



Voluntary and community sector organisations are helping patients and saving local health services time and money, but increasingly they're having to do so without adequate funding. PJ White reports



There is plenty of evidence that social prescribing is good for patients. Halfway through the six-year Ageing Well programme in Torbay, participants report more social contact and social activity, and fewer mobility problems and cases of extreme pain after people are referred by local health providers to community groups.

"These are robust findings", says Simon Sherbersky, Ageing Well director at Torbay Community Development Trust. He also reports that engaging in the programme, which links social prescribing to the Ageing Well model developed by Age UK in Cornwall, reduced levels of loneliness by half.

Janet Wheatley, chief executive of Voluntary Action Rotherham, has a clutch of similarly impressive statistics recording significant improvements in wellbeing for users of the flagship Rotherham service, which has seen more than 7,000 referrals since its two-year pilot in 2012. When patients do better, health services feel the benefit. The projects report fewer GP visits, hospital admissions and A&E visits.

Actively looking

Tom Watson, business and communications lead at the local infrastructure membership body Navca, estimates anecdotally that about one-third of its 200 members are either currently involved in or actively looking at social prescribing models. The Health and Wellbeing Fund 2017/18, launched last autumn by NHS England, invited voluntary, community and social enterprise organisations to bid for funding of up to £300,000 for the first year of their schemes. It received close to 150 applications and the expected start date was delayed for months.

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Mike Wild, chief executive, Macc

So social prescribing is popular, and has been shown to be good for patients and health services. There is an NHS England fund and some high-profile, funded projects. However, Wheatley acknowledges that Rotherham's funding is not the norm, but came about thanks to "a leap of faith" by a supportive clinical commissioning group. In most of the social prescribing projects she visits across the country, voluntary and community organisations are expected to respond to referrals with no additional funding. "Most are like a signposting service. Sometimes the adviser will go out and provide some intensive support. But then it's just signposting."

The priority for funding in social prescribing services usually goes to advisers or link workers. Their role is to engage with the healthcare staff who make referrals, talk to individual patients and maintain relationships with third sector organisations. They are vital: healthcare professionals cannot be expected to have an up-to-date knowledge of local community groups, say the authors of a guide to commissioning and running social prescribing schemes published by the University of Westminster last year. The guidance says link workers and their managers should be paid staff, receiving "appropriate supervision for their complex and often challenging roles".

Funding for the two Rotherham social prescribing services, one for mental health and one for long-term conditions, comes from clinical commissioning group contributions and the Better Care Fund. About 45 per cent of the budget funds the team of link workers. But Wheatley says the majority of the £500,000 annual spend goes to local voluntary and community groups themselves. "Otherwise, if we send referrals through, we're sending them to already overstretched voluntary and community sector organisations."

Without resourcing, there is less benefit to patients. Wheatley gives the example of a benefits check. With a resourced scheme, someone can make a home visit to do an attendance allowance check for an older person with a long-term health condition. "Otherwise you risk ringing someone up and them saying 'yes, we can do that, but we've got a waiting list of four months'."

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Janet Wheatley, chief executive, Voluntary Action Rotherham

Contracted agreements with local Rotherham organisations can be worth anything from less than £5,000 to more than £30,000. "And there are spot payments we make for one-off individual needs or sometimes to test out whether there is demand for different provision," says Wheatley.

Torbay's model, with six wellbeing coordinators employed as social prescribers by Age UK, is being tested with six years of Big Lottery Fund funding worth £6m. "What's unique is that we have a team of community workers – 15 full-time-equivalent community builders who are out on patch stimulating citizen-led positive action to try to create more connected communities," says Sherbersky. "They work very closely with the wellbeing coordinators."

But he worries about what happens when funding for the project ends: "I can see health saying 'yes, we want wellbeing coordination and we want the social prescribing service'. But who's going to pay for the community work?"

It is a concern that resonates with Sarah Burns, head of communities at Croydon Voluntary Action. A recently established social prescribing service operating across the borough from a local medical centre is underpinned and supported by community building work from CVA. "Without that, it would be set up to fail", Burns says. But there is no direct funding to support that work. Instead, CVA dips into other existing pots of money designed for health work, including £45,000 from the clinical commissioning group. Burns is grateful for supportive relationships with health colleagues, but also frustrated that what she sees as fundamental street-level community development work has to operate on a shoestring from existing resources.

Familiar picture

Mike Wild, chief executive of Macc, Manchester's local voluntary and community sector support organisation, recognises a familiar picture of public services being funded and third sector not. "One problem is that when you try to sell the social prescribing concept to GPs, they get it and they think they've struck oil," he says. "They think there's loads of free stuff and if they dig around they can save themselves a fortune."

Social prescribing services are not set up with the intention of benefiting the third sector. In the Rotherham pilot, the benefits were a spin-off, not part of its focus. They included enabling small organisations without track records in health service provision to access NHS funding for the first time. Some third sector providers found matched income from other sources, "to enhance their provision and improve the overall sustainability of their organisation", says the evaluation.

People naturally form part of that sustainability. Wheatley can point to a "huge" number of examples of users becoming volunteers. Simon Sherbersky agrees. He cites the example of a former chef, living in isolation and lacking in confidence, who plans to run breakfast training sessions with young people at a local foyer. "Someone who was dependent and isolated is now giving their skills to others," Sherbersky says.

Wheatley seems perplexed by the lack of funding across the country: "I know money is tight, but in terms of NHS resources this is not a vast amount of money." She fears that models that don't support the voluntary and community sector might hinder rather than help its sustainability: "The last thing you want to do is send the sector loads of extra referrals when they just haven't got the resources to cover it."

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