National Academy for Social Prescribing

Local Trust trusting local people

Sheffield Hallam University Knowledge Applied | Centre for Regional Economic and Social Research

COMMUNITY-LED SOCIAL PRESCRIBING

Lessons from Big Local and Beyond

Ellie Munro and Chris Dayson

January 2025

Local Trust was established in 2012 to deliver Big Local, a National Lottery Community Fund-funded programme which committed over £1m each to 150 neighbourhoods across England. The £217m originally provided by The National Lottery Community Fund to support this programme is the largest single-purpose Lottery-funded endowment ever made, and the biggest ever investment by a non-state funder in place-based, resident-led change.

The National Academy for Social Prescribing (NASP) was established as a charity in 2019 to champion social prescribing. Our work focuses on connecting different stakeholders across the social prescribing system; creating innovative partnerships, from local to international; boosting investment for frontline organisations delivering social prescribing; building the evidence base, working with academics and experts around the world; and raising the profile of social prescribing through national campaigns.

The **Centre for Regional Economic and Social Research** (CRESR) at Sheffield Hallam University is one of leading applied policy research and evaluation centres in the UK. For over thirty years we have undertaken critical, theoretical and empirical research into key regional, social and economic policy developments within the UK and internationally, influencing policy design. We have been a leading centre for social prescribing research since 2014 and our research has informed the development and roll-out of social prescribing policy in the UK and around the world.

Acknowledgements

We would like to thank all the participants from Big Local areas, primary care networks and GP federations, community projects, local authorities and health systems for their contributions to this research. We would also like to thank Cathy Harris from CRESR, Ruby Brooks from Local Trust, and Joelle Bradly, Olivia Engle and Anthea Terry of NASP, for their support with the research.

How to Cite this Report

Munro, E and Dayson, C. (2025) Community-led Social Prescribing, Lessons from Big Local and Beyond. *National Academy for Social Prescribing*.

Contents

Executive Summary

This research explored the potential for greater community involvement in and leadership of social prescribing in England based on evidence from 20 different communities, including 12 Big Local areas[1]. To frame the research the following working definition was developed:

> "Community involvement in and/or leadership of social prescribing is where residents have been able to influence and/or take a lead in the design, delivery and evaluation of local social prescribing programmes, based on residents' needs and identified solutions."

The research was not intended to develop a new social prescribing model. Rather, it was grounded in the argument that social prescribing was originally intended as a bottom-up community-based approach to health creation but that this has been lost in many places following the implementation of the NHS-led social prescribing link worker (SPLW) model. In this model SPLWs take referrals from health professionals and hold a 'what matters to you' conversation to understand an individual's needs and preferences before making an onward referral to relevant activities and services, often provided by community organisations.

The current NHS model does not provide funding for the community end of the referral and link workers are not incentivised to engage in community development. However, the findings presented in this report make it very clear that **sustainable investment in community assets and community development are a prerequisite for long-term community leadership of social prescribing** and the establishment of viable community-level social prescribing systems.

The main findings and recommendations from the research are summarised below.

A. Current practice in community-led social prescribing

> "A lot [of the work of the Big Local partnership] was informal social prescribing. We partnered with the GP practice so they could refer into those type of things. Because before people [thought it was] just a coffee session, just an activity, just a walk. And we realised it's not just a walk; it's good for physical and mental health. It's good for supporting people with social isolation." (Big Local partnership member and former worker)

1 The Big Local programme provided grants of just over £1 million to 150 hyper-local areas across England over 10-15 years. Funding was non-prescriptive, and local residents made the decisions on how to spend the money to achieve lasting change for their areas. Most Big Local areas have a population of between 3,000 and 8,000 people, in a mix of urban, rural and coastal communities.

Community organisations described being involved in a wide range of different activities falling under the umbrella of social prescribing. There was a broad spectrum of activity with different forms and degrees of leadership and involvement. Examples included link workers based in community venues; setting-up activities in collaboration with link workers for people to be prescribed into; groups 'selling' their activities and services into GP surgeries to establish referrals; and community organisations developing their own social prescribing-style support projects. In general, we found that activities fell across two related spectrums of activity associated with leadership and involvement, as set out in table 1.

Matrix of community leadership of and involvement in social prescribing

	Level of involvement (operational to strategic)	
Level of leadership (low to high)	• Operational level of involvement • High leadership	• Strategic level of involvement • High leadership
	• Operational level of involvement • Low leadership	• Strategic level of involvement • Low leadership

B. Benefits and risks of community involvement and leadership

By talking to community organisations involved in social prescribing systems and their partners we were able to identify some potential benefits and risks of greater community involvement and leadership in those systems, as summarised in table 2.

Perceived benefits of and risks to greater community involvement and leadership in social prescribing systems.

Benefits	**Risks**
Community knowledge, connection and ownership	Lack of meaningful representation at neighbourhood level
Drawing focus to the role of community groups	Underinvestment in both services and communities

The benefits of greater community involvement in or leadership of social prescribing stem from bringing small community organisations closer to health services. A community-centred approach to social prescribing will provide the health system with greater access to community knowledge, promote social connection and enable greater ownership of the factors known to be important for health creation and positive wellbeing. But there are also risks inherent in greater community involvement in social prescribing, particularly for organisations which are closest to communities but have least power to influence change. Risks include whether there can be meaningful

representation at a neighbourhood level, safety and appropriateness of referrals, rationing of resources linked to specific health needs and conditions, and whether there should be expectations of greater involvement without addressing long-term underinvestment in community activities that support the social determinants of health.

> "I think people still think you can get something for nothing with communities, which I don't think is fair… But I think community delivering with support, activities that are needed locally, is a great idea and I think it is also a way that you will get those volunteers of tomorrow through the door in some way, shape or form." (Big Local partnership member)

C. Enablers of greater community leadership and involvement

Overall, Big Local partnerships and other community organisations have had mixed experiences when trying to engage in social prescribing systems, services and processes. The research identified some of the main enabling factors associated with these experiences. Key amongst these were:

- **Building quality relationships and local knowledge over time:** good relationships, particularly between link workers and community groups, were seen as the cornerstone of effective social prescribing. Building good links with local community groups can help link workers understand which types of support are most appropriate. This extends beyond knowing what groups exist, to trusting which ones an individual with specific needs would feel 'safe' to attend.
- **A shared language and commitment across the social prescribing system:** successful examples of community involvement in socially prescribing were typically underpinned by regular exchanges of information between community organisations and link workers. This enables a shared understanding of what community organisations could offer in support of social prescribing and what they should expect from a social prescribing referral. However, this process requires an investment of time and trust on both sides.
- **Strategic partnerships:** we identified examples of community organisations developing partnerships with other organisations to support community-level social prescribing. These included consortia with other community organisations through which to engage the wider health system and investing in community buildings in which social prescribing activities could take place.
- **Long term, flexible funding to aid sustainability:** uncertainty about funding made it difficult for community organisations to plan their involvement in social prescribing. Small but regular amounts of funding for community groups, alongside core funding for the organisations providing them with support and resources, were vital for removing barriers and sustaining long term engagement with link workers and the wider health system.

- **Working safely with communities:** community organisations raised concerns about the appropriateness of some social prescribing referrals. It is important to ensure that the activities people are referred to are appropriate for people with very complicated lives and that workers and volunteers are supported to meet people's needs with compassion whilst also necessary safeguarding procedures are in place.
- **Capacity and demand:** community organisations highlighted the risk of over-prescribing into some groups. Some activities have limited capacity and are unable to cope with the numbers of individuals being sent their way without additional investment in staff or volunteer time. Link worker capacity was also a concern as many had limited time in which to engage with the community, manage their case load, and spend time working with individuals who needed more intense support.

D. Recommendations

Social prescribing could play a key role in supporting the NHS to realise its ambition to be more preventative and locate more support within communities. To achieve this, however, there is a need to re-align social prescribing more closely with community needs and assets via the following four steps.

Step 1: *Prioritise the building of relationships at a community level* between health professionals, link workers and community organisations so that they have a deep understanding of each other's roles.

Step 2: *Focus on establishing trust* between residents, community organisations and key parts of the health system. This will take time, honest conversations, and a willingness to address power imbalances. Recognition that community involvement in social prescribing requires additional investment will be a key part of this process.

Step 3: *Develop formal ways of working* between health professionals, link workers and community organisations based on co-designed referral pathways, information sharing and feedback loops and effective governance. This will enable collaboration to become embedded at an institutional level and reduce reliance on individual relationships.

Step 4: *Invest sustainably* in community assets and community development, recognising that the current NHS social prescribing model has not paid sufficient attention to the community end of the referral process. Developing shared investment approaches, that include partners beyond the health system, could be a key factor in unlocking greater investment.

Implementing these steps will require action and all levels of the health system. **Nationally,** stronger guidance is needed to emphasise the need for greater community involvement and investment if social prescribing is to be implemented effectively. **Regionally,** Integrated Care Partnerships should ensure that community infrastructure is resourced effectively and sustainability as part of strategies to address health inequalities and the social determinants of health. **Locally,** PCNs and GPs must recognise that it is their interests, and the interests of their patients, to promote community development through link workers and other allied roles within their practices.

1. Introduction

This is the final report from a year-long research project exploring the potential for **greater community involvement in and leadership of social prescribing** in England. The research was commissioned by **Local Trust** and conducted by the **Centre for Regional Economic and Social Research** (CRESR) at Sheffield Hallam University and the **National Academy for Social Prescribing** (NASP). It focussed on three questions:

- What is 'community-led social prescribing' and how does it differ from other approaches to social prescribing?
- What are the barriers and enablers of community involvement in social prescribing?
- What are the benefits of community involvement in social prescribing, from the perspective of different stakeholders?

The report draws on a range of data including:

- A literature review.
- Interviews with representatives from 12 Big Local areas with some experience of engaging with social prescribing.
- Interviews in six areas that were not part of Big Local but had their own experiences of community involvement in social prescribing.
- Interviews with six stakeholders from the public and voluntary, community and social enterprise sectors (VCSE) with broader system level knowledge of social prescribing.
- Three area-level workshops to explore experiences in more detail.

What do we mean by community-led social prescribing?

To frame the research, the research team reviewed a range of literature to propose a working definition of community-led social prescribing. As the project developed, we broadened the scope and framing of the research to consider community involvement in social prescribing, alongside leadership, in order to encompass a broader range of activities and roles. Our working definition is therefore as follows:

> "Community involvement in and/or leadership of social prescribing is where residents have been able to influence and/or take a lead in the design, delivery and evaluation of local social prescribing programmes, based on residents' needs and identified solutions."

This definition is intended to be a starting point rather than an end point. It is intended to aid discussion amongst and between policy makers, practitioners and researchers interested in progressing this agenda over the next few years.

Structure of the report

The remainder of the report is structured as follows:[2]

- Chapter 2 provides the **context for community involvement in and leadership of social prescribing**, drawing on the findings from the literature review and discussion of the English policy context in which social prescribing is being implemented.
- Chapter 3 presents findings about **what is happening already in relation to community involvement in and leadership of social prescribing** based on evidence from Big Local areas and other parts of England.
- Chapter 4 presents findings about **the benefits and risks** of greater community leadership of and involvement in social prescribing, perceived by those we interviewed.
- Chapter 5 **identifies some of the key enablers** of greater community involvement in and leadership of social prescribing based on the experiences of community representatives in Big Local areas and other parts of England.
- Chapter 6 is the conclusion. It discusses the **main findings from the research and provides recommendations for ensuring greater community involvement in and leadership of social prescribing** through community-level social prescribing systems.

2 Three appendices to the report are also provided. Appendix 1 provides more detail about the methodology for the research. Appendix 2 presents the findings of the literature review conducted at the beginning of the project. Appendix 3 is a list of references for the main report and literature review.

2. What is social prescribing and what are the drivers for greater community involvement and leadership?

This chapter discusses the background and context for the research drawing on a literature review and some broader reflections based on more recent policy developments. It discusses what social prescribing is and highlights some of the main drivers for greater community involvement in and leadership of social prescribing.

What is social prescribing?

The term social prescribing is used to describe various systems, processes and pathways which enable professionals and practitioners within health and social care settings to connect people with non-medical support, typically at a community or neighbourhood level. Although social prescribing has its origins at a community-level in the UK it is now a global phenomenon (NASP, 2024). A recent paper established an internationally accepted definition of social prescribing:[3]

> "A means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to improve health and well-being and to strengthen community connections (Muhl et al., 2023, p. 9)."

How does social prescribing currently operate in England?

In England, a universal model of social prescribing has been embedded within primary care since 2019. Prior to this social prescribing was typically delivered at the local level by community organisations working with GPs to connect local people to community activities. This 'bottom-up', small-scale social prescribing received some public funding but was not part of statutory services. Since the early 2010s, social prescribing has been increasingly 'top-down' with services commissioned by the public sector (Dayson, 2017).

Most social prescribing involves a link worker funded by NHS England via the Additional Roles Reimbursement Scheme (ARRS). The social prescribing link worker (SPLW) takes referrals from health and care professionals—usually the GP—and holds a 'what matters to you' conversation to understand the individual's needs and preferences. The SPLW then makes an onward referral to relevant activities and services, typically provided by the VCSE sector, including community organisations.

3 The Delphi method is a way to generate consensus on concepts by bringing together a group of experts to discuss and refine key ideas over several rounds of discussion and evaluation.

Referral activities tend to fall into four broad categories: creative activities linked to art, culture or heritage; physical activities; activities in nature; or information, advice and guidance in relation to financial issues. Practical examples of social prescribing referrals include helping someone who is isolated join an art class or a community gardening project; connecting someone with financial problems to a debt management service; supporting someone with dementia to join a specialist choir; or helping someone with high blood pressure to take up a community exercise class. In these final two examples a social prescribing referral is serving a dual purpose by addressing a social need through an activity that may also lead to secondary clinical benefits.

Link workers can be employed directly by Primary Care Networks (PCNs); or this can be contracted out to local VCSEs. In many areas of England NHS funded link workers are supplemented by additional social prescribing initiatives funded by local NHS commissioners, local authorities or grant funders. In some areas different social prescribing initiatives operate alongside each other, including within the same VCSE organisations; in other areas levels of collaboration vary.

What are the drivers for greater community involvement in and leadership of social prescribing?

Despite the community-level origins of social prescribing, the role of communities in its development and implementation has been largely overlooked recently in terms of practice, policy and research. Notable exceptions include Bromley-by-Bow and South Southwark in London, which have incorporated community development activity into the link worker role (Hopewell, 2017; Peer Learning for London, 2022) and Rotherham, where a collaborative model of service development involving local people, commissioners and VCSE providers has been in place since 2013 (Dayson, 2017). More recently, a model of community-enhanced social prescribing (CESP) has been developed and piloted in Manchester, which seeks to embed community engagement, in the development of social prescribing (Morris et al., 2022). What unites these approaches is an acknowledgement that to be successful social prescribing schemes engage more deeply with local communities. Although social prescribing is often still described as 'community-based', its current focus on empowering individuals to identify their own needs and find solutions means the question of how communities are empowered to do the same is too frequently overlooked.

The links between positive health and wellbeing outcomes and involvement in community development are long-established, as are the links between negative health and wellbeing outcomes and inequality and powerlessness (Rosenthal, 1983; South et al., 2015; Wallerstein, 1993). The 2010 Marmot Review identified individual and community empowerment as central to the reduction of health inequalities, emphasising that this may involve 'removing structural barriers to participation, for others facilitating and developing capacity and capability through personal and community development' (Marmot et al., 2010, p. 34). Community development is far from embedded in health systems, however. Although NHS England (2022) has issued guidance around 'proactive social prescribing', framed as a community development approach to improve access to

services for those with unmet needs, very little information is provided about how this could work in practice.

The importance of (re) locating healthcare closer to communities is a key theme in the recent 'Darzi Report', the new Labour government's rapid investigation into the state of the NHS (Darzi, 2024). In his report Lord Darzi argues high quality community services are essential to create a sustainable NHS but highlights how, currently, too great a share of the NHS is being spent in hospitals, and too little in the community. He goes on to directly link underinvestment in the community to growing waits for hospital care and is critical of previous administrations for failing to deliver on promises to shift care away from hospitals and into the community. Although Darzi falls short of advocating for further investment in social prescribing as part of this shift towards communities, the report provides a clear rationale for why a more community-focussed model of social prescribing could play a key role in the future of the NHS.

A working definition of community-led social prescribing

Based on the evidence discussed above, we proposed a working definition of community-led social prescribing to take forward into the research fieldwork.

> "Community-led social prescribing describes social prescribing activities, systems or processes that have been initiated by the local community, often involving other local partners, and based on community-identified needs and solutions."

This was intended to be an 'ideal type' that captured the range of community leadership that the literature suggested we might expect to see. However, as the project developed we broadened the scope and framing of the research to consider community involvement in social prescribing, alongside leadership, to encompass a broader range of activities and roles. As a result, our working definition was adjusted as follows:

> "Community involvement in and/or leadership of social prescribing is where residents have been able to influence and/or take a lead in the design, delivery and evaluation of local social prescribing programmes, based on residents' needs and identified solutions."

While this does not describe the same kind of wholly community-directed activity that initially framed the research, it does not exclude that. At the same time, it better captures the range of leadership and involvement taking place. It also puts more emphasis on communities and residents in the context of other partners and parts of the system – working together rather than necessarily driving activities.

3. Community-led social prescribing: current practice in Big Local and beyond

Big Local partnership members and workers, those from non-Big Local voluntary and community groups, and link workers told us about a wide range of different activities falling under the umbrella of social prescribing. What we found was a broad spectrum of community involvement and activity with different forms and degrees of community leadership. For instance, examples ranged from link workers based in and working closely with the community; setting-up activities and groups in collaboration with link workers for people to be prescribed into; groups 'selling' their activities and services into GP surgeries to establish referrals; and community organisations developing their own social prescribing-style support projects.

Social prescribing in Big Local areas

Social prescribing in Big Local areas and elsewhere exhibits different degrees of community leadership, and leadership occurs at different points of social prescribing services (e.g. provision of activities, partnerships with link workers, strategic-level involvement and more). It is by no means a given that social prescribing in Big Local areas is community-led, even where the Big Local partnership has had close involvement with social prescribing activities.

When we talked to Big Local areas, we found their activities fell across two related spectrums of activity that helped to describe both the level and type of involvement and the degree of leadership. We can locate examples on a matrix using these two axes shown in table 1:

Table 1: Matrix of community leadership of and involvement in social prescribing

	Level of involvement (operational to strategic)	
Level of leadership (low to high)	• Operational level of involvement • High leadership	• Strategic level of involvement • High leadership
	• Operational level of involvement • Low leadership	• Strategic level of involvement • Low leadership

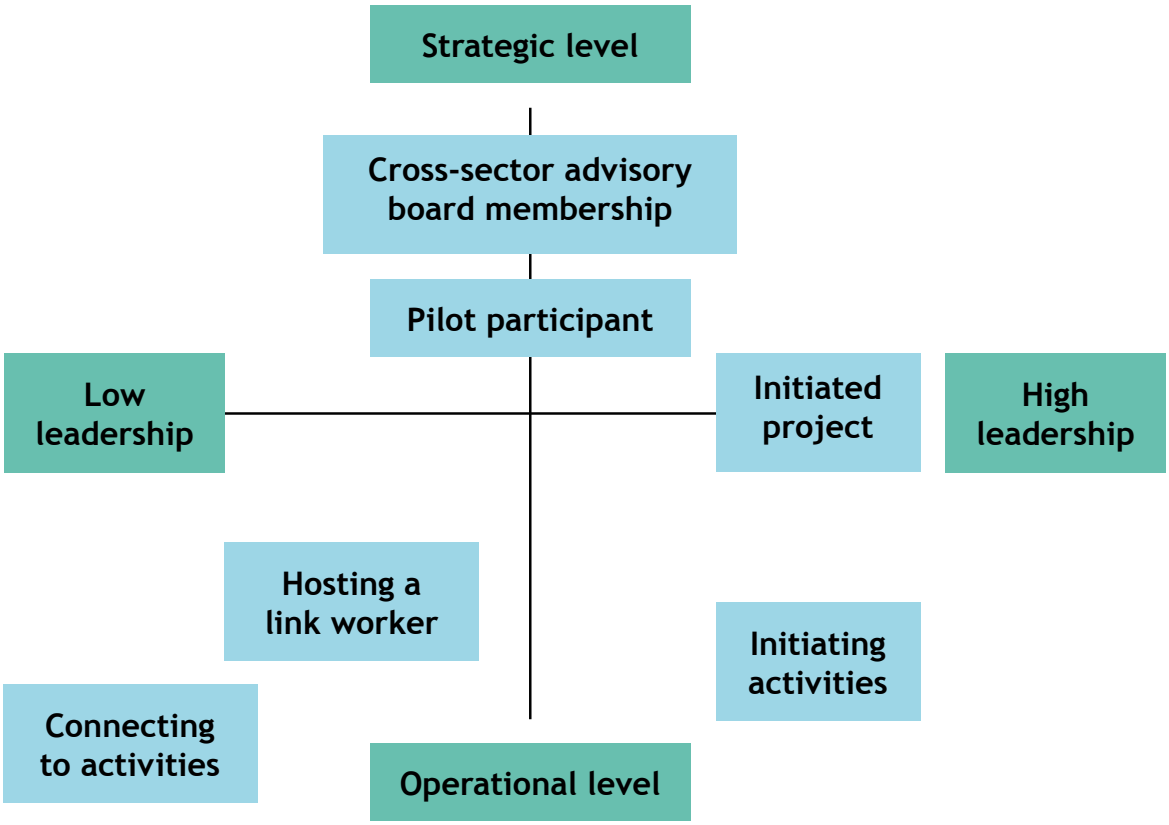
- **Level of involvement:** this is on a spectrum from strategic to operational. This includes, at one end, taking a key role in the design of social prescribing schemes, and at the other activities for implementing social prescribing such as grant-funding activity groups
- **Degree of leadership:** At one end, high leadership, meaning where a Big Local partnership has taken a more active role in leading social prescribing locally. At the other end, low leadership, meaning where Big Local areas have taken a more passive role.

It is not the case that higher or lower degrees of leadership for specific activities mean a partnership is more or less capable of taking on leadership roles, or that the quality or importance of work is of greater or lesser significance. In all of the Big Local areas we spoke to, partnerships were engaged in a range of activities, taking on different degrees of leadership with each one. Equally, for some of these activities there was no need for Big Local partnerships to take on a leadership role any greater than they already had. This work is only one element of the range of community projects and programmes Big Local areas engage in, rather than their sole or even main focus, so decisions about overall capacity and priority also play a part.

Some Big Local areas demonstrated higher levels of leadership at the operational level of social prescribing systems, including where residents had set up and grown new groups and activities to meet an identified need, and had specifically related these to health services, receiving referrals from different statutory agencies. This contrasts with the lower degree of leadership at the operational level where Big Local partnerships have funded and supported new or pre-existing activities, but not been involved beyond that, or not actively aligned these as central to social prescribing programmes.

The diagram below shows some of the different types of activities we found mapped across the two axes. This illustrates how activities can sit along a spectrum between performing strategic roles (such as setting up and running pilots, selling programmes into local health services, sitting on steering groups, etc.) and operational ones (running, funding or hosting local groups and activities such as crafts, outdoor pursuits etc., or hosting link workers within community centres by providing office or consultation space). Big Local partnerships in turn exhibited different degrees of leadership when undertaking these activities: offering space to a craft group, for instance, involves a lower degree of leadership whereas identifying a need from residents and setting up a new activity group to meet that need might show a higher degree of leadership. All of these activities play important roles in Big Local areas and in social prescribing.

Figure 1. Examples of types of Big Local involvement in social prescribing by level of involvement and degree of leadership



Examples of practice from Big Local areas

- **Low leadership: operational level**

Examples in this area include where a Big Local partnership provides office space to a local link worker; offers signposting or other advice to link workers; and offering meeting rooms and activity spaces to local groups which then received referrals from local link workers.

While this work does not involve Big Local residents or partnerships taking on roles in leading social prescribing, the activities and the support provided to both community groups and link workers can be vital to successful social prescribing programmes, as without them there might be less connection to a local area, and less to prescribe into.

> "I think as part of the Big Local we're connected with a lot of other local community hubs – there's that strength of being a part of something bigger that you're not just one group that's doing one thing. You can also signpost people to other things, there's that link up work and I think that's been the strength of the social prescribing thing." (Big Local partnership member)

Big Local partnerships have played important roles in helping to fund and support local groups and activities, including direct grants and in-kind financial support such as free venue hire. Community venues run by some of the Big Local areas we spoke to play host to food banks, warm space groups, games clubs, sporting and fitness activities, Men's Sheds and similar craft-based groups, and more. Big Local partnerships also supported groups to get started including by helping them get appropriate policies and procedures in place, where necessary.

A number of Big Local partnership members and workers told us they or the groups they supported would receive referrals from social prescribing link workers, but that was the extent of their engagement and experience with health and/or local authority-run social prescribing programmes. In some cases this resulted in capacity issues and safeguarding concerns, which are discussed in more detail in sections 4 and 5 on barriers and risks.

- **High leadership: operational level**

Some Big Local partnerships took a more active leadership role in trying to establish partnerships with local social prescribing programmes that went beyond simple signposting, including setting up and running their own activities or programme of activities to support local residents to meet their health and wellbeing needs, with clear links to social prescribing.

> "A lot [of the work of the Big Local partnership] was informal social prescribing. We partnered with the GP practice so they could refer into those type of things. Because before people [thought it was] just a coffee session, just an activity, just a walk. And we realised it's not just a walk; it's good for physical and mental health. It's good for supporting people with social isolation." (Big Local partnership member and former worker)

One example came from a successful community shed, inspired by the Men's Shed model,[4] which had successfully made links with local social prescribing schemes and received referrals through those. Another began when a local resident and Big Local partnership member recognised the benefits of outdoor activities to their own mental and physical health, including reducing dependence on medical interventions, and decided to share this with others. They trained new volunteers to lead their own walks, to enable the growth, spread and sustainability of the project. Referrals are received from mental health services and the local Police and Crime Commissioner team, which also provides some funding, and the project is advertised via local GP surgeries. While there is no mention of link workers, 'trusted individuals' (Muhl et al., 2023) are making referrals to the activity based upon identified need and people are often accompanied by friends or family members when first attending walks.

4 Men's Sheds (or Sheds) are places where people can come together to enjoy practical interests and develop skills, alongside building social connections and relationships between members. Men's Sheds Association (2024). What is a Men's Shed? Available: *https://menssheds.org.uk/* (accessed 08/11/24).

> "They just open up, and I just let them talk and offload it, because half the time that's all they need to do, offload something." (Big Local resident and partnership member)

There were also examples of programmes of work that Big Local partnerships framed as social prescribing, and that strongly resembled the definition of social prescribing referenced above, but that operated independently of statutory-led social prescribing programmes. This was not necessarily by choice, but rather because they had been unable to undertake more strategic-level activity and/or successfully build links with health systems and other partners, for a range of reasons.

> "[After facing barriers in building working links with GP surgeries and others] we went back to square one and we just really just started speaking to the community about things they would like, and rather than just offering them a grant to set things up by themselves we took more of an approach whereby the people would come forward, and then my worker would work with those individuals that seemed to be keen on a bit of more of a leadership role, and worked with them to get them DBS checked and their First Aid Certificate and all of that kind of thing and did it that way. And then just looped that information back through to the social prescribers who did then prescribe into it." (Big Local partnership member)

Big Local case study 1, from a Big Local area across two estates in Wolverhampton, illustrates both some of the quality of work and holistic whole-family approach to health and wellbeing that is possible, and some of the challenges related to partnership building with both public and voluntary sector bodies. It is very much led by local residents, supported by local groups, providing direct support through activities and practical help.

- **Medium leadership: strategic level**

Big Local partnerships are engaging in strategic-level activities around social prescribing. Although some, for instance, might participate in strategic partnership boards locally, we have only attributed a medium or mixed level of leadership to these activities, as these generally seem to be forums for sharing ideas and learning rather than taking leadership roles in influencing programmes. We did not find any examples of Big Local areas campaigning for better local provision or services specifically around social prescribing systems, or of influencing the nature and form of a local social prescribing programme.

Big Local Case study 1: The Scotlands and Bushbury Hill

The Scotlands and Bushbury Hill are two areas in the north-east part of Wolverhampton, with around 1,000 households in each. Big Local activities - including a community shop and cafe, cooking classes, and arts activities - happen across two community centres and are supported by two community workers, local groups and volunteers (Community Action and Training Services, 2013; Marsden, 2022; The Big Venture Centre Ltd., 2024).

Workers and volunteers at the Big Venture centre on the Scotlands estate said they had been doing social prescribing "since day dot" – since before they knew what the phrase meant. Support provided at the centre focuses on the whole family, and the root causes of issues they face. The community café within the centre is a place for local residents to come and talk about their problems and seek support to overcome them.

Workers at the centre realised that families were coming with often multiple, complex needs, and so through a project called Breaking the Cycle began working with the family as a whole unit, exploring the root causes of issues, rather than the symptoms, and helping parents and children to get the best support through projects and activities in and around their two community centres. As well as signposting people onto groups run by local volunteers, workers can signpost them to counselling, benefits support, housing support, or help them to access GP and other health services. The centre receives referrals from the local council, GP surgeries, local family hubs or through self-referral. Some of those who sought support with complex needs were then helped to undertake different kinds of training, and became volunteers themselves, supporting other local individuals and families in crisis.

Another local voluntary organisation holds the social prescribing contract for the city. However, while link workers send referrals their way, residents state that there is no grant funding for their local groups passed down as part of that contract. Partnership members are frustrated by this, as they feel both that they provide a valuable service that needs funding, and that they have expertise to offer. Demand has increased substantially as the project's reputation has grown, raising serious questions about capacity and sustainability. The Big Local partnership helped to form the WV10 consortium of local community organisations to try lever in funding for community-led organisations which might otherwise lose out on funding to larger organisations. One WV10 member explained their vision for a cyclical system whereby social prescribing is based on needs analysis, which then informs a collaborative approach to statutory instruments like local area plans, supporting bidding for targeted projects, meeting identified outcomes, finally influencing prescribing practice in turn. However, participants were clear that such work could only be achieved with sustained funding for both activities and core costs.

However, we found one example of a Big Local partnership offering its endorsement to a pilot social prescribing project and sitting on its advisory board, and a second that felt its seat on a local strategic group gave it an opportunity to highlight local issues to decision-makers.

> "We have more of a voice, it's quite a good way to develop a close relationship with PCN leaders and you can go back and say well these are the issues that we've got going on. So it does create a dialogue I think between different groups, providers, statutory and voluntary sector providers." (Big Local worker)

There were other examples of Big Local partnerships having representation on various local strategic boards that had a broader remit than social prescribing and building good relationships with public bodies. However, overall, this activity was limited. This is perhaps unsurprising as such partnerships tend to work at the scale of local authority, PCN or ICB, while Big Local areas cover a much smaller area. Nevertheless, given that Big Local areas are often areas of high deprivation and lack of previous engagement within those larger system footprints, there is potential benefit to statutory systems in working with them, enabling their representation and in turn sharing in their local knowledge and experience.

- **High leadership: strategic and operational levels**

These examples demonstrated higher degrees of leadership with activities at an operational level, such as running health and wellbeing-related groups; and at strategic level, such as building partnerships with parts of the health system. In these examples, partnerships played a key role in initiating and leading social prescribing work directly alongside or in partnership with public services than the examples mentioned under *high leadership: operational level*.

In some cases, however, initiated projects did not succeed. We heard from two areas that had tried to initiate social prescribing projects but had struggled to make them work. In the first case, the partnership had employed their own link worker to work with other local link workers to embed a community development approach. However, they were unable to secure commitments to share data about needs. The second area saw that nearby local councils were setting up social prescribing pilots, saw the value of the work, and attempted to set up their own with two local parish councils. However, the partnership broke down and subsequent social prescribing programmes missed out on the potential for involving residents directly, and the benefits of community development approaches. One successful example, however, involved a Big Local partnership in Bolton recognising the potential health and wellbeing benefits of activities going on in their community centre, and 'selling' these groups into a local GP's surgery to create a clear pathway for social prescriptions. Big Local Case Study 2 explores this in more detail.

Big Local Case Study 2: Tonge with the Haulgh Big Local

Tonge with the Haulgh Big Local started in 2012. It is in an area of East Bolton, covering communities including Tonge Moor, Tonge Fold and the Haulgh, with a population of roughly 13,000.

During a community consultation exercise in 2015, the Big Local partnership identified a need locally for more women-only wellbeing and creative spaces. The partnership commissioned an existing local community organisation to develop a women-only arts group centred around chronic health conditions. The Big Local community development officer at the time recognised it could be part of a social prescribing style-system and approached a local health centre with a proposal to establish it as a group into which local residents could be prescribed.

Thanks to a single, proactive and interested GP, the group was adopted by the health centre and met there for some time. The GP wrote to their patients who might benefit from the group to encourage them to attend. It was perceived that this brought a sense of legitimacy to the activity, as it came from an official source rather than "just coming from a community group" (workshop participant). Then, the GP was able to produce information tracking some of the participants, demonstrating a reduction in pain medication requests during the period they had been attending the group. This convinced a second health centre to host a second group.

The COVID-19 pandemic necessitated first a move to meeting online, and then a move to the local St Chad's Church and Community Hall, bringing the two groups together into one, and co-locating it with other local groups including a local Men's Shed, luncheon club and more. This potentially posed a challenge, as some women required a women-only space due to previous experiences, but in fact the arts group and Men's Shed were able to build a positive relationship prioritising safety and respect. At this time, the group also needed new leadership. A woman with a chronic health condition who had originally been prescribed into the group then took over the leadership of it. She described how being told about the group and going along helped her to get out of the house, socialise and get back involved in life after a car accident where she acquired the long-term health condition. Another woman who received the kind of letter from her GP described above told us how the arts group had led her to discover a brand-new arts-based hobby which had made her feel good but also brought her success, as she was soon to have an exhibition of her work in Bolton.

Local link workers stressed the difference the Big Local partnership vice chair, members and workers made to them and their work. They had visited St Chad's early in their roles, met people involved in the partnership and some of the groups they supported, been made to feel welcome and thus felt confident that people they prescribed there would feel welcome too. They and others highlighted the importance of good communication between social prescribers and community

groups, co-design and collaboration, and of gathering stories of success (and where interventions have been less successful) as evidence to inform more work.

Some of the challenges for link workers and those involved in community work included knowing what was out there, local transport to help people get to groups, having enough volunteers to run groups and sustain work into the future, and being able to convince others of the benefits of the social prescribing approach. Link workers, who worked beyond just the boundaries of the Big Local area, relied on community notice boards as well as community venues and word of mouth to find out what was going on locally. There were plans locally for both online and paper-based maps of groups and activities being developed by community workers, both for residents and professionals such as link workers, which could help improve local knowledge. In terms of getting buy-in, this project demonstrates the value of having a GP champion locally. However, workshop participants noted that while some surgeries had real advocates for the work, others were not engaged with the service. Some felt this was at least in part due to high workloads all clinicians faced.

The relationships, connections and trust built between the Big Local partnership, the local community groups it supported, the volunteers who run them, link workers and other health professionals, and residents was what made this example successful. There were some concerns about sustainability and future funding, as well as the capacity of volunteers, once Tonge with the Haulgh Big Local comes to an end. There were also clear future plans, including working with the local council as part of a community alliances programme, which may help to grow this work further.

Perspectives from outside Big Local

Examples from non-Big Local voluntary and community organisations

There was a mix of experiences and perspectives from community groups outside of the Big Local programme, with some organisations finding more success, and in some cases being commissioned to deliver social prescribing programmes; and others struggling to engage with social prescribing systems. Those who had well-established projects nevertheless faced challenges.

Several examples had been set up outside of formal social prescribing programmes, but still identified with the concepts of social prescribing and framed their work in terms of health and wellbeing. Examples included projects with a specific focus on financial health, working with older people from marginalised backgrounds, and a heritage-based social prescribing project taking a participatory approach to its work. For instance, one project worked with older people from marginalised backgrounds, in neighbourhoods with high levels of deprivation and significant ethnic minority populations. During

the COVID-19 pandemic lockdowns, the project had pivoted to running its health and wellbeing sessions online, via Zoom and supported by a WhatsApp group, attracting a large audience from a – first local and then global – South Asian background. The project leaders described a need to help more marginalised people 'connect to themselves' - feel confident, safe and secure in themselves - before being able to support them to attend groups and activities on a regular basis. We heard something similar from Big Local interviewees and link workers, and this will be discussed in more detail in the section on barriers and enablers.

One particularly strong example of community leadership in social prescribing comes from Sheffield, where PCN-commissioned[5] social prescribing programmes in some parts of the city operate alongside and in partnership with pre-existing models of community referral. The latter was made possible by grant investment from the local authority into community/neighbourhood anchor organisations across the city. A second case study example comes from Leeds, where long-term funding has enabled voluntary organisations and community groups to work across the city in neighbourhood networks to support the health and wellbeing of older people.

Non-Big Local Case study 1: community partnerships key to social prescribing in Sheffield

The city of Sheffield, part of the NHS South Yorkshire Integrated Care Board (ICB), has a unique approach to social prescribing based on pre-existing networks of local voluntary and community organisations. In 2015 the local authority established 'People Keeping Well in their Community (PKWC)' as a community-based approach to prevention that uses a social prescribing model to help to prevent and delay people needing to access health and social care services.

PKWC involves up to 17 community partnerships led by local voluntary and community organisations who receive funding from Sheffield City Council to receive referrals of individuals at risk of declining health and wellbeing and support them to access appropriate activities or services in their community. Referrals can be made by a GP, other professional, family member, friend, or through self-referral and lead to a 'what matters to you' conversation with a link worker. Common activities referred to include social cafes; community exercise sessions; housing, debt or benefits advice; health trainers; condition specific support groups; and volunteering opportunities.

5 Primary care network (PCN)

When the NHS Link Worker model was rolled-out in 2019, and primary care networks (PCNs) were able to access funding to employ their own link workers, a number of PCNs sub-contracted the link worker role to their local PKWC provider with whom they had an existing relationship. This enabled NHS link workers to be embedded within existing PKWC teams, benefiting from their existing knowledge of and reach into communities and community-based activities, and helped to build capacity within PKWC community partnerships. A number of the PKWC community partnerships are led by community anchor organisations. For example:

- **Southey and Owlerton Area Regeneration Trust (SOAR)** was established in 2004 through regeneration funding and now provides a range of services designed to improve a person's health, wellbeing and employability. PKWC and PCN funding has enabled them to work in partnership with over 20 GP Surgeries and over 40 Community Partners and employ a team of Social Prescribing Link Workers, Wellbeing Coaches, Welfare Coaches, Employment Coaches, Development Workers. This team works alongside other Community Services and Centres to promote the health and wellbeing of some of the most diverse and economically deprived areas of the city.

- **Darnall Well Being (DWB)** was established over 20 years ago by a local GP who was inspired by the Peckham Experiment, a pioneering model of community and health development in the 1930s-40s. DWB is co-located with GPs and other primary care services in a Primary Care Centre at the heart of the local community. This enables their Social Prescribing Team to work closely with GPs, nurses and other practice staff to receive referrals and support people to engage in a wider range of community-based activities. These include DWB's own community provision, such as the community allotment, and link people to other organisations active in the local community.

Non-Big Local Case study 2: long-term core funding to enable community organisations to support healthy ageing in Leeds

The city of Leeds has a longstanding model – the Leeds Neighbourhood Networks (LNNs) – that demonstrates the value of long-term core funding for community-led organisations involved in supporting older people to age well in place. Although it is not explicitly a social prescribing model there are some important lessons for efforts to increase community leadership or and involvement in social prescribing.

The LNN comprises 37 voluntary organisations working across the whole of Leeds (known as 'Neighbourhood Networks'). Each network works with members and volunteers to deliver a range of activities to improve and promote health and wellbeing, including advice and information, help around the home, healthy living activities, leisure and recreation, transport and general support.

In-depth long-term research into the LNN model identified a number of factors as being particularly significant in determining how and to what extent the LNNs contribute to health outcomes and health system priorities (Dayson et al, 2022). These are described as the five 'mechanisms of change' (five Rs) that ought to resonate with similar organisations and/or commissioners seeking to promote greater community leadership of and involvement in social prescribing.

The first 'R' focuses on what community organisations need to deliver their activities; the subsequent four 'Rs' focus on how community organisations utilise their resources to achieve outcomes. How the five Rs – resources, range, relationships, responsiveness and reassurance – operate to make a significant contribution to health outcomes and health system priorities are outlined in the image below.

Source: Dayson, C., Gilbertson, J., Chambers, J., Ellis-Paine, A., & Kara, H. (2022). *How community organisations contribute to healthy ageing*. Centre for Ageing Better.

Perspectives from the health system

Integrated care systems (ICS) include both local authority and NHS bodies, and individuals within them offer an additional perspective on the role and place of community in social prescribing. At this strategic level, our interviewees expressed a commitment to the principles of involving communities in decision-making, usually via local voluntary or community organisations, but some hesitation regarding how to do this in a meaningful way. These strategic leaders were trying to navigate complex issues of power, recognising the structural institutional imbalance as an operational reality.

> "Ultimately there will always be that power dynamic but how do you wear that power dynamic, how are you gracious in that, how do you enable challenge and decision making of that? Where people talk about shared power or a commissioning body giving away power, fundamentally I work for a political institution that politicians make the decisions, but how do you develop ideas and thoughts together… We can't give away the council's power but how do you do that graciously and in partnership?" (Local authority official)

We also interviewed some link workers employed by or through primary care networks (PCNs). Some of these worked directly for a PCN or GP Federation, while others were subcontracted to work for other organisations such as local charities. Practice varied significantly, often influenced by the scope of the role commissioned by the PCN. For instance, in one area a link worker based in a local library worked to build relationships with both individuals and community groups over a long term, not constrained by a quota number of sessions, and in a way that fostered individuals' leadership skills and interests so they might take on roles in the future beyond attending groups. Another locality-based service working specifically with older people often from an ethnic minority background, set up and run by a voluntary group, was also mindful of fostering volunteers' own leadership and practical skills. The project leader viewed investing in volunteers' leadership skills as something to help with sustainability of the work, so if funding could not be renewed at least some work in the local community could continue.

In another city-based service, the link worker told us the service only funded interventions for individuals, and did not fund community groups or community engagement. The worker was still running their own walking group and had made efforts to respond to community views on local gaps in provision, but it was clearly a much more limited role than other link workers who were embedded in communities, and other systems that also funded voluntary action. Similarly, constraints of the service specification were raised as an issue by commissioned voluntary organisations, and we will discuss this in more detail in the section on barriers and enablers.

Comparing Big Local with other examples

Comparing Big Local and longer-established non-Big Local projects provides some insight into possible future directions for neighbourhood-level groups. One difference between the engagement of voluntary organisations in social prescribing versus Big Local partnerships was the higher degree to which the former engaged with/in formal commissioning processes, and across diverse health stakeholders such as ICBs and PCNs. The work we found in Big Local areas was smaller scale, more likely to be driven by individuals working with their local community and, if funded, funded from their own money (either their Big Local funding or that generated from other community activities like building rental or community shops). The work was less specific to, or segmented by, health conditions and seemed more spontaneous and flexible. In contrast the more established voluntary organisations we spoke to were more likely to talk about commissioning relationships and arrangements with local councils and primary care networks, which funded their social prescribing work, including employing their own social prescribers and establishing medicalised condition-based pathways. This work was more likely to be formally organised according to the commissioning arrangement. In both cases, paid workers were present and important, and there were examples in both Big Local and non-Big Local groups of directly employing link worker-style roles. However, we did not find any examples of Big Local partnerships employing health system-commissioned link workers; they instead designed and funded these roles themselves after recognising the potential for positive impact.

There were, of course, variations on both sides. There were examples of Big Local partnerships which wanted to engage more in health and other statutory systems principally to ensure they were funded for what they did. However, they faced challenges in achieving this including a lack of knowledge about how to navigate such complex systems or how to make their case, or in some cases a lack of interest on the part of the systems. These will be discussed more in the next section. Equally, some of the more established voluntary organisations we spoke to had grant funding that allowed them to engage closely with local neighbourhoods, estates and communities in creative ways that enabled residents to influence their programmes of work outside of a strictly commissioned service. Often it felt like these voluntary organisations were still a step removed from those communities, unlike Big Local partnerships which were very much based within them, but in others they also employed and worked closely with local residents, just with more of an organisational bureaucracy around them.

From the point of view of link workers, both those employed by primary care networks directly and those employed through voluntary organisations, there was significant variation in their ability to engage with the community. Principally their role was described as serving individuals, helping them to find support and activities to meet identified needs, as per the link worker role description. In some areas, this was all the link worker role was funded to do; there was no additional funding in the service to work with communities to understand what was on offer, to support community initiatives or to engage in any kind of community development work in partnership with local groups. In some, the link worker was based in a community building (including Big Local

buildings) and were supported and funded to work directly with community groups. This still tended to be work focused on the individual, as per the service design, but did mean they were able to develop a breadth and depth of knowledge about the local community, groups within it, opportunities and tensions and so on.

Some link workers based in community organisations had established new social groups within those organisations for condition-based pathways (such as diabetes, long-term conditions etc.), which both reflected health priorities in their local areas and were part of the service specification. However, there was limited evidence of link workers being able to engage more in community development approaches. This is not just about service funding, but also about capacity of both workers and individuals: some link workers told us their case load had spiralled to well beyond the initial service design, and that the individuals they were helping had such basic needs, such as safe housing, food and stability, that there was no room for anything else. One example where this work did feature, at least to some extent, was an area where the link worker was not limited to a set number of meetings or interactions with an individual so they were able to build up a long term relationship, see that individual gain confidence in being able to engage in groups in the first place, understand their needs and interests, and support them if they wanted to get more involved in leadership roles, even setting up new groups.

This section has described the kinds of social prescribing projects we encountered, where there was an element of community leadership or strong community involvement. The next section will discuss the perceived benefits and risks of a greater role for communities in social prescribing systems, before turning to what some of the main enabling factors are.

4. Benefits and risks of community involvement and leadership in social prescribing

When talking to those involved in community groups and social prescribing systems, we were able to identify some potential benefits and risks of greater community involvement and leadership in those systems, as summarised in table 1. This section discusses these in more detail and presents the close interplay between them. While each is important, none is a reason by itself for greater or lesser community involvement or leadership. Rather, they are important issues to consider when developing future services.

Table 2: Perceived benefits of and risks to greater community involvement and leadership in social prescribing systems.

Benefits	Risks
Community knowledge, connection and ownership	Lack of meaningful representation at neighbourhood level
Drawing focus to the role of community groups	Underinvestment in both services and communities

Benefit: Community knowledge, connection and ownership

Many interviewees talked about the power of community knowledge – knowing local residents, local issues and local assets. This included knowing what groups were out there but crucially went beyond this (and, indeed, many were clear they did not know all the groups in the community).

> "The local knowledge means that they [project volunteers] actually know a lot of the area. They know the area well. They know the issues within the area. They know things like who they can actually refer to, what projects are going in the area." (Big Local area worker)

Community work can build connections between individuals and groups. Community-led social prescribing can emphasise this element of the work and bring to the fore benefits beyond individuals' health outcomes.

> "We've got a lot of older people who come down to our service. They're traditional people who think they're set in their ways but working with people who are vulnerable, who might have certain conditions, it's almost started talking points and it gives them a feeling that actually they're part of something as well. They're helping people out. They are the community. Someone might be saying, I'm retired now, what am I doing but actually I'm giving back because I'm helping other people, I'm passing on my skills. I'm being involved and it helps." (Big Local resident and partnership member)

Big Local areas told us that people came to them because they trusted them, because their groups and services were more flexible and open than other provision.

> "I think the organisations like NHS and the [national charities] or whoever, [are] perhaps more structured, we kind of just have an open door, people can come for ten minutes." (Big Local resident and partnership member)

These are benefits often associated with voluntary and community action, and so it is expected they would also bring these benefits to social prescribing. However, these groups and organisations are not always funded to deliver these benefits. There is not necessarily a need for large amounts of funding or formal commissioning arrangements, but core funding for (often low) operating costs makes a crucial difference.

Risk: Meaningful Representation at Neighbourhood Level

Some Big Local areas reflected that one of the benefits of their work was bringing together different people from different backgrounds. Others noted some specific gaps, such as support for disabled people. One of the non-Big Local projects specifically catered to people from a minority ethnic group and noted the benefits of trust and legitimacy, brought about by being community-based over a long period of time.

Some health and local authority systems interviewees raised questions about the consequences of a neighbourhood or locality approach, which might mean some areas of a city have little or no service offer compared to others, or that communities that don't identify on a fixed locality-basis, such as Gypsy, Roma and Traveller communities, are left out. Additionally, some areas have relatively weaker voluntary sector fields, and voluntary and community infrastructure, than others. While funding and support through social prescribing schemes, if available, could help to stimulate growth in this area, real sustainable strength involves investment and community-building over a long period.

Representation can also be a matter of skills and approach. Interviewees highlighted both how community members might need training, support and ongoing learning to engage with local statutory systems, and how those systems needed to do engagement in the 'right' way – namely, in a forum where they can actually make a difference,

where they have the right information and where it doesn't just become tokenistic engagement. Interviewees from an integrated care system (ICS) raised similar issues of power and representation, arguing that systems couldn't simply hand over responsibility to communities, or involve residents and community groups at every strategic level without proper information or structures to enable them to have a meaningful say, as this risked tokenism. However, they offered positive examples of community and voluntary sector engagement including a voluntary, community and social enterprise (VCSE) forum and a participatory funding project involving local people.

> "There's all sorts of risk. Because you've got to make sure that the people are taking, not necessarily the leadership role, but taking the lead in any initiative, have the necessary skills and don't bring any personal sort of issues or agenda to the table, we're not there to sort of hit the council over the head with a sledgehammer."(Big Local partnership chair and resident)

Interviewees highlighted how ideas that come from individuals in the community might not represent widely-held community need, that there was a risk of self-selection of leaders and a narrow view of local priorities. Some interviewees stressed the role of voluntary sector infrastructure organisations that may have a broader view, and broader network, of local voluntary and community groups, although some community groups we spoke to felt unrepresented by their local VCSE infrastructure organisation.

> "You've got to somehow try and engage with the full community and it's got to be accessible so that might be that people can engage in different formats, and I know that you've mentioned like residents in the definition, but I do also think that maybe it's a bit wider than that and other like services and community groups who are constantly dealing with the residents, they have a good knowledge of what's going off in the community and needs as well I think, and I think there's some role for their involvement as well." (PCN link worker)

Systems and projects that make claims to community leadership can benefit from regular reflexive learning practices, to help assess their degree of representation and pathways to influence. Different structures and approaches will be appropriate for different groups, but throughout, there should be a realistic assessment of purpose, to guard against tokenistic involvement of community groups and residents.

Benefit: Drawing focus to the role of community groups

Interviewees from Big Local areas and other projects generally felt they were doing community-led social prescribing – that they had been doing it long before they knew what social prescribing was. By defining and referring to community-led social prescribing as a specific form of social prescribing, there is potential for drawing greater attention to the role of community groups and residents themselves in forming and shaping parts of the social prescribing system. It also raises useful questions about how much that system, from its specification and commissioning to operation, takes community groups and community capacity into account.

> "Having the 'community led' [part] emphasises that the community does and should have a role in saying what they need. So, yes, I kind of think people should have [been] using this right at the start to put across how we've been developing our social prescribing." (Non-Big Local project worker)

There remains an issue around the definition and boundaries of social prescribing. Returning to the definition mentioned at the beginning of this report can provide clarity around what may be within the scope of social prescribing. Key features include: needs-based conversations between a person and a trusted individual, co-production of a 'prescription' for non-clinical community-based support, and the bridging of the gap between clinical and non-clinical support. While framing a wider range of community activity in terms of social prescribing might raise its profile in some ways, there is also a risk that it raises expectations and creates additional demand that exceeds the capacity of community organisations – an issue that some of our interviewees raised. Given the relationship to health and wellbeing needs, there is an additional risk of gatekeeping community activity and other forms of support only for those able to present with a health or care need, potentially impeding access for others. Community action can be a 'good' in and of itself, rather than necessarily having to be related to a set of clinical outcomes.

If funding for community activity that contributes to health and wellbeing only comes through social prescribing, and that funding either does not include support for community organisations or does not include funding that goes beyond the link worker or service manager, there is a risk that some community groups may disappear. Drawing focus to the role of community groups must be accompanied by resources for community venues, group costs and support for residents to get involved.

Risk: underinvestment in services and communities

Interviewees raised concerns about two sides of the funding coin: a potential underinvestment in voluntary and community groups into which individuals were supposed to be prescribed; and an ongoing defunding of other public services that has reduced capacity in the system for helping those with a range of needs. Some link workers and Big Local volunteers highlighted the complexity of some of the cases coming through their doors, leaving little room for anything beyond sorting out basic needs such as food, housing and safety. This is echoed by research elsewhere which examines the role of link workers in 'holding' for individuals with complex needs, which involves supporting and sustaining individuals waiting for services and preparing for change, reducing the emotional burden of primary healthcare professionals and bearing witness to individuals' distress (Westlake et al., 2024). Community groups were not necessarily equipped to deal with these needs, but there was also a sense that there weren't a lot of other services left to help them either.

> "Social prescribers pick up on people that are falling through the net, if there is a net. We had Social Services previously, so where social workers would stay in contact with families and support them, where previously we did have youth and community centres and youth workers and community workers and community development workers and we had all these kind of statutory services in place, that's kind of been removed in the last ten years and more. Once you remove all that then you leave communities very vulnerable, and I don't know whether a purely community led approach would be viable because the problems are just too complex." (Big Local resident and partnership member)

Social prescribing is not a threat to other services or community groups, but there is a risk that community health and other care funding is cut back further and so it increasingly becomes the only option for accessing support. This will undermine the potential of social prescribing to help people thrive beyond points of immediate crisis management, put more pressure on community groups to deal with higher numbers of more complex cases without secure and sustainable funding, and also deskill and dismantle other forms and sources of health and care support. Additionally, it puts an enormous burden on link workers to manage complex cases and undertake highly emotional work. Social prescribing has significant strengths and benefits when done well, but it must be part of the system, not all of the system.

A lack of funding for community organisations playing a part in social prescribing systems was highlighted as a significant issue, discussed in more detail later in this report. For one Big Local partnership member, this came down to a much more longstanding culture of viewing the voluntary and community sector as cost-free. This also led a worker from a different area to suggest they were being 'set up to fail', as they were not supported to cope with the demand for their services from social prescribers, the local council,

other parts of the system and residents directly. Investment had the potential to help groups meet this kind of demand, but also to improve their sustainability – not just in terms of funding, but also being able to support and encourage existing and new volunteers and residents to carry on the work of different groups.

> "I think people still think you can get something for nothing with communities which I don't think is fair… But I think community delivering with support, activities that are needed locally, is a great idea and I think it is also a way that you will get those volunteers of tomorrow through the door in some way, shape or form." (Big Local partnership member)

> "There is always, always role for peer support, but there has to be someone to support the people that are supporting, there still has to be infrastructure and guidance and safety considerations put in." (Big Local partnership member)

Throughout this section, and the previous, we have indicated a number of factors that can enable greater community involvement and leadership in social prescribing, such as issues of funding and commissioning, relationships and more. We will now look at these in more detail, before turning to what needs to happen to enable greater, and more meaningful, community involvement in these systems.

5. Enablers of greater community leadership and involvement in social prescribing

As discussed in the previous chapter, Big Local partnerships and other community organisations have had mixed experiences when trying to engage in social prescribing systems, services and processes. In this section we go into more depth by discussing the main enabling factors associated with these experiences, including funding, relationships, partnerships and safeguarding.

Building quality relationships and local knowledge

Link workers and public sector interviewees were particularly clear on the relational aspects of this work, and the benefits of strong relationships with community groups and the individual leaders within them. One link worker described how knowing local community groups in depth, and building strong relationships with them, helped them understand better which would offer the best support for individuals. This was not just about knowing what arts, walking, social or other groups were out there, but knowing in more detail about those where an individual with specific needs and experiences would feel 'safe' to go to. Equally, because this particular link worker was able to work with individuals over a long period of time, rather than offering a set number of sessions or conversations, they were able to identify where an individual had potential interest or skills around taking on leadership roles themselves in community groups and help them build their capacity to do so. Other projects, both Big Local and non-Big Local, also worked closely with local residents to empower them to take on volunteer roles, recognising their skills and potential alongside their local knowledge and connections.

> "Local people, local knowledge. Training with volunteers, working with volunteers, giving them the opportunity to you know to get involved. Enabling people to become themselves and to flourish. I think it's making a massive difference." (Big Local area worker)

Link workers described the value of individual Big Local partnership members, and their role in facilitating their knowledge of the community, which was echoed by Big Local interviewees as well. This involved being welcomed to the community centre, introduced to the groups it hosted and the people who ran them, getting to know other local residents and feeling like it was a safe place to refer individuals into.

> "I think what I've found that has given the Social Prescribers confidence is not just hearing about us but inviting them down, spending time with them, letting them get to know the people that are down here already so that they build up that picture that it's – I know it's a cliché but it's a safe space for the people on their books to come down to. We're all just volunteers but we have to present ourselves professionally when we have these kind of visitors and just show them that actually, they can have confidence that we can look after them, we can cater to the people that they send down to us." (Big Local partnership member)

One link worker described how they worked to build relationships with and in-depth knowledge of local voluntary organisations and community groups, alongside building relationships with the individuals they were supporting. What they described went beyond knowing what groups were out there, to building knowledge about how groups ran, having information about safety and privacy precautions taken by some, and knowing which would be suitable and successful for individuals with specific needs, including disabled and neurodivergent people and those with experiences of violence and abuse. Because they had the time to build this in-depth knowledge and relationships with groups, they were then better able to support individuals to attend things that would work for them, especially when the individual had significant challenges to overcome to be able to attend groups in the first place.

In contrast, where there were poor relations between voluntary organisations locally, or where link workers were not resourced to build relationships with residents and communities, it constrained the extent to which communities could be involved in social prescribing. Developing skills, capacity and resources for link workers to engage with the community is therefore a pre-requisite for greater community involvement in social prescribing.

A number of interviewees talked about a lack of engagement from link workers with their projects and Big Local partnerships. This included some areas that had previously had close relationships with social prescribing projects, including being part of initial pilots, and those who had struggled to be involved at all. Non-Big Local projects in two localities also struggled with a lack of relationship with local link workers. In one case, the interviewee felt link workers had no interest in working with them and preferred to set up their own groups and projects, even if this resulted in duplication. In the second, interviewees felt a lack of city-wide coordination and partnership working meant that link workers themselves had not been able to build useful links, even with other link workers. Other areas complained that link workers were not visible, and did not visit activities or community centres, although they would still receive referrals. As mentioned earlier, however, one link worker told us the service was only funded to manage referrals, and not to invest in and support community groups. While they had a strong appetite for this work, it simply wasn't possible in their location.

> "We don't see any social prescribers anymore. So now they've gone into the NHS [having previously been based within a voluntary sector provider], we're quite frustrated that we don't see them." (Big Local area worker and former chair)

> "I wouldn't find anything out from a social prescriber unless I actually bumped into them." (Big Local area worker)

Link workers are expected to meet a set of national standards outlined in a competency framework, including competencies to engage and connect with people, to enable and support people, to enable community development, and for safe and effective practice. However, one Big Local area worker expressed concerns about the approaches of health system-based link workers. The worker felt that, in their area at least, there was a lack of appropriate communication skills and methods within other parts of social prescribing systems for working with people in areas of high deprivation. Another non-Big Local project, but similarly based in a hyper-local area of a city, highlighted how working with community-led social prescribing projects such as theirs could bring additional skills and cultural competencies including when working with marginalised groups in the area, although this did not always happen in practice.

A shared language and commitment across the social prescribing system

Enabling relationships included regular exchanges of information between Big Local area workers and local link workers; an active effort to speak the same language across different sectors; and a clear understanding on the part of systems partners of what Big Local partnerships and funded groups could provide. A Big Local partnership co-chair from one area described having spent time over the years learning to speak the language of statutory partners and teaching them how to speak the language of the voluntary and community sector in return. In another area, the Big Local worker attended a Quarterly Navigators (or link workers) meeting alongside other voluntary and community sector partners, where groups could come together with link workers from across multiple local social prescribing providers to share ideas, information and learning. This group created a 'top tips' for social prescribers, shared below.

Figure 2: 'Top Tips' document produced by Big Local partnership worker together with local VCSE organisations, presented to navigator forum to influence practice

1. Maintain contact with local VCSE organisations and be aware of current offers (these might change due to short-term funding)
2. Use organisational referral form where these exist
3. Many small VCSE/community organisations prefer navigators to phone them directly to chat about the needs of an individual and the scope of the organisation to provide a relevant offer
4. Navigators should share accurate information about the offer with the individual including - any costs, location, travel information, timing and duration of the offer, and an idea of what to expect, opportunity to take part in a taster session or observe an activity
5. Navigators need to get consent to share contact details and background information about the needs of an individual (including language and culturally specific needs) with organisations offering opportunities
6. VCSE and community organisations may need time to prepare to welcome new participants
7. Navigators should support referrals [those referred] to make contact with organisations and make sure that they are able to access offers. This includes information on where or when activities happen, a named contact who will be there to welcome them or accompany the individuals to get through the door
8. Navigators should collect feedback from referees and maintain relationships with VCSE and community partners to review their experiences
9. Be mindful of the limits of small organisations to offer services - in cases where a referral has been successful there could be a tendency to introduce more people than there is capacity to support. Organisations may be in a good place to share information about relevant alternative offers.

While some Big Local areas had good relationships with key individuals in the social prescribing system, other struggled to find common language or get the support of GPs and others. One interviewee had found mixed responses when trying to get buy-in from GPs for a social prescribing-related project. In their experience, some GPs expressed reluctance as they did not value the approach, understand the purpose of it, or buy into ideas of the social context of health. Others, however, felt quite the opposite and were keen to participate. In one case, which centred around a database of groups and services set up by a nurse practitioner and funded by the Big Local partnership, it helped to have a clinical champion involved as well, to help persuade other clinicians of the value of the approach.

> "It has to be fifty-fifty, it has to be the practices coming to you as well as you going to them. Like I say there's absolutely no point knocking on a closed door... I know that they don't open." (Big Local partnership member)

Many of the issues around people and relationships came down to trust – whether trust in community groups to be able to appropriately support individuals, trust between public sector institutions and voluntary organisations, or the trust of individual residents in local community centres and groups. In the latter case, one example of a community centre from a Big Local area was described by volunteers and stakeholders as a trusted place run by trusted people. This was why residents from the local estate went there for support, when they would not necessarily access other services – because they trusted that they would get real support with often complex issues in a non-judgmental way. This was also why residents kept coming back to the centre, and in a number of cases became trained volunteers to help other residents in turn. Time is also important here. It takes time to build trust between statutory systems and community groups, and between community groups and residents. It also takes time to work with and support individuals to feel confident in engaging in groups and activities, finding the right activities for them, and to build their capacity to get more involved (or just to keep going back). Finally, it takes time – and investment of resources over time – to build strong local fields of community action to support people to meet their needs.

Strategic partnerships

Going beyond individual relationships and those with local groups, interviewees noted the importance of more strategic-level partnerships between voluntary and community groups, and/or with parts of statutory systems.

One Big Local partnership had been able to establish a local consortium of voluntary and community groups with which it had built relationships in recent years. Members of the consortium and Big Local workers felt that this lent them a sense of legitimacy when engaging with the local council or local health systems. Another non-Big Local project owned a large community building and was refurbishing a second. This meant it could host other voluntary organisations as tenants, which led them to be natural partners in their community-led social prescribing work. It hoped to eventually host health system-commissioned link workers as well, offering access to community groups and hopefully receiving better links to statutory systems in return. On the part of the public sector, a health systems leader also described the importance of co-producing a memorandum of understanding with local voluntary organisations involved in one of their strategic boards, in order to embed good practice and meaningful engagement in the partnership. It wasn't so much the document itself that made this a successful partnership, although it helped, but rather the process of bringing it together which set the tone and expectations for ways of working together.

> "It's a document at the end of the day, it's a document that says how we all think that we ought to work, but the value is not in the document, the value was in the process of designing the document. [Now people say] well we still don't feel like we've got parity of esteem in the system, but it was a really good process developing that MOU, we feel clear about the direction that we

> all want to go in, there are some really good examples of where that's coming to life, we're not quite there yet, but we can [get there], we feel. This feels different, this feels like we're going in the [right direction]." (Health system leader)

One Big Local area, however, felt actively excluded from conversations between local councils, local health bodies and what was at the time the Clinical Commissioning Group (CCG), even when they had a leading role as a partner and funder in a local social prescribing project.

> "What we found is that quite often you'd turn up to a meeting and you'd find a Council, the Parish Council and the doctors had had this conversation and you're like, well hang on a minute, we're like the lead funders, do you want to let us in in your little [private] conversation? But they're just residents, what do they know?" (Big Local area worker)

There were perceived benefits around data sharing between statutory services and voluntary and community groups, as one form of strategic partnership, but a reluctance to do so. There are also likely practical difficulties in sharing data safely. Interviewees from Big Local and non-Big Local community groups told us they felt there would be a great benefit in both sharing data to understand local needs, demands and gaps in provision, and to help community groups understand the potential cost-benefits to health and other systems of the work they were doing. Similarly, having basic information about a person's needs when they were referred to community groups would help those groups understand what they could provide, and how to do that in a way that was safe and helpful to the individual and other individuals attending the group. This is a complicated topic, and it is understandable that there is a level of risk aversion among health and care professionals. However, there appear to be potential benefits that could be tested and developed with more work in this area.

Relationships and partnerships can be a matter of simple, organic one-to-one connections between people trying to provide things that make people's lives better, or they can involve more strategic, formal, contractual arrangements through commissioning and grant investment or mechanisms for enabling joint working. The ability of communities to take on greater involvement or leadership in health and other systems clearly relies a lot on these relationships. It also relies on the strength of the local voluntary and community sector more generally. As one health system interviewee pointed out, what might work in one city or area may well not in another, due to the presence or absence of strong voluntary and community groups, equipped to empower other community groups and residents in turn. Some of the examples we heard about lacked this, which resulted in some cases in a much more top-down system, and in others a great deal of frustration that community groups were not better involved, supported and resourced.

Long term, flexible funding to aid sustainability

Funding – specifically long-term, flexible, non-prescriptive funding, including for core costs - is a key enabler of community involvement in social prescribing. With their funding guaranteed for 10 years or more, Big Local areas have been able to experiment, give money where it is needed based on local knowledge, and, importantly, make mistakes and learn from them. Indeed, two interviewees described approaches towards community-led social prescribing that had not worked, but which would not have even been possible to try without Big Local funding, and which in one case at least still carried some benefits to residents. We talked to non-Big Local projects and identified other examples which had also benefited from long-term sustained core funding. This had enabled them to cement their place in their communities and continue to respond to community needs whilst also building links to the social prescribing system. Funding must, however, keep up with rising costs over time, to prevent reductions in service and preserve community organisations financial sustainability.

Groups did not necessarily need large amounts of funding to set up and operate, and in-kind support could be just as useful. However, a small amount of funding was perceived as helpful in removing little barriers in the way of residents starting their own projects to meet local needs.

> "It allowed things to spring up that probably would not have sprung up otherwise because actually people didn't just need money, they just needed a bit of support. So the benefit for the area was that even very fledgling activities were given support to develop." (Big Local resident and partnership member)

Some interviewees raised issues of sustainability, relating to funding. Many Big Local areas are at, or are approaching, a point of transition as their 10+ year investment comes to an end. This means they have to make decisions about what comes next – whether they set up a new 'legacy' organisation, continue as collectives of volunteers and groups, try to change or expand into new areas, or try to access new funding sources. Many Big Local partnerships have been successful in securing additional funding from other sources already and so have a good base from which to start, but continuing core funding – rather than time- and scope-limited project funding – will be an ongoing challenge, both for the evolving Big Local partnerships and the small groups many of them fund.

> “For Big Local we were always about kind of getting things rolling, getting things started... but we know that that’s always going to be a concern once it stops, some little community groups we have, they get funded very regularly, you know the community group that regularly puts on summer activities for the children including food and lunches and all that, what will happen when Big Local goes because yes, that’s somewhere where [social prescribers] would refer to, if families are struggling then they would need to go to a scheme that covers that.” (Big Local partnership member)

In reality, though, a number of participants said they felt community groups were being ‘set up to fail’ because of a lack of funding trickling down to that level from commissioned social prescribing services, or because of very short-term funding. They were expected to take on referrals but not funded to do the work. In one case, a Big Local partnership felt this was a wasted opportunity: with a relatively small amount of funding sustained over time, they would be able to support individuals much more effectively. They also believed this would represent value for money for health systems: they could help people before they needed to attend a GP or other health service and support them to meet their own needs without medical or other intervention.

One Big Local interviewee highlighted the barrier of onerous reporting requirements that some funders had in place - for relatively small grants. This stands in contrast to Big Local partnership grant funding in many areas, where the grant reporting requirements are light touch. A non-Big Local project interviewee also described the challenge of applying for short-term funding and having to restart projects again every three or so years.

> “People come in [to the community] because they’ve got the funding, they do what they need to do and then they disappear and somebody else comes and sometimes people in the community don’t see the results.” (Voluntary sector link worker)

An interviewee from a non-Big Local organisation discussed how making pots of grant funding available was a central feature of their model that supported the wider health of the local voluntary and community sector. However, this requires time, trust and flexibility from funders and commissioners. A service specification for social prescribing may not include the ability (or impetus) to pass funding down. If it did, and if a commissioned organisation had the knowledge, culture and networks to make the most of this, it could help with sustainability of neighbourhood-level groups and activities.

Working safely with communities

Big Local areas talked, in some cases, about concerns regarding the appropriateness of social prescribing referrals. Sometimes community workers needed to act as a safety check for both individuals and community groups. One interviewee noted that opportunities needed to be appropriate for people from very deprived areas with complicated lives, and workers and volunteers needed to demonstrate patience and compassion. As noted, one PCN link worker also embedded this approach in their practice, although others felt constrained from doing so by local service specifications. Another Big Local area described the challenge of trying to sustain a relationship with an individual, to make them feel not only welcome but part of something.

> "I still feel that there is another level of people that we aren't quite reaching because there's just one extra step that they need to take and I don't know what that [is] - it's something in their mind to get them to actually think, yes I'm a part of something and it works with some people but with others it doesn't." (Big Local partnership member)

In other areas, interviewees highlighted their own roles in supporting groups to work safely through helping them to establish appropriate safeguarding, health and safety and other policies so that they were able to support potentially vulnerable individuals.

One Big Local worker felt there was a lack of awareness of social prescribing in deprived areas, and the hurdles that people needed to overcome to start taking part in groups. This included cost of activities, but also the skills necessary to identify needs. The worker felt people in their area might potentially face prejudice from health workers relating to class, substance misuse, life history and more. Other areas also stressed that there needed to be a clear understanding of what groups could and could not do, and that they could not 'solve' people's problems or replace statutory services.

> "We want to make it as inclusive and as safe and as welcoming as possible but with it, with the boundary of I'm not here to counsel you, we can advise, you know as compassionate and kind human beings, but we are not the solution to [problems]." (Big Local partnership member)

Interviewees told us that engagement of individuals took time. As noted, some community projects and link workers were empowered to build relationships with individuals over sustained periods of time, and they felt this made a real difference to those individuals. One partnership member and group organiser had found that people might need extra support in order to join their group. This was echoed by other projects. A further area indicated that keeping people coming back could be a struggle without proper support. This is a key part of the role for some social prescribing link workers but not all.

> "Sometimes you have to ask someone three or four times before they [participants] come. Sometimes when they decide to come, they might then not see them for the next three times. It takes time." (Big Local area worker and former chair)

Another area also described how individuals would be sent to groups by social prescribing link workers, but the link workers failed to communicate to those groups in advance. As a result, the group would not know that the person was coming, would not know about access and/or language needs, or how best to support them. This was difficult to manage for the groups, and unhelpful for the individuals.

Capacity and demand

There was a risk of over-prescribing into some groups. Several interviewees mentioned issues with capacity, with groups including community lunches, play schemes and others "selling out" soon after being advertised, or unable to cope with the numbers of individuals being sent their way.

Link worker capacity was also a concern: this could be in terms of their capacity to engage with the community, to manage their case load, and to spend time working with individuals who needed more intense support. There were examples of social prescribing projects that might be more accurately described as signposting, as individuals were not supported to attend the groups for which they were given prescriptions.

> "It's really striking the difference of if someone makes an appointment with a Social Prescriber, ninety five percent of the time, they'll be there [attending the group alongside the individual] but with [national charity running a social prescribing project] it's the other way round. It's really striking – you do need someone there with you that first time." (Big Local partnership member)

Several Big Local areas and other projects echoed some concern about some services that did not appear to offer support to individuals beyond signposting. One area felt this lay in the outcomes targets set by health systems, that emphasised volume over individual experience. This lack of capacity among link workers meant that community groups had to do more work to support individuals sent to them, but they often did not receive any funding whatsoever from social prescribing systems, either to run the group in the first place or to undertake extra work to support the individuals referred to them.

> “I’ve got a worry, how big can we actually get? We do everything to sustain what we have got. And it’s just getting exciting now. We’ve got so much more to do. I think for me one of the biggest things is that we need to go out there and we need to say, look, this is what we deliver. You’re putting all your money into big organisations because you think that they’re the best but, actually, they’re not. There are local communities out there that are actually delivering some fantastic work.” (Big Local area worker)

Some link workers told us that, even though they were based in community organisations and supported some condition-related pathways and groups for local residents, there was no capacity to do substantial community development work because of both the volume of referrals, and the scale of challenges they had to help individuals face. These challenges included hunger, housing, poverty and other basic human needs, leaving little room for further community engagement and empowerment. To some degree this echoes a point made earlier about the need to help people engage with themselves before they can engage with their communities: some individuals are not yet in a place where they can get involved in sustained community work when they access social prescribing, but rather need support to manage the immediate crises in front of them at that time, and/or to build confidence within themselves.

However, the projects we encountered in both Big Local areas and beyond demonstrate that, with time and sustained support to address those problems, individuals certainly can move to a place where they are able to start taking a lead in their communities. As these examples show, the potential for empowerment and improving communities, based on residents’ own needs and experiences, is huge, but significantly constrained by service specifications and allocated resources.

We have discussed the benefits, risks, barriers and enablers to greater community leadership and involvement in social prescribing from the perspective of different actors in the system. This includes issues of funding, relationships, capacity and safety. In the final section we outline why, based on our findings, greater community involvement and leadership is important and suggest how it could be achieved.

6. Conclusion: towards a model for greater community leadership and involvement across social prescribing systems

This report has explored the potential for greater community involvement in and leadership of social prescribing in England based on lessons from Big Local areas and other communities across the country. Its starting point has been the argument that social prescribing originated as a community level, community-led approach to health creation but that the 'bottom-up' nature of social prescribing has been lost in many areas following its implementation as a 'top-down' national policy initiative. Although in some areas community organisations do have opportunities to lead social prescribing initiatives and are involved in social prescribing services, systems, processes or pathways, these examples tend to be the exception rather than the norm.

In this concluding section, we reflect on the key findings of the research to discuss the reasons why greater community involvement in and leadership of social prescribing is important for residents, community organisations and health systems. To help key actors at local, regional and national levels we provide recommendations for how to re-centre social prescribing around greater community involvement and leadership moving forward.

6.1. Why does greater community involvement in and leadership of social prescribing matter?

Key reports into the future of health systems and health inequalities (Marmot,2020; Darzi, 2024) highlight the importance of preventing of ill-health and emphasise the need for more community-based models of support. These are necessary to ensure that we have a sustainable health and care system that is fit for the future and able to respond to individual and community needs. In this context it is essential that social prescribing makes better use of existing community assets and plays an active role their development and sustainability.

As this research has demonstrated, the benefits of great community involvement in or leadership of social prescribing stem from bringing community organisations, including very small and hyper-local ones, closer to social prescribing services. A community-centred approach to social prescribing can provide health systems with greater access to community knowledge, promote social connection and enable greater ownership of the factors known to be important for health creation and positive wellbeing.

However, there are also risks inherent in greater community involvement in social prescribing, particularly for those organisations which are closest to communities but have least power in these processes. Specific risks have been identified in relation to whether there can be meaningful representation at a neighbourhood level, even with these organisations involved; safety and appropriateness of referrals; rationing of resources linked to specific health needs and conditions; and whether there can be greater involvement without addressing long-term underinvestment in communities.

6.2. Recommendations for increasing community involvement in and leadership of social prescribing

In order to play an active role in community-level social prescribing systems individual community organisations will need to be clear about the role they want to play, now and in the future. Do they want to play a leadership role, for example in the design or oversight of social prescribing systems; or do they simply want to be more involved, for example by delivering activities to which residents can be referred? But there should also be an onus on leaders within the health system to facilitate greater community involvement in and leadership of social prescribing through openness and proactive engagement at a community level.

Lack of resources – for residents, for community organisations and for the health system – was a consistent theme throughout the research. But it is not only more funding that is necessary to realise the benefits of greater community leadership of and involvement in social prescribing. Below, we identify four steps that are needed to achieve this goal. These represent broad stages toward developing what could be described as community-level social prescribing systems that are nested with the existing NHS primary-care based approach. Different areas will be at different points along this pathway, but it ought to provide a blueprint for development, whatever the start point may be.

1. Build relationships

Often, the key stakeholders in social prescribing at a community level – GPs/other health professionals, link workers, community organisations – are disconnected from each other and there is a lack of understanding about who does what, what opportunities are available or what are the limits of each other's role. In areas where community leadership of or involvement in social prescribing is greatest there is evidence of strong and long-term relationships between these different stakeholders, characterised by a deep understanding of each other's roles. In areas where these ties are weak, the focus needs to be on developing good relationships between different stakeholders before social prescribing systems and processes are formalised.

2. Establish trust

In many communities trust in the health system, and trust between the health system and community organisations is low. Even where relationships exist or are being developed, trust may still be low or take longer to establish. In areas where community leadership of or involvement in social prescribing is high this often accompanied by high levels of trust between key actors within the social prescribing system. Building trust is not easy, however. It requires time to get to know community centres and groups on their terms and territories; honest conversations about how systems work, where the power lies and what resources there are; and where possible long-term investment in core costs so spaces and groups providing 'safe spaces' for residents can be sustained.

3. Develop effective ways of working

Once trust-based relationships have been established, or are becoming established, it will be necessary to develop formal ways of working between social prescribing systems, community organisations and local residents. Key components could include:

- **Referral pathways:** co-design processes for how link workers connect people with community activities and ensure they are supported to access these opportunities when it is needed (for example through befriending support).
- **Information sharing and feedback loops:** information will need to flow to and from key partners. Community organisations will need information about support needs and other considerations such as safeguarding before referrals can be accepted; link workers and health professionals will need to know what types of support people have accessed, or if there have been barriers to engagement; and a shared understanding should be reached around the impact and benefits of engagement.
- **Governance models:** fora will need to be established to shape the development of community-level social prescribing systems. These should provide opportunities for health practitioners, link workers, community organisations and residents to shape the design, delivery and resourcing of community-level social prescribing services.

These are important steps in the **embedding of institutional collaboration** by securing a shift from individual relationships between key individuals, which tend to characterise community-level social prescribing initiatives, to institutional level relationships that can be sustained long-term, particularly if those key individuals move on to other roles.

4. Sustainable community development, capacity and resources

The current NHS model of social prescribing delivered through link workers in PCNs does not enable investment in the community capacity and resources necessary for effective social prescribing, nor does it actively promote community development. However, there are examples of social prescribing being delivered in tandem with other community development initiatives (in Sheffield for example), and where local commissioners have invested in community-level capacity to provide activities that support the delivery of local social prescribing services (in Rotherham for example, where this has happened for more than 10 years). These provide vital opportunities to learn about how sustainable community-level social prescribing systems could be developed.

Sustainable investment in community development, capacity and resources will be a prerequisite for long-term community leadership of and involvement in social prescribing and the establishment of viable community-level social prescribing systems. However, currently there is a lack of guidance from the NHS or Department of Health for ICBs, ICPs or PCNs to consider their role in supporting communities to play a more central role in social prescribing systems:

- **Nationally:** stronger policy guidance from central government is needed, but it will only be effective if additional investment is made available and/or new resourcing models for social prescribing and community infrastructure are developed.
- **Regionally:** ICBs, ICPs, local authorities and Mayoral Combined Authorities need to consider their roles and responsibilities in supporting community resources and infrastructure. This is essential for the development of community-level social prescribing systems, but it also has a key role to play in addressing inequalities, the effects of poverty and the wider social determinants of health. Shared responsibility is needed to ensure that onus to invest in community capacity and resources extends beyond the health system to the wider public and private sectors in each region.
- **Locally:** PCNs and individual GP practices need to understand that it is their interests, and the interests of their patients, to ensure that they are community oriented and promote and support community development and resources through social prescribing link worker roles, and other allied roles, within their practices.

6.3. What gaps in knowledge remain?

This report has provided an important starting point for improving our understanding of community involvement in and leadership of social prescribing but gaps in the evidence base remain. Priorities for future research include:

- Extensive mapping of widespread community involvement in or leadership of social prescribing – across the UK and in other parts of the world – to understand the key components of different models and what makes them effective, or not.
- Exploring what would a sustainable funding or investment model for community-level social prescribing should look like, based on best practice and the promotion of innovation.
- Better understanding the benefits (and downsides) of community-level approaches to social prescribing. In particular, does it lead to better outcomes, experiences or quality of service and if so, for whom?

Appendix 1: Methodology

This project was based around qualitative research undertaken in 20 communities where community-led organisations and partners have attempted to engage in social prescribing services and systems. These areas were identified through purposive sampling approach that took advantage of the knowledge and reach of the research partners – Local Trust and National Academy of Social Prescribing – of social prescribing practice across England, along with connections held by members of the research team. 12 of the areas selected were Big Local areas and six were non-Big Local areas. Areas were selected on the basis of their prior and/or ongoing involvement in social prescribing and to ensure broad national coverage that took account of demographic and geographic factors such as urban-rural location and ethnic diversity. To provide additional context and a wider range of perspectives on the topic of the research. An additional four stakeholder interviews were undertaken with employees from the public, voluntary and community sectors. These participants were selected due to their knowledge of social prescribing practice at a system and community level.

The main characteristics of each community and the community organisation or health system we engaged with are summarise in table A1.

Table 1A: Overview of fieldwork locations

Area	Lead organisation	Location	No of interviewees	Workshop location
BL1	Big Local partnership	Yorkshire and the Humber	1	
BL2	Big Local partnership	Yorkshire and the Humber	1	
BL3	Big Local partnership	South East	1	
BL4	Big Local partnership	Yorkshire and the Humber	1	
BL5	Big Local partnership	Greater London	1	
BL6	Big Local partnership	East Midlands	1	
BL7	Big Local partnership	North East	1	
BL8	Big Local partnership	North West	1	
BL9	Big Local partnership	North East	1	
BL10	Big Local partnership	West Midlands	1	
BL11	Big Local partnership, local community groups, PCN	Greater Manchester	15	Greater Manchester and Sheffield
BL12	Big Local partnership, GP surgery, local voluntary organisations	West Midlands	12	West Midlands
NBL1	Local branch of a national charity	Hertfordshire	1	
NBL2	Local heritage organisation	Northamptonshire	1	
NBL3	Local community project	Leicestershire	2	
NBL4	Local charity	South Yorkshire	2	Sheffield
NBL5	Local charity	South Yorkshire	2	Sheffield
NBL6	Local charity	South Derbyshire	1	Sheffield

Area	Lead organisation	Location	No of interviewees	Workshop location
Health System 1	Integrated Care Board	South Yorkshire	1	
Health System 2	Local authority	South Yorkshire	1	
Health system 3	PCN-employed link worker	South Yorkshire	1	
Health system 4	PCN-employed link worker	Cambridgeshire	1	

In each location qualitative interviews were undertaken with leaders of the Big Local partnerships or key community organisations involved in social prescribing. In three locations an additional workshop was undertaken to enable the involvement of a wider range of stakeholders. These areas were selected as workshops because community involvement and leadership of social prescribing was particularly well developed and embedded, and the workshops were designed to elicit further detail on the factors associated with this. In the two workshops with Big Local area projects, we asked participants to collectively draw out a timeline of their project, in order to elicit in-depth information about their work and that of related organisations. Facilitators also took notes during all workshops which were included in the data. We ran one additional learning exchange workshop, open to all those who had been involved in the research, where we sense tested our interim findings and gathered additional feedback on our emergent key themes. We recorded conversations all four workshops, and also gathered written feedback from participants who were asked to reflect on the definition of community-led social prescribing; barriers and enablers; and the key messages they would give to decision-makers.

Data was analysed thematically and coded according to themes relating to our research questions, as well as additional codes that arose from the data. We grouped all interviews and workshop recordings together to look across the full breadth of data, as well as considering the context of individual interviews. We also then looked at outputs from the workshops and used this data both as part of the whole set for analysis, and to produce in-depth case studies of projects.

Appendix 2: Literature Review - Contextualising Social Prescribing

Note that the following review was finalised in January 2024 to inform the main data collection phase of the project. Some of the ideas and thinking presented were further developed during the course of the project.

1. Introduction

Throughout the development and spread of social prescribing in England, there has been emphasis on social prescribing as a 'community-based' intervention (see for example Muhl et al., 2023). However, the role of communities in the development and implementation of social prescribing has been largely overlooked in terms of practice, policy and research. The little work that has addressed the role of communities has examined the often fraught relationship between the VCSE sector and the health care system (Cole et al., 2020; Dayson et al., 2020), particularly with respect to funding. Although social prescribing may be defined as 'community-based', it focuses on empowering individuals to identify their own needs and find solutions and therefore research has not sufficiently addressed how communities are empowered to identify their own needs and find solutions and how this in turn interacts with social prescribing.

This review addresses this gap by turning attention to community-led social prescribing. The review consists of four parts:

- **Introduction.** In Section 1, we define key terms and concepts involved in understanding CLSP, including social prescribing, community and community action.
- **Community development and health and wellbeing**. In Section 2, we review the policy context of community development in health, including perceived benefits and different approaches. We then outline barriers and enablers to and critical perspectives on community development in health and wellbeing.
- **Social prescribing, the VCSE sector and communities.** In Section 3, we detail the most common social prescribing model in England and the degree to which it engages communities and the voluntary and community sector. Then we outline three models and approaches to engaging communities in social prescribing more purposively.
- **Community-led social prescribing.** In Section 4, we discuss and propose a definition of community-led social prescribing, using a matrix and typology to illustrate the definition, and conclude with next steps.

We have chosen to focus on community development as a policy context both because it is a key approach for Big Local areas, and because it is largely neglected in the existing literature around social prescribing, despite the potential it offers. There is important emerging work on the experience of voluntary organisations which are part

of social prescribing schemes, but a much smaller amount on the potential link between social prescribing and community action, which may be distinct from activity delivered by charities. Through this project, we intend to explore the potential value, and challenges, that bringing these two concepts together can offer.

This review will inform fieldwork with Big Local areas and other projects and provide a reference point for our findings in relation to theory and wider literature.

What is Social prescribing?

A recent paper used the Delphi method[6] to establish internationally-accepted conceptual and operational definitions of social prescribing. The short conceptual definition is:

> a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to improve health and well-being and to strengthen community connections (Muhl et al., 2023, p. 9).

Operationally, social prescribing is 'a holistic, person-centred and community-based approach to health and well-being that bridges the gap between clinical and non-clinical supports and services' which requires an 'identifier' to identify an individual's unmet non-medical, health-related social need and make an onward referral to activities and services (Muhl et al., 2023, p. 9).

In England, a universal model of social prescribing has been embedded within primary care since 2019. Prior to its large-scale implementation within the NHS, social prescribing was typically delivered at the local level by community organisations working with a small number of GPs to connect patients to community activities. This 'bottom-up', small-scale social prescribing received some public funding but was not a formalised part of statutory services. Social prescribing has been increasingly seen as a 'top-down' policy within health care services and commissioning (Dayson, 2017a).

The NHS Long Term Plan (2019) reinforced social prescribing as a key aspect of personalised care within the primary care model. Primary care-based social prescribing involves a link worker, which is one of three key personalised primary care roles, alongside Health and Wellbeing Coaches and Care Coordinators, funded by NHS England. The social prescribing link worker (SPLW) takes referrals from health and care

6 The Delphi method brings together participants with expertise in a given area to generate and evaluate ideas and form consensus across several rounds of questioning. It is used particularly where there is a lack of existing research on a topic, or the research is conflicting.

professionals—usually the GP—and starts with a 'what matters to you' conversation to understand the individual's needs and preferences. They then make an onward referral to the activities and services, typically provided by the VCSE sector. Since 2019, the number of SPLWs and the number of referrals to NHS England-funded SPLWs has grown considerably. The recent NHS Long Term Workforce Plan (2023) committed to increasing the number of SPLWs to 9,000 by 2036/7.

Community and community development

The existence and construction of communities is complex and imbued with power dynamics (Bradshaw, 2008; Chavis and Lee, 2015; Farrington, 1914; MacQueen et al., 2001; Winterton et al., 2014). Some neighbourhoods or localities may have weak or non-existing social ties and shared interests, and so may not be described as communities. Some communities may be dispersed beyond a single geographical place, or may coalesce around shared identities and interests rather than place. For this study, we will consider place-based communities, at a relatively small neighbourhood level, as this is the most relevant to the Big Local programme and the work of local partnerships. We are mindful, however, that some social prescribing schemes will operate at different geographies to Big Local areas. The questions of place and who is being served by different schemes are important ones to explore later in this project.

Community development as a concept goes beyond basic involvement or consultation and is characterised by community capacity building, control and participatory democratic engagement (Walters et al., 2023). Looking across a range of definitions of dimensions of and conditions for community development, Alison Gilchrist proposes seven 'E's:

Enabling people to become involved by removing practical barriers

Encouraging individuals to contribute to activities and decision-making

Empowering them by increasing confidence and the ability to influence decisions

Educating people by helping them to reflect, learn from others and discuss

Equalising situations so people have equal access to opportunities and resources

Evaluating the impact of these interventions

Engaging with groups and organisations to increase community involvement (Gilchrist, 2009; Seebohm et al., 2009).

While community organisations, community development and resident-led community action are not synonymous with the VCSE sector, and indeed too often are not included in studies that focus on more formal charities, voluntary organisations of different kinds are often the site of community development.

Resident-led decision-making is core to the Big Local programme, in ways that embrace community development principles. Local Trust has written and commissioned writing on community development from a range of perspectives (Boyle and Wyler, 2021; Pollard et al., 2021; Taylor, 2021; Terry et al., 2023; Tiller, 2021). As such, Big Local areas provide useful sites to explore whether there could be a relationship between community development and social prescribing in practice, whether that is in the form of engaging with health system-led programmes, or designing and delivering projects directly.

2. Community development and health and wellbeing

This section will set out the existing research on the relationship between community development and broader health projects, in order to frame the future research that forms the main part of this project. As noted, community development principles are at the heart of the Big Local programme. Many Big Local areas include a focus on health and wellbeing - either as a dedicated area of work, or a cross-cutting theme - in their local plans. As such, understanding how community development and health have come together in health policy research and practice provides a frame for analysis for our own research. It also addresses a gap in the specific context of social prescribing, where the role of community organisations and action is underrepresented in the literature.

Health benefits of community development

The potential links between positive health and wellbeing outcomes and involvement in community development are long-established, as are the links between negative health and wellbeing outcomes and inequality and powerlessness (Rosenthal, 1983; South et al., 2015; Wallerstein, 1993). Community development approaches are seen as having potential to tackle issues of health inequality within and between communities (Raj et al., 2023; Sykes et al., 2018; Tang, 2018; Walters et al., 2023; Wilton, 2021), including for marginalised populations, such as Gypsy and Traveller communities (Hudson, 2009).

The benefits of community development and empowerment on health and wellbeing are demonstrated in relation to clinical factors, social support and connections including reducing loneliness and isolation, behavioural change, self-efficacy and self-confidence, critical knowledge, breaking down stigma and encouraging conversation, and democratic engagement to improve services (Abel et al., 2011; Brunton et al., 2023; Jones et al., 2013; O'Mara-Eves et al., n.d.; Peeler et al., 2023; Public Health England, 2021; Williams et al., 2023; Woodall et al., 2010). One study specifically focussing on Big Local areas describes how collective control and social cohesion are associated with better mental wellbeing among residents, although with variations according to gender and level of education (Akhter et al., 2023). However, there is a lack of evidence regarding the benefits of some community-based methods for people with long-term conditions, which raises issues of access and inclusion, as well as a need for further research with this population (Blickem et al., 2018).

Health and community development in policy

The 2010 Marmot Review was a landmark report for community development and health and wellbeing. It considered individual and community empowerment as central to the reduction of health inequalities, emphasising that this may involve 'removing structural barriers to participation, for others facilitating and developing capacity and capability through personal and community development' (Marmot et al., 2010, p. 34). The report argues that '[e]ffective local delivery requires effective participatory decision-making at local level' (ibid., p. 15). More recently, and of direct relevance to this project, NHS England (2022) has issued guidance around 'proactive social prescribing', which

is framed as a community development approach in which system partners include a targeted programme to improve access to services for those with unmet needs.

However, wider political, economic and social conditions have had an impact on communities, individuals and services, affecting access to healthcare and other provision. 'Austerity' policies since the financial crisis of 2008 have seen significant cuts to local authorities, welfare benefits, community teams, health services and the VCSE sector, reducing capacity for community development around health and beyond, with some evidence of a link between cuts and worsening health outcomes (Fahy et al., 2023; Jenkins et al., 2021; Walsh et al., 2022). The 10-year follow-up report to the Marmot Review recognised the challenges of austerity in the 2010s, while also emphasising that 'many local areas have prioritised reducing health inequalities and have made significant system-wide changes to enable this to happen' (Marmot et al., 2020, p. 138).

Outcomes and approaches

South et al. (2017) identify four main groups of community-centred approaches that can help to achieve positive health and wellbeing outcomes: (i) strengthening communities, (ii) volunteer and peer roles, (iii) collaborations and partnerships and (iv) access to community resources. There is, however, a lack of evidence about whether any particular method of community engagement or community development is more effective than any other (O'Mara-Eves et al., n.d.). There also remains a sense that the health sector and community development remain siloed (Sykes et al., 2018).

Several examples look specifically at the methodology of asset-based community development (ABCD), and conclude that it is important to identify, connect and harness local assets, engaging in genuine co-production and sustaining that through ongoing organisational support (Cassetti et al., 2019; Harrison et al., 2019; Ure et al., 2021; J. Wildman et al., 2019). Harrison et al. caution that ABCD is likely to be most effective 'where building trust is mirrored by an institutional and relational environment that is trustworthy and facilitative of developing people's capabilities' (2019, p. 1).

Barriers and enablers to community development in health

Enablers for successful community development and health projects include having the right professional capabilities, the right relationships and skilled political leadership (Darlington et al., 2022; Lockyer and South, 2006; Seebohm et al., 2009; Seebohm et al., 2012; Walters et al., 2023). Peerbhoy et al. (2021) note the importance of 'community connectors' for obtaining community feedback in their participatory health research project with Black, Asian and minority ethnic communities in Liverpool. Carlisle (2010)'s study of disagreements within community representative groups, wherein rivalries, suspicion and clashing priorities proved hard to manage, highlights the importance of developing skills to share diverse perspectives and manage conflict within community development endeavours. Shared agendas and collective action planning, conversely, helped cross-sector partnerships function effectively (Fieldhouse and Donskoy, 2013).

Barriers include the pressure of time on community development work, applied by short-term funding and changing political priorities (Lamb et al., 2015; McCabe and Davis, 2012; Richardson and Grose, 2014; Smith, 2015). Walters et al. (2023) also caution that a perception of high-cost of community development projects can leave them vulnerable to being cut as a so-called luxury in times of austerity. Power imbalances can also pose problems. Ritchie et al. (2004) note the disempowerment felt by partner organisations in their case study in Scotland in the early 2000s as a result of unequal representation and power compared to the local health board. Several studies (Rapport et al., 2008; Richardson et al., 2013; Snooks et al., 2011) note that those with political power needed to take action to embed community development to achieve long term change: 'with limited involvement or expression of long-term commitment from organisations such as health agencies and local authorities, it is questionable whether change will be achieved over the longer term' (Rapport et al., 2008, p. 222).

Critical perspectives on community development approaches to health

While community empowerment can be a powerful tool for improved health outcomes, particularly in areas of high deprivation, Raj et al. (2023) highlight the risk that community-based initiatives might entrench, rather than reduce, inequity. Collective control might be enhanced in more affluent neighbourhoods, but undermined in more disadvantaged groups and areas where there are greater risks and responsibilities in return for lower levels of power than in the former. A number of authors criticise ABCD specifically for placing high demands on scarce time and resources, and for playing a role in justifying cuts to public services (Lamb et al., 2015; MacLeod and Emejulu, 2014).

Both Lewis (2012) and Quinn and Knifton (2012) call for more rights-based approaches to community development in health systems. A number of the studies on mental health also use a social model of disability and advocate for the power of bringing this together with community development methodology, recognising individual and collective strengths and challenging structural inequalities (McCabe and Davis, 2012; Quinn and Knifton, 2012). Applying a lens of the social model of disability to groups with other impairments and long-term conditions, as well as lenses of race equity, queer theory, feminist studies and intersectionality to health systems and health-related community development programmes would help further articulate issues of power and disparity in health outcomes.

Finally, some authors highlight a conflict between the often radical nature of community development-based projects, and health systems. Clark et al. (2019) consider the risk that statutory bodies may become less able to support radical or experimental projects as resources become more and more constrained. Sykes, Wills and Popple, in the context of a successful community development-based project to build critical health literacy in communities, also caution against policy delivered 'through' communities and not 'by' them, as well as the potential for policy initiatives to undermine the 'true and radical element of community development' (2018, p. 762). These tensions are common across

policy domains, where community organisations and government interact, often with conflicting goals. These issues might also be present within the social prescribing policy area.

In the following sections we will explore existing research on the role of the VCSE sector in social prescribing, and different models of social prescribing that place voluntary and community action more centrally to the system. We will then describe the ways in which we might expect community action to interact with, at the very least, and lead, at most, social prescribing programmes.

3. Social prescribing, the VCSE sector and communities

The VCSE sector and social prescribing in the primary care system

The most common model of social prescribing in England is centred in the NHS primary care system under the umbrella of personalised care. The statutory health service, usually the Primary Care Network (PCN), delivers or contracts the social prescribing service. It hinges on the availability of a social prescribing link worker to identify an individual's unmet social need, to produce an onward referral to community-based activities, and to empower individuals to navigate community resources. It subsequently requires VCSE activity providers, both large and small, to have the funding, capability and capacity to take referrals from the social prescribing link worker. This model is therefore described as community-based and drawing on community assets.

The formalisation of social prescribing builds on the 'long (and proud) history of partnership between the health sector and local voluntary, community and faith groups' (Calderón-Larrañaga et al., 2023, p. 12). The link worker themselves may be seen as key to connecting the VCSE sector with the health care system and health care professionals, especially where the former is concerned about receiving appropriate referrals and a reasonable demand and where the latter may be sceptical about the ability for the VCSE sector to support patients (Skivington et al., 2018; Tierney et al., 2020). According to Wildman et al., the 'intensive support provided by link workers is likely to be a more successful model of social prescribing than simply "signposting" to community resources' (2019, p. 10). In a study exploring the use of social prescribing for preventing type 2 diabetes, reliance on 'community-based, local organisations' - as opposed to private providers in other prevention programmes - 'contributed to strengthening the local community' (Calderón-Larrañaga et al., 2023, p. 12).

South et al. (2008) argued that social prescribing could provide a key mechanism to strengthen community-professional partnerships in health and community sectors. However, Fisher (2014) stresses a clear distinction between community development and social prescribing: while the latter might involve VCSE organisations, and offers a relevant response to needs, it often will not show any principles of community development, and the patient remains a passive receiver of service. Burgess also highlights how social prescribing interventions can be divorced from the structural causes of inequity, with a risk that richer areas might benefit more from social prescribing than deprived areas (Lewis et al., 2023). Cormac Russell (2017) also argues that social prescribing is too focussed on formal services rather than resident-to-resident relationships and the civic or associational life of neighbourhoods. This does not necessarily have to be the case, however. Indeed, Burgess calls for a greater focus on collective justice in social prescribing, in line with a community development approach (Lewis et al., 2023).

Within NHS England, the Integrated Care Partnership (ICP) and Integrated Care Board (ICB) have a statutory requirement to develop formal agreements for engaging and embedding the VCSE sector in Integrated Care System (ICS) governance and decision-making, ideally through a VCSE alliance, which are supported by the national VCSE Health and Wellbeing Alliance (NHS England, 2021). However, beyond this, just 7 of 42 ICBs have a constitutionally mandated role for the VCSE sector on the board, despite delivering a high proportion of contracted services (Allen, 2023). As indicated above, much of the literature addressing community engagement and social prescribing has related to the relationship between the VCSE and health care sectors, particularly the challenges that arise. While there may be a 'long (and proud)' historical relationship between these two sectors (Calderón-Larrañaga et al., 2023, p. 12), researchers have found that there are some underlying issues that have not been sufficiently addressed in the commissioning relationship that may be manifesting in social prescribing (Sheaff et al., 2023). Moreover, much of the research focuses on the relationship between larger voluntary sector organisations and the health system, rather than smaller community groups, which may have less visibility or power in health care commissioning.

The first and foremost of these issues is funding, which also underpins other issues. Findings from He et al. (2022) show that VCSE organisations are experiencing increased demand for their services without an increase in funding. While organisations might receive some funding for contracted activities, these payments are unlikely to cover the full cost of provision by VCSEs (Dayson and Batty, 2020) or any core operational costs (He et al., 2022), and smaller community groups may especially struggle. There is also a view that applying for and receiving funding can be difficult, competitive or even unfair. There is a particular feeling that the health care system funds link worker roles rather than the community-based activities patients are referred to, erroneously assuming that these services are 'free' (Baxter and Fancourt, 2020).

In a catch-22, the health system may be reluctant to commission VCSE organisations due to concerns over financial sustainability (Baxter and Fancourt, 2020). Lack of sustained funding and the need to adjust funding proposals to health sector priorities mean that services are 'temporary and contingent' (He et al., 2022, p. 8). And yet, 'the sustainability of such programmes is dependent on the availability of community infrastructure' (Holding et al., 2020, p. 1541). Link workers may '[encounter] difficulties sourcing befriending, transport and other community services' (ibid.). This was underscored by the perception that 'bidding for commissions tended to introduce competition and mistrust between VCSEs' which served as a 'practical obstacle to VCSE activities which relied on inter-organizational collaboration' (Sheaff et al., 2023, p. 6).

Other issues raised in research concern the coordination and communication between the VCSE and health sectors. VCSE providers worry that the health sector is not aware of locally-available services, which will prevent referrals, while simultaneously experiencing high demand for services and some inappropriate referrals for individuals with complex mental health needs that small organisations are not equipped to handle (He et al., 2022; Jones et al., 2016). There is an additional perception that the VCSE and health sectors are speaking a different language and that a shared language would be beneficial (Baxter and Fancourt, 2020; Polley et al., 2023).

This may be reflected in the commissioning relationship between the VCSE and health sectors, particularly where there are different perspectives on what outcomes are and how or whether they should be measured (Sheaff et al., 2023). Moreover, the priorities to which funding proposals are addressed may not align with the priorities of the local communities in which VCSE organisations operate (Garside et al., 2020), although the ICP is tasked with developing an integrated care strategy through a population health management perspective. This is where 'collaborative commissioning' may play a role. As opposed to competitive or commodified commissioning, collaborative commissioning adapts to the 'fluid, emergent character of much VCSE activity', draws on both horizontal and vertical networks and cooperation and addresses population needs (Sheaff et al., 2023, p. 8). However, collaborative commissioning is likely an ideal practice rather than currently widespread within NHS England. Moreover, smaller community groups may have less professional experience or bargaining power in commissioning and therefore be at a disadvantage in these processes, compared with larger voluntary organisations or charities.

There remains a tension between the health and VCSE sectors in the commissioning of social prescribing services. There is a feeling that providing non-medical activities to address individuals' unmet social needs is something that the VCSE sector has always done and that there is a risk that 'social prescribing' becomes a by-word in the health system for all local voluntary action. This issue is exacerbated both by definitional issues around social prescribing, whether social prescribing can sufficiently address community needs and/or health inequalities (see for example Gibson et al., 2021; Mackenzie et al., 2020), and a wider debate around whether social needs should be medicalised or addressed in the health care system at all (see for example Haslam, 2022).

Community engagement in social prescribing

During our scoping review, we identified frameworks for understanding community engagement in social prescribing, which are a starting point for understanding what community-led social prescribing may be. In this section, we discuss the foremost of these: co-production, social prescribing 'plus' and community-enhanced social prescribing.

CO-PRODUCTION

Co-production is one of the most common approaches through which the community as well as community-based VCSE providers have been engaged in the design and implementation of social prescribing in England. Co-production involves 'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours' (Boyle and Harris, 2009, p. 11). Co-production encompasses not only co-design but also co-delivery and co-assessment. Co-design can be implemented as its own activity but is considered essential to co-production (Bovaird and Loeffler, 2012). There is considerable evidence around the impact of co-production in health interventions, including community-based provision and non-medical support (Hubbard et al., 2020; Mayrhofer et al., 2020). While the

evidence with respect to co-produced social prescribing is still emerging, it appears that these interventions can result in (Thomas et al., 2021):

- Confidence, positive mood and sense of control
- Reduction of social isolation
- Feelings of 'connectedness'
- Reciprocal relationships between service users and providers

These outcomes were reported for co-produced social prescribing interventions for people with long-term conditions, mental health problems, dementia, and those living in communities suffering from health inequalities (Thomas et al., 2021). Perhaps unsurprisingly, co-produced social prescribing interventions may face the same challenges in the relationship between communities, community-based VCSE providers and statutory services seen in social prescribing more broadly, as described above. Barriers to co-produced social prescribing included unequal relationships, a lack of awareness of support available in the VCSE sector, and short-term funding (Baker and Irving, 2016; Whitelaw et al., 2017). Issues of coordination and communication likewise pose problems for meaningful engagement with communities (He et al., 2022; Thomas et al., 2021).

This body of work suggests that 'a co-productive and co-designed approach is necessary in the development of interventions that seek to improve community well-being outcomes' (Thomas et al., 2021, p. 2). The studies reviewed by the authors suggest that co-production 'contributes to the development of sustainable healthy communities as it leads to interventions that are tailored to community needs and available community resources' (Thomas et al., 2021, p. 11). They conclude, therefore, 'that applying a co-designed, co-produced approach to the design of SP interventions in future would be effective practice, particularly within a community setting' (ibid.).

SOCIAL PRESCRIBING 'PLUS'

Social prescribing 'plus' is a proposed model of social prescribing which situates social prescribing's potential policy development within the 'context of a broader body of literature on asset-based and collaborative approaches to designing and implementing innovative ways to support people with multiple and complex needs through integrated health and social care services' (Dayson, 2017b, p. 102). Social prescribing is understood as an asset-based approach to health care, meaning that it simultaneously seeks to address the symptoms of ill health while supporting community capacity to support good health. Dayson (2017b) suggests that social prescribing 'plus' more closely aligns with the criteria of asset-based approaches outlined by Morgan (2014) than social prescribing alone by:

- Committing to improving well-being, including through long-term investment and in commissioning strategies
- Using principles of co-production
- Understanding service user needs versus availability of community resources and supporting community capacity to meet those needs
- Working in a multi-disciplinary, integrated manner to address wider population needs
- Embedding evaluation to inform service delivery and commissioning.

While social prescribing is understood as a 'social innovation', which addresses unmet social needs while also creating social value, Dayson argues that there has been limited discussion of the processes through which social prescribing has been adopted and scaled throughout England (Dayson, 2017a). Dayson suggests that 'collaborative innovation' is a useful idea to understand how social prescribing 'plus' understands problems and challenges, develops and tests new ideas, implements solutions and diffuses successful approaches. Bringing together these concepts, Dayson argues that social prescribing 'plus', as demonstrated in the Rotherham Social Prescribing Service, is a 'model of asset-based collaborative policy innovation' (Dayson, 2017b, p. 101) based upon five key principles:

1. Placing service users at the centre of the design and delivery of social prescribing
2. Harnessing and investing in voluntary and community assets through social prescribing
3. Taking on board the needs and views of professionals involved in social prescribing
4. Multi-stakeholder and inter-disciplinary collaboration throughout the development and implementation of social prescribing
5. Understanding the delivery of social prescribing as a process of adaptive implementation.

For Dayson, this proposed model of social prescribing 'plus' raises key questions about the policy development and implementation of social prescribing in England. He asks, 'will their approaches draw on the asset-based collaborative principles that are evident in the development and implementation of social prescribing 'plus'; or will social prescribing become a convenient way of framing an expectation that people and communities need to do more to help themselves, without significant investment in the capacity and capabilities necessary to support this alternate model of welfare?' (2017b, p. 102) This key question relates to wider debates around the responsibilisation of individuals for their own health and wellbeing, not only in social prescribing but also other areas of health and social care, as discussed above (see for example Dowling, 2021). It underscores the importance of involving communities in meaningful ways in social prescribing to ensure that it is not just a matter of individual responsibility or individual outcomes but community responsibility and outcomes, and providing resources and building capacity in communities to enable this.

COMMUNITY-ENHANCED SOCIAL PRESCRIBING

Community-enhanced social prescribing (CESP) is a new model of social prescribing, 'combining community engagement, organisational change and individual-level practice which aims to improve both community and individual wellbeing. It provides a way of thinking about the reciprocal value of individual and community wellbeing in the context of primary health care and local communities' (Morris et al., 2022, pp. 179–180). The authors begin from the premise that the NHS Long Term Plan (2019) is too focused on individual outcomes and that social prescribing schemes 'will need to engage with, and orient themselves more towards, local communities' (2022, p. 180). They propose the CESP model as a framework for reorienting social prescribing towards not only individual wellbeing but also community wellbeing, which is not currently a part of mainstream understandings of social prescribing. Indeed, as Morris et al. note, 'it can be argued that the genesis for social prescribing owes significantly more to the individualisation of social diagnosis than to the collective development of social solutions' (2022, p. 183). The authors acknowledge the challenge in defining what a community is, but argue that its conceptual complexity is not an excuse for not engaging with communities.

Community connection and empowerment are associated with reduced social isolation and loneliness (see for example Baba et al., 2017; Elliott et al., 2014). CESP recognises that communities are 'not only potential sources of health benefits for individuals, but they provide opportunities for people to enrich existing capacity and develop new assets for the benefit of all' (Morris et al., 2022, p. 185). The model explicitly integrates community development into social prescribing thereby addressing individual and community wellbeing. Fostering a sense of community is particularly important to the CESP model 'as it supports people to enhance their connections with, and contributions to their communities, as well as deriving benefits from these' (ibid.). CESP 'aims to impact positively on the culture of primary care practice and provide a way to connect it with community assets, whilst recognising that communities are dynamic and that capacity-building may be required' (ibid.).

Drawing together the Connected Communities and Connecting People approaches developed by the University of Central Lancashire, CESP brings together 'embedded assets, networks and resources of local communities in order to support individuals who are seeking to improve their wellbeing'. As such, it requires a coordinated, integrated or whole systems approach - what Thomas (2017) refers to as 'community-oriented integrated care'. To enable this, Morris et al. outline two necessary changes:

- At PCN level, a shared focus on community wellbeing, with a citizens panel to inform organisational change and objectives in this area.
- At individual level, development of referrals for target groups, e.g., major conditions.

They suggest that this approach ‘will enable CESP to be applied in locally-relevant ways that also help to incrementally transform the whole system towards effective use of local networks, resources and community assets’ (Morris et al., 2022, p. 189). What is critical to the implementation of CESP is the use of a citizens panel to iteratively and continuously map local community assets, networks and resources, including those that are informal or less visible, and that the link worker works closely with this panel to ensure that social prescribing is based upon community need and also utilises or supports community capacity. This mirrors some of the examples above of community development, engagement and action research in wider health systems, which worked through existing or newly-created panels and forums to identify needs and responses (e.g. Rapport et al., 2008; Snooks et al., 2011).

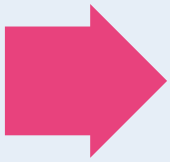
4. Community-led social prescribing

While each of these approaches and models differs slightly, there are some commonalities that we have drawn out that suggest that there is something distinct about the degrees of community engagement in designing and implementing social prescribing services. In co-production, social prescribing 'plus' and CESP, social prescribing is:

- based upon a community need,
- involves communities from the start and throughout, and
- draws on and supports community assets, networks and resources.

In so doing, these models and approaches speak to 'how public sector bodies involve voluntary and community organisations, and the people they represent, in the transformation and commissioning of public services' (Dayson, 2017b, p. 102).

Even with these factors, there may remain variation in the degree to which communities are initiating and leading these efforts. In each of these approaches and models, the locus of social prescribing policy development and implementation is the health care system and its commissioners. However, as our initial exploration into Big Local partnerships has suggested, communities - whether citizens or VCSE organisations - may take a more active role in initiating and leading social prescribing efforts. As such, based upon our scoping review, we propose the following definition of community-led social prescribing:



Community-led social prescribing describes social prescribing activities, systems or processes that have been initiated by the local community, often involving other local partners, and based on community-identified needs and solutions.

This forms a starting point for our research project with Big Local areas. We expect to test and refine the definition over the course of the project. We also expect to find a range of examples of engagement in social prescribing, which might be to a greater or lesser extent community led, and based in a range of settings. To help us articulate this range of activity we have developed a matrix (page 21) which will allow us to later situate examples according to whether the community or health system is leading them, and whether they are operating predominantly within the community or in a statutory setting.

We have also initially identified five ways (page 21) in which the community might initiate and lead social prescribing schemes, based on our scoping work on Big Local areas involved in social prescribing. One of these is co-production, which is not only a wider approach to community engagement but is also an element of both social prescribing 'plus', explicitly, and CESP, implicitly.

Figure 1A. Matrix of community-led and community-based social prescribing initiatives

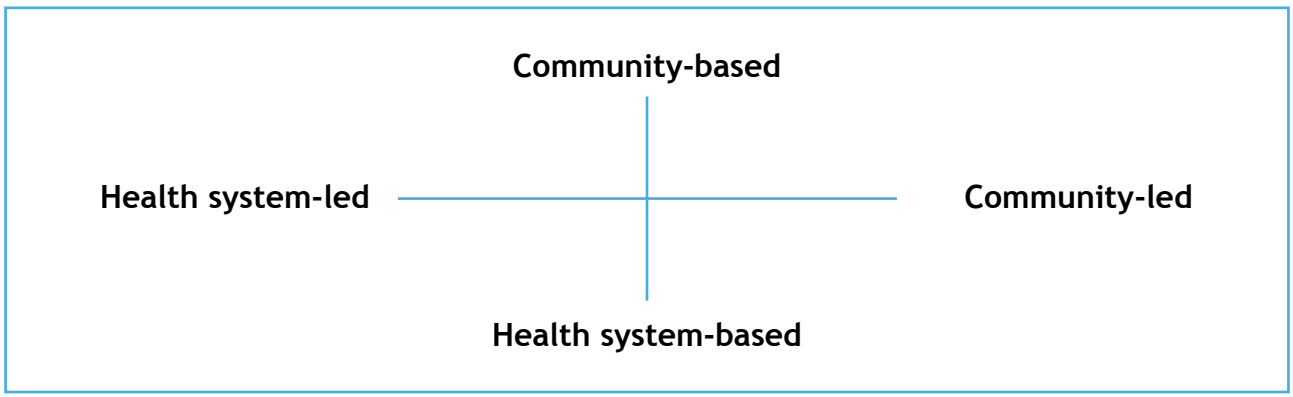


Figure 2A: Possible forms of community engagement and leadership in social prescribing

Co-production and co-design	Community organisation and/or community members and/or service users work in partnership with health services and others to co-design and/or co-deliver social prescribing scheme. Individuals are involved in the co-design and/or co-delivery of a social prescribing scheme.
Investment	Community organisation provides funds to other organisations or individuals to enable a social prescribing scheme, or to participate as a service in one.
Development	Community organisation builds capacity and capability of groups and individuals to contribute to the design and/or delivery of a social prescribing scheme.
Spaces	Community organisation provides or facilitates physical space for social prescribing scheme.
Partnerships	Community organisation builds relationships with other groups and health services, and/or facilitates others to do the same, to enable or take part in social prescribing schemes.

5. Conclusion

This review has reviewed relevant literature on community development and engagement in health and wellbeing, including in social prescribing. Section 1 defined the concepts of social prescribing, community and community development and introduced a gap in current understanding of social prescribing with respect to community engagement and leadership in social prescribing activities. Section 2 set out the existing research on the relationship between community development and health and wellbeing, as both are key aspects of the Big Local programme, especially where Big Local areas have chosen to engage in social prescribing activities. Section 3 reviewed recent scholarship on the relationship between the VCSE sector and social prescribing under the NHS and highlighted the opportunities and challenges therein. It also outlined three models for understanding community engagement in social prescribing, which share three characteristics: 1) based upon a community need, 2) involves communities from the start and throughout, and 3) draws on and supports community assets, networks and resources. Section 4 builds on this learning to articulate a working definition of community-led social prescribing.

This review suggests that there is potentially an important place for community-led social prescribing within social prescribing policy and implementation in England. It appears that co-production, social prescribing 'plus' and CESP may engage communities to a greater degree than the standard NHS England social prescribing model insofar as they are based on community need, involve communities from the start and throughout and draw on community assets, networks and resources. Our scoping work with Local Trust suggests that there may be an additional factor around the initiation and leadership of social prescribing activities. In Big Local areas, the partnerships have identified a community need and initiated engagement with social prescribing - in various forms (see Figure 2) - and/or led the development and implementation of the social prescribing activity. Our initial searching into other community-led examples suggest that this may be happening outside the context of the Big Local programme as well.

The next steps for this research project involve exploring whether community-led social prescribing exists in practice, the ways in which community groups and residents take the lead in different ways in initiating, evaluating and 'doing' social prescribing, and specifically what this looks like in Big Local areas. While it is outside the scope of this project to measure or compare health and wellbeing outcomes from this model, we aim to understand and detail in-depth what sets it apart from other models, including perceived benefits, barriers and enablers. Our final report will help communicate the experience of communities and residents getting involved in social prescribing, and the difference their involvement can make.

Appendix 3: References

Abel, J., Bowra, J., Walter, T., Howarth, G., 2011. Compassionate community networks: supporting home dying. BMJ Support Palliat. Care 1, 129–133.

Akhter, N., McGowan, V.J., Halliday, E., Popay, J., Kasim, A., Bambra, C., 2023. Community empowerment and mental wellbeing: longitudinal findings from a survey of people actively involved in the big local place-based initiative in England. J. Public Health 45, 423–431. https://doi.org/10.1093/pubmed/fdac073

Allen, P., 2023. The architecture of the NHS and social care system in 2023.

Arnstein, S.R., 1969. A Ladder of Participation. J. Am. Inst. Plann. 35, 216–224. https://doi.org/10.1080/01944366908977225

Baba, C., Kearns, A., McIntosh, E., Tannahill, C., Lewsey, J., 2017. Is empowerment a route to improving mental health and wellbeing in an urban regeneration (UR) context? Urban Stud. 54, 1619–1637. https://doi.org/10.1177/0042098016632435

Baker, K., Irving, A., 2016. Co-producing Approaches to the Management of Dementia through Social Prescribing. Soc. Policy Adm. 50, 379–397. https://doi.org/10.1111/spol.12127

Baxter, L., Fancourt, D., 2020. What are the barriers to, and enablers of, working with people with lived experience of mental illness amongst community and voluntary sector organisations? A qualitative study. PLOS ONE 15, e0235334. https://doi.org/10.1371/journal.pone.0235334

Blickem, C., Dawson, S., Kirk, S., Vassilev, I., Mathieson, A., Harrison, R., Bower, P., Lamb, J., 2018. What is Asset-Based Community Development and How Might It Improve the Health of People With Long-Term Conditions? A Realist Synthesis. SAGE Open 8, 2158244018787223. https://doi.org/10.1177/2158244018787223

Bovaird, T., Loeffler, E., 2012. From Engagement to Co-production: The Contribution of Users and Communities to Outcomes and Public Value. Volunt. Int. J. Volunt. Nonprofit Organ. 23, 1119–1138. https://doi.org/10.1007/s11266-012-9309-6

Boyle, D., Harris, M.D., 2009. The Challenge of Co-Production. How Equal Partnerships between Professionals and the Public Are Crucial to Improving Public Services. National Endowment for Science, Technology and the Arts (NESTA), London, UK.

Boyle, D., Wyler, S., 2021. “Us and them”: A mindset that has failed our communities. Local Trust. URL https://longreads.localtrust.org.uk/2021/12/10/us-and-them-a-mindset-that-has-failed-our-communities/ (accessed 11.20.23).

Bradshaw, T.K., 2008. The Post-Place Community: Contributions to the Debate about the Definition of Community. Community Dev. 39, 5–16. https://doi.org/10.1080/15575330809489738

Bridgen, P., 2004. Evaluating the empowering potential of community-based health schemes: The case of community health policies in the UK since 1997. Community Dev. J. 39, 289–302. https://doi.org/10.1093/cdj/bsh023

Brown, L.T., 2021. The Black Butterfly: The Harmful Politics of Race and Space in America. Hopkins Press, Baltimore MD.

Brunton, G., Caird, J., Stokes, G., Stansfield, C., Kneale, D., Richardson, M., Thomas, J., 2023. Review 1: Community engagement for health via coalitions, collaborations and partnerships - a systematic review. EPPI-Centre, London.

Calderón-Larrañaga, S., Greenhalgh, T., Clinch, M., Robson, J., Dostal, I., Eto, F., Finer, S., 2023. Unravelling the potential of social prescribing in individual-level type 2 diabetes prevention: a mixed-methods realist evaluation. BMC Med. 21, 1–15. https://doi.org/10.1186/s12916-023-02796-9

Carlisle, S., 2010. Tackling health inequalities and social exclusion through partnership and community engagement? A reality check for policy and practice aspirations from a Social Inclusion Partnership in Scotland. Crit. Public Health 20, 117–127. https://doi.org/10.1080/09581590802277341

Cassetti, V., Powell, K., Barnes, A., Sanders, T., 2019. A systematic scoping review of asset-based approaches to promote health in communities: development of a framework. Glob. Health Promot. 27, 15–23. https://doi.org/10.1177/1757975919848925

Chavis, D.M., Lee, K., 2015. What Is Community Anyway? Stanf. Soc. Innov. Rev. URL https://ssir.org/articles/entry/what_is_community_anyway# (accessed 11.20.23).

Clark, J., Jenkins, N., Noone, S., 2019. Soft power and hard choices: A critical perspective on health and inclusion in disadvantaged communities. Local Econ. 34, 730–738. https://doi.org/10.1177/0269094219889605

Cochrane, M., Fisher, B., 1983. Peckham Health Project: Community Dev. J. 18.

Cole, A., Jones, D., Jopling, K., 2020. Rolling Out Social Prescribing: Understanding the experience of the voluntary, community and social enterprise sector. National Voices, London, UK.

Community Action and Training Services (2013),. Our Big Local Profile: By Scotlands and Bushbury Hill Wolverhampton. Available: https://tinyurl.com/3paysh86 (accessed: 08/11/24)

Crawshaw, P., Bunton, R., Gillen, K., 2003. Health Action Zones and the problem of community. Health Soc. Care Community 11, 36–44. https://doi.org/10.1046/j.1365-2524.2003.00397.x

Danley, S., 2018. A Neighborhood Politics of Last Resort, Post-Katrina New Orleans and the Right to the City. McGill-Queen's University Press. https://doi.org/10.1515/9780773555891

Darlington, E.J., Pearce, G., Vilaça, T., Masson, J., Bernard, S., Anastácio, Z., Magee, P., Christensen, F., Hansen, H., Carvalho, G.S., 2022. How can we promote co-creation in communities? The perspective of health promoting professionals in four European countries. Health Educ. 122, 402–423. https://doi.org/10.1108/HE-02-2021-0033

Dayson, C., 2017a. Evaluating social innovations and their contribution to social value: the benefits of a 'blended value' approach. Policy Polit. 45, 395–411. https://doi.org/10.1332/030557316X14564838832035

Dayson, C., 2017b. Policy commentary - Social prescribing "plus": a model of asset-based collaborative innovation? People Place Policy 11, 90–104. https://doi.org/10.3351/ppp.2017.4839587343

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

Dayson, C., Fraser, A., Lowe, T., 2020. A Comparative Analysis of Social Impact Bond and Conventional Financing Approaches to Health Service Commissioning in England: The Case of Social Prescribing. J. Comp. Policy Anal. Res. Pract. 22, 153–169. https://doi.org/10.1080/13876988.2019.1643614

Dayson, C., Gilbertson, J., Chambers, J., Ellis-Paine, A., & Kara, H. (2022). How community organisations contribute to healthy ageing. Centre for Ageing Better.

Dowling, E., 2021. The care crisis: what caused it and how can we end it?, First edition paperback. ed. Verso, London ; New York.

Elliott, J., Gale, C.R., Parsons, S., Kuh, D., 2014. Neighbourhood cohesion and mental wellbeing among older adults: A mixed methods approach. Soc. Sci. Med. 107, 44–51. https://doi.org/10.1016/j.socscimed.2014.02.027

Emejulu, A., Shaw, M., 2010. Community Empowerment: Critical Perspectives from Scotland. Community Dev. J.

Fahy, K., Alexiou, A., Daras, K., Mason, K., Bennett, D., Taylor-Robinson, D., Barr, B., 2023. Mental health impact of cuts to local government spending on cultural, environmental and planning services in England: a longitudinal ecological study. BMC Public Health 23, 1441. https://doi.org/10.1186/s12889-023-16340-0

Farrington, F., 1914. Community Development: Making the Small Town a Better Place to Live and a Better Place in Which to Do Business. Ronald Press, New York (NY).

Fieldhouse, J., Donskoy, A., 2013. Community participation and social inclusion in Bristol. Ment. Health Soc. Incl. 17, 156–164. https://doi.org/10.1108/MHSI-05-2013-0014

Fisher, B., 2014. Community development through health gain and service change - do it now! Lond. J. Prim. Care 6, 154–158. https://doi.org/10.1080/17571472.2014.11494367

Garside, R., Orr, N., Short, R., Lovell, R., Husk, K., McEachan, R., Rashid, R., Dickie, I., 2020. Therapeutic Nature: Nature-Based Social Prescribing for Diagnosed Mental Health Conditions in the UK. Final Report for DEFRA.

Gibson, K., Pollard, T.M., Moffatt, S., 2021. Social prescribing and classed inequality: A journey of upward health mobility? Soc. Sci. Med. 280, 114037. https://doi.org/10.1016/j.socscimed.2021.114037

Gilchrist, Alison., 2009. The well-connected community: a networking approach to community development. The Policy Press.

Harrison, R., Blickem, C., Lamb, J., Kirk, S., Vassilev, I., 2019. Asset-Based Community Development: Narratives, Practice, and Conditions of Possibility—A Qualitative Study With Community Practitioners. SAGE Open 9, 2158244018823081. https://doi.org/10.1177/2158244018823081

Haslam, D., 2022. Side effects: how our healthcare lost its way - and how we fix it. Atlantic Books, London.

He, Y., Jorgensen, A., Sun, Q., Corcoran, A., Alfaro-Simmonds, M.J., 2022. Negotiating Complexity: Challenges to Implementing Community-Led Nature-Based Solutions in England Pre- and Post-COVID-19. Int. J. Environ. Res. Public. Health 19, 14906. https://doi.org/10.3390/ijerph192214906

Holding, E., Thompson, J., Foster, A., Haywood, A., 2020. Connecting communities: A qualitative investigation of the challenges in delivering a national social prescribing service to reduce loneliness. Health Soc. Care Community 28, 1535–1543. https://doi.org/10.1111/hsc.12976

Hopewell, D., 2017. Insights from a BBB evaluation of Social Prescribing: A Theory of Change approach. Bromley by Bow Health Partnership, London.

Hubbard, G., Thompson, C.W., Locke, R., Jenkins, D., Munoz, S.-A., Van Woerden, H., Maxwell, M., Yang, Y., Gorely, T., 2020. Co-production of "nature walks for wellbeing" public health intervention for people with severe mental illness: use of theory and practical know-how. BMC Public Health 20, 428. https://doi.org/10.1186/s12889-020-08518-7

Hudson, L.W., 2009. Hearing the human rights voices of Gypsy and traveller mothers in the UK. J. Soc. Welf. Fam. Law 31, 121–132. https://doi.org/10.1080/09649060903043505

Jenkins, R.H., Aliabadi, S., Vamos, E.P., Taylor-Robinson, D., Wickham, S., Millett, C., Laverty, A.A., 2021. The relationship between austerity and food insecurity in the UK: a systematic review. E-Clin. Med. 15. https://doi.org/10.1016/j.eclinm.2021.100781

Jones, G., Meegan, R., Kennett, P., Croft, J., 2016. The uneven impact of austerity on the voluntary and community sector: A tale of two cities. Urban Stud. 53, 2064–2080. https://doi.org/10.1177/0042098015587240

Jones, M., Kimberlee, R., Deave, T., Evans, S., 2013. The role of community centre-based arts, leisure and social activities in promoting adult well-being and healthy lifestyles. Int. J. Environ. Res. Public Health 10, 1948–1962.

Lamb, J., Dowrick, C., Burroughs, H., Beatty, S., Edwards, S., Bristow, K., Clarke, P., Hammond, J., Waheed, W., Gabbay, M., Gask, L., 2015. Community Engagement in a complex intervention to improve access to primary mental health care for hard-to-reach groups. Health Expect. 18, 2865–2879. https://doi.org/10.1111/hex.12272

Ledwith, M., 2011. Community Development: a critical approach, 2nd ed. Policy Press, Bristol.

Lewis, C., Phillipson, C., Yarker, S., Lang, L., 2023. The role of community organisations and social infrastructure, in: COVID-19, Inequality and Older People. Policy Press, pp. 101–119.

Lewis, L., 2012. The capabilities approach, adult community learning and mental health. Community Dev. J. 47, 522–537. https://doi.org/10.1093/cdj/bss027

Lockyer, S., South, J., 2006. Tackling inequalities through partnership working: the development of a neighbourhood project. Prim. Health Care Res. Dev. 7, 50–59. https://doi.org/10.1191/1463423606pc275oa

Lunt, N., Bainbridge, L., Rippon, S., 2021. Strengths, assets and place – The emergence of Local Area Coordination initiatives in England and Wales. J. Soc. Work 21, 1041–1064. https://doi.org/10.1177/1468017320918174

Mackenzie, M., Skivington, K., Fergie, G., 2020. "The state They're in": Unpicking fantasy paradigms of health improvement interventions as tools for addressing health inequalities. Soc. Sci. Med. 256, 113047. https://doi.org/10.1016/j.socscimed.2020.113047

MacLeod, M.A., Emejulu, A., 2014. Neoliberalism With a Community Face? A Critical Analysis of Asset-Based Community Development in Scotland. J. Community Pract. 22, 430–450. https://doi.org/10.1080/10705422.2014.959147

MacQueen, K.M., McLellan, E., Metzger, D.S., Kegeles, S., Strauss, R.P., Scotti, R., Blanchard, L., Trotter, R.T., 2001. What is Community? An Evidence-Based Definition for Participatory Public Health. Am. J. Public Health 91, 1929–1938. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.91.12.1929

Marmot, M., Allen, J., Boyce, T., Goldblatt, P., Morrison, J., 2020. Health Equity in England: The Marmot Review 10 Years On. Institute of Health Equity, London, UK.

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., Geddes, I., 2010. Fair Society, Healthy Lives: The Marmot Review.

Marsden, H (2022). 'The pink ladies of Scotlands and Bushbury Hill'. Local Trust, available: https://tinyurl.com/mr2rv9b4 (accessed: 08/11/24)

Mayrhofer, A.M., Mathie, E., McKeown, J., Goodman, C., Irvine, L., Hall, N., Walker, M., 2020. Young onset dementia: Public involvement in co-designing community-based support. Dementia 19, 1051–1066. https://doi.org/10.1177/1471301218793463

McCabe, A., Davis, A., 2012. Community development as mental health promotion: principles, practice and outcomes. Community Dev. J. 47, 506–521. https://doi.org/10.1093/cdj/bss026

Morgan, A., 2014. Revisiting the Asset Model: a clarification of ideas and terms. Glob. Health Promot. 21, 3–6. https://doi.org/10.1177/1757975914536849

Morris, D., Thomas, P., Ridley, J., Webber, M., 2022. Community-Enhanced Social Prescribing: Integrating Community in Policy and Practice. Int. J. Community Well-Being 5, 179–195. https://doi.org/10.1007/s42413-020-00080-9

Muhl, C., Mulligan, K., Bayoumi, I., Ashcroft, R., Godfrey, C., 2023. Establishing internationally accepted conceptual and operational definitions of social prescribing through expert consensus: a Delphi study. BMJ Open 13, e070184. https://doi.org/10.1136/bmjopen-2022-070184

NHS, 2023. NHS Long Term Workforce Plan. National Health Service (NHS).

NHS, 2019. The NHS Long Term Plan. National Health Service (NHS).

NHS England, 2022. Network Contract Directed Enhanced Service (DES): Personalised Care: Social prescribing; shared decision making; digitising personalised care and support planning. NHS England.

NHS England, 2021. Building strong integrated care systems everywhere: ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector. NHS England.

O'Mara-Eves, A., Brunto, G., McDaid, D., Oliver, S., Kavanagh, J., Jamal, F., Matosevic, T., Harden, A., Thomas, J., n.d. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Public Health Res. 1. https://doi.org/10.3310/phr01040

Peeler, A., Doran, A., Winter-Dean, L., Ijaz, M., Brittain, M., Hansford, L., Wyatt, K., Sallnow, L., Harding, R., 2023. Public health palliative care interventions that enable communities to support people who are dying and their carers: a scoping review of studies that assess person-centered outcomes. Front. Public Health 11.

Peer Learning for London, 2022. Proactive outreach and community development in the work of Social Prescribing Link Workers.

Peerbhoy, D., Minou, M., Stratton, G., 2021. Women, wellbeing and the city: A model of participatory health research exploring physical activity in Black, Asian and minority ethnic communities. Health Educ. J. 80, 287–299. https://doi.org/10.1177/0017896920971329

Pollard, G., Studdert, J., Tiratelli, L., 2021. Community Power: The Evidence. New Local, London.

Polley, M., Sabey, A., Seers, H., Chatterjee, H.J., 2023. Supporting the voluntary, community, faith and social enterprise sector to evaluate social prescribing. National Academy for Social Prescribing (NASP), London, UK.

Public Health England, 2021. Community champions: A rapid scoping review of community champion approaches for the pandemic response and recovery. Public Health England, London.

Quinn, N., Knifton, L., 2012. Positive Mental Attitudes: how community development principles have shaped a ten-year mental health inequalities programme in Scotland. Community Dev. J. 47, 588–603. https://doi.org/10.1093/cdj/bss025

Raj, T., MacKenzie, A., Lohman, K., Mead, R., Popay, J., 2023. Editorial: The role of community development in achieving health equity. Community Dev. J. 58, 589–594.

Rapport, F., Snooks, H., Evans, A., Tee, A., 2008. "Getting involved means making a difference?" Insider views on the impact of a "healthy living" community intervention. Crit. Public Health 18, 211–224. https://doi.org/10.1080/09581590701499319

Richardson, J., Goss, Z., Pratt, A., Sharman, J., Tighe, M., 2013. Building HIA approaches into strategies for green space use: an example from Plymouth's (UK) Stepping Stones to Nature project. Health Promot. Int. 28, 502–511. https://doi.org/10.1093/heapro/das033

Richardson, J., Grose, J., 2014. Partnership research in green space community development: a reflection on multi-professional working. Reflective Pract. 15, 304–316. https://doi.org/10.1080/14623943.2014.900011

Ritchie, D., Parry, O., Gnich, W., Platt, S., 2004. Issues of participation, ownership and empowerment in a community development programme: tackling smoking in a low-income area in Scotland. Health Promot. Int. 19, 51–59. https://doi.org/10.1093/heapro/dah107

Rosenthal, H., 1983. Neighbourhood Health Projects - Some New Approaches to Health and Community Work in parts of the United Kingdom. Community Dev. J. 18.

Russell, C., 2017. Social Prescribing, a panacea or another top-down programme? Part 1. Nurture Dev. URL https://www.nurturedevelopment.org/blog/abcd-approach/social-prescribing-panacea-another-top-programme-part-1/ (accessed 11.20.23).

Seebohm, P., Gilchrist, A., Morris, D., 2012. Bold but balanced: how community development contributes to mental health and inclusion. Community Dev. J. 47, 473–490. https://doi.org/10.1093/cdj/bss023

Seebohm, P., Gilchrist, A., Morris, D., 2009. In the driving seat: community development and social inclusion. Life Day 13.

Shaw, M., Armstrong, A., Craig, G., 2016. Re-visiting the Community Development Projects of the 1970s in the UK. Concept 7, 1–17.

Sheaff, R., Ellis-Paine, A., Exworthy, M., Hardwick, R., Smith, C.Q., 2023. Commodification and healthcare in the third sector in England: from gift to commodity—and back? Public Money Manag. 1–10. https://doi.org/10.1080/09540962.2023.2244350

Skivington, K., Smith, M., Chng, N.R., Mackenzie, M., Wyke, S., Mercer, S.W., 2018. Delivering a primary care-based social prescribing initiative: a qualitative study of the benefits and challenges. Br. J. Gen. Pract. 68, e487–e494. https://doi.org/10.3399/bjgp18X696617

Smith, L.K., 1991. Community Participation in Health: A Case Study of World Health Organization's Healthy Cities Project in Barcelona and Sheffield. Community Dev. J. 26.

Smith, S., 2015. Capacity building deconstructed. Community Pract. 11, 51–52.

Snooks, H., Evans, A., Cohen, D., Nugent, M., Rapport, F., Skone, J., Meredith, A., Davies, T., O'Sullivan, D., 2011. Costs and effects of a "healthy living" approach to community development in two deprived communities: findings from a mixed methods study. BMC Public Health 11, 1–12. https://doi.org/10.1186/1471-2458-11-25

South, J., 2015. A guide to community-centred approaches for health and wellbeing. Public Health England, NHS England.

South, J., Bagnall, A.-M., Stansfield, J., Southby, K., Mehta, P., 2017. An evidence-based framework on community-centred approaches for health: England, UK. Health Promot. Int. 34, 356–366. https://doi.org/10.1093/heapro/dax083

South, J., Higgins, T.J., Woodall, J., White, S.M., 2008. Can social prescribing provide the missing link? Prim. Health Care Res. Dev. 9, 310–318. https://doi.org/10.1017/S146342360800087X

South, J., Stansfield, J., Fenton, K., 2015. Putting communities at the heart of public health. Perspect. Public Health 135, 291–293. https://doi.org/10.1177/1757913915610495

Sykes, S., Wills, J., Popple, K., 2018. The role of community development in building critical health literacy. Community Dev. J. 53, 751–767.

Tang, L., 2018. Barriers to recovery for Chinese mental health service-users in the UK: a case for community development. Community Dev. J. 53, 358–374. https://doi.org/10.1093/cdj/bsw025

Taylor, M., 2021. The many histories of community development. Local Trust. URL https://localtrust.org.uk/news-and-stories/blog/the-many-histories-of-community-development/ (accessed 11.20.23).

Terry, V., Usher, R., Rooney, K., Buckley, E., Garforth, H., 2023. Building community leadership: Learning from the Community Leadership Academy. Local Trust, Institute for Voluntary Action Research and Just Ideas, London.

The Big Venture Centre Ltd (2024). Facebook page, available: https://www.facebook.com/venturecentre1 (accessed: 08/11/24)

Thomas, G., Lynch, M., Spencer, L.H., 2021. A Systematic Review to Examine the Evidence in Developing Social Prescribing Interventions That Apply a Co-Productive, Co-Designed Approach to Improve Well-Being Outcomes in a Community Setting. Int. J. Environ. Res. Public. Health 18, 3896. https://doi.org/10.3390/ijerph18083896

Thomas, P., 2017. Collaborating sites for community-oriented integrated care and health promotion. Lond. J. Prim. Care 9, 2–6. https://doi.org/10.1080/17571472.2016.1271491

Tierney, S., Wong, G., Roberts, N., Boylan, A.-M., Park, S., Abrams, R., Reeve, J., Williams, V., Mahtani, K.R., 2020. Supporting social prescribing in primary care by linking people to local assets: a realist review. BMC Med. 18, 49. https://doi.org/10.1186/s12916-020-1510-7

Tiller, C., 2021. How can participatory art give rise to community empowerment? Local Trust. URL https://localtrust.org.uk/news-and-stories/blog/how-can-participatory-art-give-rise-to-community-empowerment/ (accessed 11.20.23).

Ure, C., Hargreaves, S.C., Burns, E.J., Coffey, M., Audrey, S., Ardern, K., Cook, P.A., 2021. An asset-based community development approach to reducing alcohol harm: Exploring barriers and facilitators to community mobilisation at initial implementation stage. Health Place 68, 102504. https://doi.org/10.1016/j.healthplace.2020.102504

Wallerstein, N., 1993. Empowerment and health: The theory and practice of community change. Community Dev. J. 28, 218–227.

Walsh, D., Dundas, R., McCartney, G., Gibson, M., Seaman, R., 2022. Bearing the burden of austerity: how do changing mortality rates in the UK compare between men and women? J. Epidemiol. Community Health 76, 1027. https://doi.org/10.1136/jech-2022-219645

Walters, E., Findlay, G., Curtis-Tyler, K., Harden, A., 2023. Embedding community development approaches in local systems to address health inequalities: a scoping review. Community Dev. J. 58, 699–718. https://doi.org/10.1093/cdj/bsad017

Westlake, Debra, Wong, Geoffrey, Markham, Steven, Turk, Amadea, Gorenberg, Jordan, Pope, Catherine, Reeve, Joanne, Mitchell, Caroline, Husk, Kerryn, Redwood, Sabi, Meacock, Anthony, Mahtani, Kamal R., Tierney, Stephanie (2024). “She’s Been a Rock”: The Function and Importance of “Holding” by Social Prescribing Link Workers in Primary Care in England—Findings from a Realist Evaluation, Health & Social Care in the Community, vol.1, pp.1-16.

Whitelaw, S., Thirlwall, C., Morrison, A., Osborne, J., Tattum, L., Walker, S., 2017. Developing and implementing a social prescribing initiative in primary care: insights into the possibility of normalisation and sustainability from a UK case study. Prim. Health Care Res. Dev. 18, 112–121. https://doi.org/10.1017/S1463423616000219

Wildman, J., Valtorta, N., Moffatt, S., Hanratty, B., 2019. “What works here doesn’t work there”: The significance of local context for a sustainable and replicable asset-based community intervention aimed at promoting social interaction in later life. Health Soc. Care Community 27, 1102–1110.

Wildman, J.M., Moffatt, S., Steer, M., Laing, K., Penn, L., O’Brien, N., 2019. Service-users’ perspectives of link worker social prescribing: a qualitative follow-up study. BMC Public Health 19, 98. https://doi.org/10.1186/s12889-018-6349-x

Williams, A., Wyatt, K., Stevens, K., Price, L., 2023. A complexity-informed in-depth case study into the sustainability and impact of a culture of health: The TR14ers community youth dance group. Plos One 18. https://doi.org/10.1371/journal.pone.0293274

Wilton, C., 2021. Coproduction and partnership with people and communities. BMJ Lead. 5, 79. https://doi.org/10.1136/leader-2020-000424

Wilton, C., 2018. Co-production and community development - a primer. NHS Leadership Academy, London.

Winterton, R., Hulme Chambers, A., Farmer, J., Munoz, S.-A., 2014. Considering the implications of place-based approaches for improving rural community wellbeing: The value of a relational lens. Rural Soc. 23, 283–295. https://doi.org/10.1080/10371656.2014.11082071

Wood, J., 2023. The power to act: dissecting distinctive elements of power and ownership in community organizing in England and Wales. Community Dev. J. bsad023. https://doi.org/10.1093/cdj/bsad023

Woodall, J., Raine, G., South, J., Warwick-Booth, L., 2010. Empowerment & health and wellbeing: evidence review. Centre for Health Promotion Research, Leeds Metropolitan University, Leeds.

WV10 Consortium (2024). Big Venture Centre. Available: https://wv10consortium.co.uk/big-venture-centre/ (accessed: 08/11/24).

National Academy for Social Prescribing

Get in touch

socialprescribingacademy.org.uk

hello@nasp.info

@NASPTweets

@NASP_insta

Registered charity in England (1191145)