and interacting with service users meant in many cases follow up was not required or deemed proportionate in line with the service model.

Several SPLWs also raised the issue of long waiting lists within the organisations they are referring to, which meant that often their fixed-term interaction with the service user was over before the individual managed to engage with services. In this case, many respondents made clear they would not be expected to engage with service users following this fixed term period to explore whether intended outcomes were achieved. Despite this, many did state that where SPLWs were embedded into ongoing community activities delivered by local VCSEs, they would often "check in" with their clients post engagement

"some clients are referred to groups run by the [SPLW's] organisation so they will see them there/engaging in projects they run",

however many were not and would not receive feedback from their service user regarding their experience unless they were rereferred to the service and able to engage directly with the SPLW again.

Impact on health services

Again, while the literature would suggest the process of social prescribing is contributing to reducing service user engagement with health services, the research that underpins these assumptions remains immature and data to analyse not readily available to policymakers or commissioners **(Dayson & Batty et al., 2017; Family Action, 2018; Social Prescribing Torfaen, 2018; Together Co, 2020; White et al, 2020; Bertotti et al., 2018; Ferguson & Hogarth, 2018; Cole et al., 2020; Polley et al., 2020; Wildman et al., 2019; Pescheny et al., 2018).** This research and analysis have demonstrated that the current methods of collecting centralised data do not enable SPLWs to express the full extent of their work due to the fact there are limitations on how many engagements can be entered into the system and how many resources are being allocated to these engagements. This is problematic as commissioners are unable to identify whether those who were 'frequent fliers' in general practices for example have been supported to self-manage or are simply now 'frequent fliers' to social prescribing services.

The primary data collected demonstrated that GPs were identified as the most common referring organisation, as to be expected in line with the model's intended policy aims. This data also demonstrates a significant proportion of SPLWs receive self-referrals in addition to referrals from non-health related organisations. From the responses provided, it is impossible to comment on what impact this has on health services. One scenario for example may be that service users are being truly enveloped in a preventative approach and are receiving support without attending a GP service, further reducing healthcare service demand. Another however may be that individuals are engaged in multiple health, social and VCSE services and have simply engaged with the SPLW through one of many organisations that might have referred them.

Nearly three quarters of respondents expressed that the impact of their work on GPs and the broader NHS system is not successfully measured using current processes. While the RCGP data was considered to reflect the impact of social prescribing on NHS stake-holders most accurately out of all the stakeholders discussed, a number of issues were raised in relation to how accurate this picture is. The reasons for this are discussed in the "current data" section of this chapter.

Impact on Voluntary, Community and Social Enterprise sector

It is clear from the evidence that the number of referrals both into and out of social prescribing services are increasing. It has also been demonstrated that the voluntary and community sector is, in several cases, not meeting demand caused by issues such as COVID19 and the cost-of-living crisis and the increase in demand caused by the increase in referral numbers by social prescribing workers **(Dayson & Batty et al., 2017; Family Action, 2018; Social Prescribing Torfaen, 2018; Together Co, 2020; White et al, 2020; Bertotti et al., 2018; Ferguson & Hogarth, 2018; Cole et al., 2020; Polley et al., 2020; Wildman et al., 2019; Pescheny et al., 2018).** NHS England target of having 900,000 people referred into social prescribing services by 2023/24 **(NHS England 2019),** has been exceeded and a new target set. While this push to grow social prescribing within the sector is widely welcomed, concerns have been raised as to the further impact this may have on the already struggling VCS. Calls for an increased focus on community development as a core role of SPLWs and key goal of commissioners are recurring in the literature **(Elemental, 2020; Polley et al., 2020; Cole et al., 2020; Wallace et al., 2020).** Social prescribing link workers explained that longer waiting lists for access to VCSEs have the potential to significantly impact the efficacy of social prescribing services as SPLWs are required to discharge service users from their case load before they can engage in the services that are designed to address their issues, meaning programmes are not delivered in line with the expected model. It is not clear from the evidence what impact this is having on the delivery of the social prescribing model as expected, nor on the outcomes experienced by service users.

The data

The SPO data was argued to only show a snapshot of the overall time and effort SPLWs take with service users. Secondly, a lack of knowledge of how to use these codes or training was indicated, with a small number of respondents unsure what SNOMED codes were – this means those who are recording on clinical systems may not be recording this information in a way that would be reflected in the dataset. While most respondents did utilise an electronic coded system to monitor track their referral activity, a significant proportion did not, indicating that a significant portion of social prescribing activity may not be picked up by the RCGP Social Prescribing observatory. Second, concerns regarding the use of SNOMED codes and how these are reported on within the RCGP statistics were raised, with one respondent highlighting that SPLWs would often see the same client repeatedly, and that the current data does not effectively reflect either the amount of time an SPLW will spend with each service user, nor the numbers of times an individual may be referred or self-refer to the social prescribing service. Less than 50% of organisational clinical coding systems used by respondents included codes to represent a referral to a VCSE, with much of this information included within qualitative notes contained in clinical systems, or external databases. This poses issues, due to the data extraction and analysis issues, in understanding a) which services are receiving most onward activity from SPLWs and b) which services referred to have the most significant impact on patient outcomes.

Collection of outcomes data appears to land with social prescribing link workers, who, even where this work is embedded in their service model, are rapidly losing the capacity to undertake this work as their caseloads rise. This approach also poses several problems to understanding the impact of programmes due to the differences in data collection forms and approaches. Finally, this work has demonstrated that there is likely a significant proportion of the public who engage with communications/resources developed by SPLWs. There does not appear to have yet been any exploration of their experience and the impact of this activity on the outcomes for service users.

The research demonstrated that current systems in many cases do not allow for the collation of comparable data on what types of organisations absorb most of the onward referral, only the issues for which the service user has been referred for. This lack of specificity makes it difficult to ascertain with certainty which services are absorbing what percentage of referrals and therefore the impact on different parts of the sector.

While the CA data and other VCSE databases like it will offer a more accurate picture of onward referral impact, there are still limitations in utilising this data, primarily the fact that VCSE staff are reliant on clients a) recognising they have been part of a social prescribing referral and b) telling the VCSE staff that this was the programme that signposted them to the service. This is particularly difficult when the client is self-referring to a VCSE due to picking up literature or communications developed by social prescribing services, as this would still be considered a self-referral, however it is one that was influenced by the work of SPLWs and may not have happened had that information not been available.

Furthermore, VCSEs are not exempt from common issues in relation to the collection of administrative data to demonstrate true impact of social prescribing referrals on their capacity. The CA data explored, for example, shows the number of people referred by link workers, but currently the database does not offer an easy way to capture which SP scheme the client was referred from. Finally, while a service user may be referred to a VCSE for one issue, they may present to that service with a range of issues that were not discussed with an SPLW or were only identified post-engagement with the VCSE organisation. In these cases, it is likely a significant proportion of VCSE activity related to social prescribing referrals is not being recorded as such.

The role of community development

Due to questionnaire capacity, we were unable to discuss the role of community development directly with SPLWs, however responses provided were perceived to reinforce the state of community development portrayed in the literature. While this research has demonstrated that some social prescribing services collect thorough data regarding onward referrals, however this recording is varied in its frequency, form, and thoroughness. This inconsistency in reporting can make it difficult to ascertain with certainty the impact of social prescribing services on VCSEs and therefore where community development work should be concentrated.

Concerns related to the implementation of community development initiatives having the potential to impact population health inequalities were raised in the literature and the data makes clear SPLW and CA activity is much higher in some geographical spaces than others. While we cannot comment on whether such results would be expected and therefore should be enacted upon, they are significant and should be explored further. The literature made clear that community development work should follow need, however we were unable to ascertain from the research undertaken as to whether this was occurring.

Another difficulty identified in relation to measuring impact was the lack of a clear pathway of care that enveloped SPLWs and the services to which they might refer. Some respondents alluded to the fact that social prescribing was often considered an ‘add-on’ service to existing healthcare services, rather than an integral part of a clear pathway, with one SPLW stating, “it's important that anyone in NHS roles understands their role in social prescribing, so it isn't seen as only the preserve of one/a small number of professionals” and another describing their service as something of a “holding pen”. This context also led to some SPLWs expressing concerns that their work wasn’t influenced by long-term planning, leading to them stating,

> *“we are mostly dealing with reactive social prescribing rather than proactive. We cannot adequately make a difference as we are fire-fighting most of the time to help people try to meet their very basic needs.”*

Community development efforts, when discussed in the qualitative responses were clearly varied in their form and function, however most of this work discussed by SPLWs focused on addressing issues related to data sharing which particularly hampered the development of integrated pathways of care that enable referral to outcome monitoring. Some social prescribing link workers described formalized partnerships with local VCSEs,

“we have an SLA with a local charity who provides us with a monthly report”,

whereas others appear to adopt a more independent informal approach utilizing existing arrangements to support their work:

“I have built up a partnership based relationship with staff at the referral agency and encourage the person I've signposted to agree and sign to information sharing so the agency and I can provide a more wrap around service”.

One key theme that arose from the responses was the lack of clarity across respondents and the programmes they represent as to whose responsibility it is to measure the impact of social prescribing and the services they refer onto. In some cases, feedback loops with service users and evaluation of their experience was clearly embedded into the service model, with feedback the responsibility of the SPLW, whereas other responses indicated others perceived it would be the responsibility of the VCSE organisations to feedback to social prescribing link worker programmes,

“[we get] no feedback from [the onward referral] service unless asked for”.

A small number of respondents identified a lack of collaboration across the range of services involved as a reason for an inability to access accurate data to measure their impact

“[there’s] not really the channels or data sharing arrangements to make this happen”.

Key Recommendations

The following section details the recommendations that have been developed as a result of this research.

1) Understanding impact on service users

It is recommended that academics seeking to determine the impact of social prescribing services focus on the full service user pathway to demonstrate where and how impact occurs – this includes the experience of interacting with and the impact of engaging with the services users have been referred to / signposted to. The findings of this work would enable focused investment in future social prescribing services and the partnerships the are involved in to enhance their impact.

We recommended that commissioners and those working to embed integrated care in our systems ensure a full pathway approach is taken when considering the development of and monitoring of social prescribing services. Commissioners should also encourage cross pathway collaboration, embedding mechanisms in contracts and ways of working that promote data sharing between social prescribing services and the key VCSE organisations they refer onto so all stakeholders can better understand the impact of their work on service users. This work should be enabled by introduction of Integrated Care Boards and provider collaboratives that underpin them.

It is recommended that social prescribing service leads review their methods for follow-up with clients to enable increased reporting on service user outcomes. Inspiration may come from other services where follow-up occurs post engagement (e.g., the emergency services). This work would bolster the existing evidence related to the impact of SPLW programmes and support the future development of improved programmes.

2) Understanding impact on health services

For academics seeking to understand the full impact of social prescribing on VCSEs, it is recommended particular attention is paid to those who do not enter an SPLW's caseload, and it should be explored to what extent these individuals were influenced by SPLW communications and directories. This work will importantly enable VCSE organisations to estimate the range of their activity that can be attributed indirectly to social prescribing activity and therefore demonstrate the full impact of social prescribing services on their ability to support service users.

While is not possible to ensure individual VCSE organisations can be routinely recorded within clinical systems due to the broad range and ever changing state of organisations nationally, policymakers and those who develop centralised reporting systems (e.g. the SNOMED codes) should develop defined categories of onward referral organisations (e.g. information, advice and guidance services, peer support services, movement/exercise services) and provide guidance on the types of organisations that would fall into these categories. This would enable VCSEs to better demonstrate the impact of SPLWs on their capacity in discussions with commissioners and policymakers, empowering them to be part of a truly integrated pathway.

It is recommended that social prescribing service leads review their methods for follow-up with clients and assessing the outcome of their service, not just the outputs. Commissioners should ensure this work is embedded into contractual expectations, adopting an outcome, rather than outputs centred approach to the KPIs they develop across their contracts, raising capability as members of anchor organisations.

3) Understanding impact on voluntary, community and social enterprise sector

It is recommended that policymakers assess, determine, and then formalise their expectations in relation to the role different stakeholders should take in the collection and monitoring of data regarding the impact of social prescribing services. Having a formal framework in place will enable all stakeholders to undertake the range of recommendations outlined within this report. Improving centralised data collection and monitoring activities would improve confidence and support the system focused, long-term community development work promoted in policy.

It is recommended that commissioners, SPLWs and VCSEs focus, in the absence of this clear centralised approach, on working together to develop clear mechanisms to collect and monitor activity to better inform any future resource allocation locally. Again, agreed definitions for the types of organisations SPLWs refer onto would be a practical route, enabling those responsible for community development to allocate effort and resources into those spaces that are absorbing the most.

Implementing the Professional Records Standards Body (PRSB, 2022) Social Prescribing Information Standard published in 2022 is encouraged to enable the sharing and recording of information for the whole patient journey and exploring how NALW digital social prescribing partners such as Elemental Access can help.

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Appendix 2: Stakeholder Validation Meeting

There were 9 participants. The first three questions in the meeting determined some descriptive information about the participants. They had a broad range of expertise, with experience as directors and leads on programmes and social prescribing. Five participants were from Citizens Advice with one working for a PCN and the remaining three working for a healthcare trust (one participant missed answering this question).

The participants were asked

"Without using the title of your job, tell us what you do?"

Responses are below:

- Lead PCN team to support patients' holistic needs.
- I lead an organisation delivering advice, advocacy and information services and other services linked to addresses health inequalities.
- Run a local CA - juggling, living, and keeping sane!
- I lead on research and campaigns, wellbeing, volunteers, training and
- EDI work
- Organise volunteers to support clients to improve mental and physical health.
- Provide all front-line health staff in Liverpool with access to social welfare sup-port.
- Pester Health and social care for investment.
- I support people to gain confidence to manage their situations.

QUESTIONNAIRE VALIDATION ACTIVITY

The meeting moderator shared each question below and asked for each participant to vote for inclusion of the question for the link worker survey using "Yes" or "No". The results are presented in Table 2.

Table 2 : Questionnaire validation activity results

No.	Question description	No. voting*	% voted Yes**
01	**Where is your work based?** a. General Practice b. Community c. Hospital d. Other (please specify)	9	N/A
02	**How would you describe your role?** a. Link worker/social prescriber b. Social Prescribing service Manager/lead c. Other (please specify)	8	N/A
03	**Are you employed by?** a. A PCN b. A GP practice or GP Federation c. Health and Social Care Partnership/ Integrated Care System d. Local Authority e. NHS Trust f. VCSE (Voluntary, Community, Social Enterprise organization) g. Other, please state:	8	N/A
04	**What region or nation are you based in?** a. London b. South East c. South West d. East of England e. East Midlands f. West Midlands g. Yorkshire & the Humber h. North East i. North West j. Wales k.Northern Ireland l. Scotland	8	N/A

No.	Question description	No. voting*	% voted Yes**
5a	**How many referrals have you personally received on average per month in the past 12 months?** a. 5 – 10 b. 10 – 15 c. 15 – 20 d. 20 – 25 e. 25 +	8	63
5b	**Do you receive referrals from:** a. General Practice b. Hospital c. Pharmacy d. Social Care e. Community health f. VCSE (Voluntary, Community and Social Enterprise) g. Local Authority h. Client self-referral i. Other: please describe	9	100
06	**Have you seen an increase in the referrals you receive in the past 12 months?** Yes/No	9	89
7a	**How many onward referrals have you personally made on average per month in the past 12 months?** a. 5-10 b. 10-15 c. 15-20 d. 20-25 e. 25+	Missing	Missing

No.	Question description	No. voting*	% voted Yes**
8	**Have you seen an increase in your onward referrals in the past 12 months?** Yes/No	9	89
9a	**What percentage of your activity is an immediate sign-post per month?** a. 0-20% b. 20%-40% c. 40%-60% d. 60%-80% e. 80%-100%	9	78
9b	**Are these recorded?** Yes/No	9	78
9c	**If recorded, do you record where you signpost clients to in these instances?** Yes/No	9	100
10a & b	**Do you use an electronic coded system to record referrals?** Yes/No **If Yes, do you have a code for VCSE?** Yes/No **If No, how do you record referrals to VCSE?**	9	89

No.	Question description	No. voting*	% voted Yes**
11	**Do you have any way of knowing if patients followed through with contacting the VCSE if you advised them to do this?** Yes/No	9	89
12	**Do you think SNOMED codes accurately reflect social prescribing referral numbers?** Yes/No	9	100
13	**Do you think that SNOMED codes accurately reflect the impact social prescribing has on Clients/patients out-comes, the NHS, VCSE?** a. Clients' outcomes? Yes/No b. The NHS? Yes / No c. VSCEs? Yes/No	9	89
14	**What would be useful to help you recording referring on to VCSEs, what do you think is good practice?**	9	89
15	**Do you have any examples of particularly good data reporting mechanisms/ structures? If so, please share.**	9	100
16a & b	**Do you think the full impact of social prescribing referrals on VCSEs is being successfully measured?** Yes/No. If No, what do you think could be done to improve this?	9	89

No.	Question description		
17a & b	**Do you think the full impact of social prescribing referrals on the NHS is being successfully measured?** Yes/No. If No, what do you think could be done to improve this?	9	100
18	**Do you think the VCSEs you are referring clients to are contributing to improving health outcomes for your clients and improving the social determinants of health?** Yes/No. If No, what do you think could be done to improve this?	9	89
19	**Please choose all that apply for the reasons for referral to the VCSE:** a. Social isolation and loneliness b. Healthy lifestyles and physical activity c. Maintaining independence d. Managing long term health conditions e. Creativity, hobbies and learning new skills f. Housing issues g. Money issues h. Other: Please state reasoni.	9	89
20a & b	**Does your organisation develop or share communications regarding self-help (e.g., leaflets) that may en-courage users to self-refer to VCSE?** Yes/No If Yes, can you tell us more about the content of them and where they are made available?	9	89

No.	Question description	No. voting*	% voted Yes**
21 a & b	**Does your organisation have, or signpost to, a website/directory that people can access without being referred to a link worker?** Yes/No If yes, can you tell us what % of traffic reaches the VCSE pages of the website? a. 0-20% b. 20%-40% c. 40%-60% d. 60%-80% e. 80%-100%	9	100

Group discussion after voting

Consensus voting

The majority of the questions gained more than 70% of the votes.

Only Q5a gained less than 70% consensus (68%). This was discussed upon completion of the voting. The options provided when answering Q5a started at 5-10 referrals, however discussion from the participants highlighted that this should start at zero. This was accepted by the group. This would also be the case for Q7a.

Further discussion points

It was suggested that:

- It needs to be made very clear who is completing the questionnaire, i.e., link worker or a manager with a caseload and that the questions are to be completed on an individual basis, not for a programme.
- The list for employing organizations in Q3 needs to have health boards included in the options.
- CA have been excluded from responses in certain questions, namely Q3 and Q5b (it is included in VCSE but perhaps needs to be separated out or clearer)
- It would be useful to capture if people have access to clinical systems.
- It may be helpful to measure how many presentations for isolation or physical fitness also require benefits, debt, housing, etcetera support (experience is at least 70%)
- It would be useful to know what percentage of referrals are sent for debt advice or percentage of referrals for housing in Q19.

A lot of discussion centred around language clarity. Clarity on what “signposting out” what's “referring out” and what's “referring in” and what that means because different social prescribing link workers and different organisations would class signposting as referring, whereas others class information, signposting and referring as different things. One participant highlighted that they support people to make decisions to help them move forward. Encouraging people to think about it themselves and with information and with the right access to the right resources. Another highlighted that once a patient's activated, they don't want to deactivate them by doing it for them. There is a difference between doing an actual referral to a service versus the supporting a person to take those steps to contact the advice service themselves. This would need to be clear in the questionnaire.

Conclusion

In conclusion the stakeholder validation meeting garnered very useful feedback that informed phase two of the research. The questionnaire for the survey was amended based on the results from the questionnaire validation activity and discussions.

Amendments made

- At the beginning of the questionnaire, it is clear who is asked to complete the questionnaire: link worker or a manager with a caseload and that the questions are to be completed on an individual basis, not for a programme.
- Language was amended to make clear the separation between “referral” and “supported signposting”.
- Q5a and Q7a options now start at zero
- Q3 now has “Other” option to specify any other employing organisations.
- Q3 - CA has been added to options
- Q5b – IGA has been added to include CA
- Q10a – “clinical systems” has been added to the question
- Q19 - Measure what percentage of referrals are sent for debt or housing advice

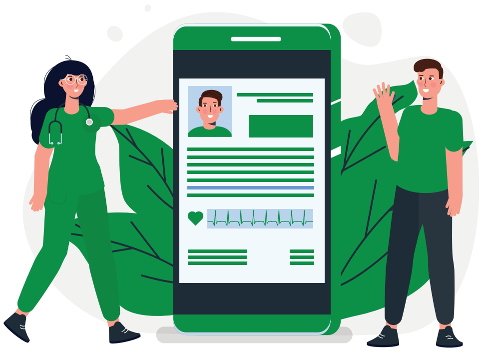
Amendments not included

It was beyond the scope of the project to include the following suggestion:

- Measure how many presentations for isolation or physical fitness also require benefits, debt, housing, etcetera support (experience is at least 70%)

These additions would have required additional questions, and this could be too burdensome for participants to complete.

See Appendix 3 for the final version of the SPLW Survey.



Appendix 3:
Social Prescribing Link Worker Survey

Citizen's Advice (CA), a national Information, Advice and Guidance (IAG) service, has commissioned the National Association of Link Workers (NALW) to undertake research to explore the role social prescribing link workers play in CA's rising referral rates, why published and local accounts of demand may differ, and the impact this has on local information, advice, and guidance services. This research will also help us to understand link workers caseloads.

We are asking you to complete this questionnaire if you are:

- An individual social prescriber/link worker
- A social prescribing service manager/lead with a caseload

The survey needs to be completed by the 14th February 2023. If you have any ques-tions, please email **research@nalw.org.uk**

Please note that some questions may not be relevant to you, or you may not know the answer so you can skip to the next relevant question. Thank you in advance for taking

Q	Demographic information
01	**Where is your work based?** ☐ General Practice ☐ Community ☐ Hospital ☐ Other, please specify: ______________________

Q	Demographic information
02	**How would you describe your role?** ☐ Link worker/social prescriber ☐ Social Prescribing service Manager/lead ☐ Other, please specify: ______________________________
03	**Are you employed by?** ☐ A PCN ☐ A GP practice or GP Federation ☐ Health and Social Care Partnership/Integrated Care System ☐ Local Authority ☐ Citizens Advice ☐ NHS Trust ☐ VCSE (Voluntary, Community, Social Enterprise organization) ☐ Other, please specify: ___________________________
04	**What region or nation are you based in?** ☐ London ☐ South East ☐ South West ☐ East of England ☐ East Midlands ☐ West Midlands ☐ Yorkshire & the Humber ☐ North East ☐ North West ☐ Wales ☐ Northern Ireland ☐ Scotland

Q	Referrals received
05	**How many referrals have you personally received on average per month in the past 12 months?** ☐ 0 - 25 ☐ 25 - 50 ☐ 50 – 75 ☐ 75 – 100 ☐ 100 – 125 ☐ 125 +

Q	Referrals received
06	**Have you seen an increase in the referrals you receive in the past 12 months?** ☐ Yes ☐ No
07	**Where do you receive referrals from? (please tick all that apply)** ☐ General Practice ☐ Urgent and Emergency Care ☐ Pharmacy ☐ Social Care ☐ Community Health ☐ VCSE (Voluntary, Community and Social Enterprise) ☐ Local Authority ☐ Client self-referral ☐ Information Advice and Guidance (IAG) Services ☐ Other, please specify: ______________
Q	**Referrals and Supported Signposting**
08	**How many for clients have you personally supported with signposting to services (i.e., supporting them with contacting the service themselves) or referring to ser-vices (i.e., contacting the service on behalf of the client) on average per month in the past 12 months?** ☐ 0 - 25 ☐ 25 - 50 ☐ 50 – 75 ☐ 75 – 100 ☐ 100 – 125 ☐ 125 +
09	**What services do you support clients to contact / refer to? Please choose all that apply:** ☐ Information Advice and Guidance (IAG) services (e.g., Citizens Advice) ☐ Community groups ☐ Charities ☐ Statutory services ☐ Other, please specify: ______________

Q	Referrals and Supported Signposting
10	**Do you record what services you refer / support signposting to?** ☐ Yes ☐ No
11	**What percentage of your signposting to services / referrals to services are related to housing or money issues?** ☐ 0-20% ☐ 21%-40% ☐ 41%-60% ☐ 61%-80% ☐ 81%-100% ☐ Not sure
12	**Have you seen an increase in the referrals and supported signposting you make in the past 12 months?** ☐ Yes ☐ No
Q	**Recording Referrals and supported signposting**
13	**Do you use an electronic coded system /Clinical System to record your referrals?** ☐ Yes ☐ No
14	**If you answered "Yes" to Q13, that you do use an electronic coded system, do you have a code for VCSE or IAG services?** ☐ Yes ☐ No, please tell us how you record these referrals to VSCE/IAG: ____

Q	Recording Referrals and supported signposting
15	**Do you think SNOMED codes accurately reflect social prescribing referral numbers?** ☐ Yes ☐ No ☐ Other, please explain: ______________________________
16	**Do you think that SNOMED codes accurately reflect the impact social prescribing has on the following? Please tick all that apply:** ☐ Clients' outcomes? ☐ The NHS? ☐ IAG services? ☐ VCSE? ☐ None of the above ____________________________
17	**What would be useful to help you record referrals to IAG services /VCSEs? What is good practice? Please share any examples you may have of good data reporting mechanisms/structures:** ____ ____
18	**Do you have any way of knowing if clients followed through with engaging with the IAG service/VCSE after supported signposting?** ☐ Yes ☐ No
19	**If you answered "Yes" to Q18 please tell us why:** ____
20	**If you answered "No" to Q18 please tell us why:** ____

Q	Impact of social prescribing on IAGs, VCSEs, the NHS and social determinants of health
21	**Do you think the full impact of social prescribing referrals on IAG services and VCSEs is being successfully measured?** ☐ Yes ☐ No
22	**If you answered “No” to Q21, what do you think could be done to improve this?** ______________________________
23	**Do you think the full impact of social prescribing referrals on the NHS is being successful-ly measured?** ☐ Yes ☐ No
24	**If you answered “No” to Q23, what do you think could be done to improve this?** ______________________________
25	**Do you think the IAGs and VCSEs you are referring /signposting clients to are contributing to improving health outcomes for your clients and improving the social determinants of health?** ☐ Yes ☐ No
26	**Please explain your answer to Q25:** ______________________________ ______________________________ ______________________________ ______________________________

Q	Referral / Signposting Reasons
27	**What are the reasons you refer/signpost clients to IAG and/or VCSE services? Please choose all that apply:** ☐ Social isolation and loneliness ☐ Healthy lifestyles and physical activity ☐ Maintaining independence ☐ Managing long term health conditions ☐ Creativity, hobbies and learning new skills ☐ Housing issues ☐ Money issues ☐ Other, please specify: ____________________
Q	**Encouraging self-referrals to services from website/general communications**
28	**Does your organisation develop or share communications regarding self-help (e.g., leaflets) that may encourage users to self-refer to an IAG service or VCSE?** ☐ Yes ☐ No
29	**If you answered "Yes" to Q28, can you tell us more about the content of them and where they are made available?** ______________________________
30	**Does your organisation have, or signpost to, a website/directory that people can access without being referred to a link worker?** ☐ Yes ☐ No
31	**If you answered "Yes" to Q30, can you tell us approximately what % of traffic reaches the IAG service / VCSE pages of the website?** ☐ 0-20% ☐ 20%-40% ☐ 40%-60% ☐ 60%-80% ☐ 80%-100% ☐ Not sure

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publication, contact us at:

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National Association of Link Workers

citizens
advice