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Research Article

Responding to the Global Pandemic: Delivering Social Prescribing in an Ever-Shifting Landscape

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Background: Social prescribing programmes across the United Kingdom were obliged to adapt and change as a result of COVID-19. However, as we emerge from the pandemic and only now begin to witness the extent to which service users and providers continue to be affected, is it realistic to expect social prescribing services to meet the increasing demands placed upon them? How might schemes manage to deliver effectively against a backlog of referrals, escalating mental health issues and growing health inequalities across the population? This paper explores the challenges faced by service providers and service users of social prescribing programmes during the global pandemic. Drawing from primary and secondary research, the discussion considers how the implementation of one social prescribing programme was impacted by COVID-19, how service providers responded, how service users were affected and, finally, what questions have been raised for the development and delivery of social prescribing in a postpandemic landscape.

Methods: Using the reach, effectiveness, adoption, implementation and maintenance (RE-AIM) framework, this discrete qualitative case study sits within the wider evaluation of *Community Connect,* London Borough of Bexley's social prescribing programme. To investigate the impacts upon the programme through the key domains of implementation, maintenance and effectiveness, data were collected between April 2020 and November 2022. One reflexive discussion group and 26 semistructured interviews were conducted with a purposive sample of stakeholders, including social prescribers ($n = 6$), service users ($n = 12$), service provider organisations ($n = 6$), volunteer telephone befrienders ($n = 6$) and service commissioners ($n = 2$). Framework analysis was subsequently used to code and analyse the resulting qualitative data.

Results: Following a period of programme interruption, *Community Connect* adapted to remote delivery in support of both existing and new service users. Service users experiencing multimorbidity, combined with mental health problems, loneliness and isolation were adversely affected physically, emotionally and socially. Volunteers likewise reported feelings of isolation and uselessness, motivating them to support those in need. An interim 'telephone befriending' intervention engendered feelings of self-worth and reduced social isolation, having a positive impact on mental wellbeing. However, social prescribers experienced challenges in working from home, while attempting to build relationships with new referrals and/or providing meaningful support to digitally excluded individuals. Limited capacity meant many service users experienced intermittent contact with social prescribers, while few were offered consistent support in managing worsening health and/or mental health conditions. In addition, restricted access to voluntary service provider organisations adversely affected all areas of the programme. Those living in deprived circumstances and/or with complex health needs experienced negative impacts upon their long-term conditions, housing or finances. Many service users now report finding themselves in an escalating state of crisis, while *Community Connect* and all linked services attempt to address the continuing challenges resulting from COVID-19 and the current economic crisis.

Conclusions: Social prescribing offered valuable support to certain individuals during the first phase of the pandemic but remote contact had limited impact for service users with complex health and/or social needs. Continuing and increasing pressures placed upon social prescribing and voluntary services have resulted in negative outcomes. Findings highlight the vulnerability of social prescribing's implementation and efficacy when voluntary service organisations and other linked services are disrupted by unforeseen global events.

Keywords: COVID-19; maintenance and effectiveness; programme implementation; social prescribing

1. Introduction

Social prescribing is a topic of growing policy, practice, political and academic interest. Promoted as an effective means for addressing social issues affecting health and wellbeing, it has become a part of mainstream National Health Service (NHS) service provision [1]. Social prescribing is for the most part targeted at patients with long-term health conditions (LTCs) and/or mental health issues, aiming to address the nonmedical needs of individuals [2, 3]. Ranging from active signposting through to more intensive approaches, social prescribing typically involves a link worker/social prescriber who addresses patients' personalised support needs [4]. This is often through 'co-producing' a personalised plan followed by referrals to relevant voluntary and community sector (VSC) activities, local authority or health services [5–7]. Despite there being a paucity of robust research regarding its effectiveness [8], social prescribing is being implemented on a large scale in the United Kingdom and gaining international traction [9] with initiatives in Canada, the United States, Australia, New Zealand and elsewhere [10–14]. Identified as playing a key role in the delivery of the NHS Model of Personalised Care, there is an aim for 900,000 people in England to be referred to social prescribing by 2024 [15]. In addition, it is increasingly framed as part of a broader commitment to reducing health inequalities, in spite of a lack of evidence that individualised interventions such as social prescribing can reduce health inequalities [16]. In response, the 10-year review of The Marmot Report [17] observed that health inequalities are increasing in the United Kingdom and called for more research into how social prescribing might affect these inequalities [18]. All of this prior to the unforeseen outbreak of the global pandemic and its overwhelming consequences, considerably affected by, for example, government policy and priorities; media pressure; and a lack of national preparedness.

At the time of writing, there have been towards 250,000 deaths from COVID-19 in the United Kingdom [19] (the highest number in Western Europe), with thousands more people likely to suffer from its long-term effects in the years to come. The pandemic has been the most significant test of the NHS since its creation. Even before the pandemic hit our shores, NHS waiting lists were at record levels and sharply rising across the United Kingdom. By February 2020, 4.43 million people in England were on waiting lists, while those waiting for cancer diagnostic tests had more than doubled in 10 years. Without the necessary infrastructure, staff, capacity or even adequate pandemic planning, routine healthcare was paused, significantly adding to a backlog which since then has grown to a record 6.5 million people on waiting lists in England, the greatest the NHS has ever seen. Additionally, between April 2020 and February 2022, there were over 31 million fewer outpatient appointments, pointing to a parallel medical care backlog (i.e., long-term conditions, mental health issues and chronic care) which remains unknown but is likely to hide the suffering of millions more people [20]. No other event has had a greater or more negative impact on NHS staff. The crisis brought about rapid and radical alterations to the ways in which health and social care services are delivered. Meeting the immediate demands of the pandemic required a major redeployment of staff, the creation of new and expanded teams, increased cross-sectoral coordination and collaboration. This resulted in significant alterations to roles and responsibilities, often at extremely short notice. It also resulted in changes to the ways patients accessed and experienced services, including those of social prescribing.

2. Background

Informed by a social prescribing pilot programme [21], NHS Bexley Clinical Commissioning Group and the London Borough of Bexley Council co-commissioned a 6-year service (April 2017 to March 2023), to deliver social prescribing through primary care to patients experiencing a range of physical health, psychological health and social issues. At the beginning of 2020, the global pandemic impacted upon the delivery and evaluation of *Community Connect* [22], requiring a rapid response in an ever-shifting landscape. However, as we emerge from the pandemic and only now begin to witness the extent to which service users and providers have been affected, is it realistic to expect social prescribing services to meet the increasing demands placed upon them? How might schemes manage to deliver effectively against a backlog of referrals, escalating mental health issues and growing health inequalities across the population? This paper will explore the challenges faced by service providers and service users of social prescribing programmes during the global pandemic. Drawing from both primary and secondary research, the discussion considers how social prescribing has been impacted by COVID-19, how service providers have responded, how patient needs have altered and, finally, what questions have been raised for the development and delivery of social prescribing in a postpandemic landscape.

3. Design

The burgeoning of social prescribing studies during the past two decades has contributed to more systematic and rigorous methods, yet the evidence base for social prescribing continues to lag behind its practice [23]. Conversely, there is an increasing awareness of the importance of using theories, frameworks and models (TFMs) in implementation research and practice [24], including social prescribing. Since the overarching study aims to evaluate both implementation outcomes and individual-level outcomes of *Community Connect*, a combination of implementation theory and evaluation framework was required. Evaluation themes and/or questions have been guided by the reach, effectiveness, adoption, implementation and maintenance (RE-AIM) framework [25] as recommended by Nilsen and for several reasons. Firstly, RE-AIM has been tested with a number of

comparable health interventions, describing both its strengths and limitations, while providing recommendations for using in a real-world setting. Secondly, the dimensions of the RE-AIM framework are well suited to inform the diverse needs of *Community Connect's* range of stakeholders including: service users, service providers, commissioners and/or funders, policy makers and research audiences. Thirdly, although there have been more than 400 publications using the RE-AIM model for the planning and evaluation of health programmes and/or policies, recent reviews reveal qualitative methods have to date been used less frequently and more specifically with reference to social prescribing studies [26].

Informed by implementation science and using the RE-AIM framework, this discrete qualitative case study therefore sits within the wider evaluation of *Community Connect,* London Borough of Bexley's social prescribing programme. The overarching investigation employs a convergent, parallel mixed-methods design and sets out to examine the outcomes of *Community Connect*, including how the social prescribing intervention has been implemented, adapted and sustained in a real-world setting. To investigate the specific impacts upon the programme's 'implementation,' 'maintenance' and 'effectiveness' in response to COVID-19, data for this case study were subsequently collected between April 2020 and November 2022.

4. Methods

The study included one reflexive discussion group and 26 semistructured interviews conducted with a purposive sample of *Community Connect*'s stakeholders, including social prescribers or *Community Wellbeing Coordinators* (CWCs) ($n = 6$), service users ($n = 12$), voluntary service provider organisations ($n = 6$), service commissioners ($n = 2$), volunteer telephone befrienders ($n = 6$) and service commissioners ($n = 2$). Boyd (2001) suggests between two and 10 participants or research subjects as sufficient to reach saturation [27] and Creswell, recommends "long interviews with up to 10 people or more" for a phenomenological study [28], and therefore, a minimum sample size of six and maximum of 12 participants was selected for each strand of the qualitative research.

Adults using and/or delivering *Community Connect* and fulfilling inclusion criteria were invited to participate in the study (i.e., were over 18 years of age; had mental capacity to consent; had English of a standard to understand and take part). The methods of delivery aimed to ensure the highest levels of health, safety and comfort for all participants. Data collection tools were designed to be both inclusive and accessible. In addition, data collection methods aimed to be sensitive and flexible to the specific needs of individuals. Verbal consent was obtained in the first instance through discussion with potential participants. A written information sheet explained the requirements of the study and allowing time to make an informed decision as to their involvement. This was followed by written consent. However, it was made clear to all individuals that participation in the study was optional.

Semistructured topic guides were designed for both the discussion group and one-to-one interviews. Each was informed by those guides piloted and conducted in the wider *Community Connect* research study, following the University of Kent's ethical protocols and approvals. The reflexive discussion group lasted 2 hours and was attended by six delivering team members (i.e., four social prescribers and two programme managers). The discussion was recorded, with audio file transcribed verbatim. Each interview lasted between 30 and 45 min. Telephone and/or online interviews were audio recorded, with audio files transcribed verbatim.

5. Analysis

Resulting data were input into NVivo Version 12 for Windows and analysed using the RE-AIM framework, and as aligned to those three domains of interest for this specific case study, that is, implementation, maintenance and effectiveness. The use of a discussion group guide and interview schedule(s) meant the analysis contained elements of a 'top-down' deductive approach. However, transcripts were re-read, and themes identified at the semantic level—primarily by inductive analysis—using a 'bottom-up' approach and where themes are strongly linked to the data itself [29]. Key themes were coded into categories, involving several close readings of the data (Table 1). At the same time, the 'theoretical and epistemological commitments' [30] of the researcher were recognised and a process of 'confirmability' of the codes was sought to ensure aims were met and interpretations of the data traceable [31]. Table 1 provides a summary of themes for analysis and accompanying codes, while Table 2 provides a summary of the RE-AIM framework analysis, with examples from the data, pertaining to the three domains of implementation, effectiveness and maintenance.

6. Results

6.1. Effectiveness. Findings revealed service users experiencing multimorbidity, combined with mental health problems, loneliness and isolation were adversely affected physically, emotionally and socially by the national lockdowns. Individuals who had been furloughed were recruited to support an interim 'telephone befriending' intervention delivered by *Community Connect*. This was evidenced to engender feelings of self-worth and reduced social isolation for service users, having a positive impact on mental wellbeing. Volunteers likewise reported feelings of isolation and uselessness, motivating them to support those in need. Matched partners went on to develop respectful and trusting relationships over time, described as a mutually beneficial experience. However, as people returned to work following the period(s) of lockdown, service providers described challenges in either retaining or recruiting individuals to sustain voluntary sector organisations key to delivering *Community Connect*, thereby minimising the effectiveness of the programme and its provision for service users.

Table 1: Summary of themes for analysis and accompanying codes.

Thematic area	Codes
Implementation	(I1) Readiness for service implementation (I2) Processes of service implementation (I3) Changes made to service implementation (I4) Barriers to service implementation (I5) Facilitators to service implementation
Effectiveness	(E1) Improved mental wellbeing in participants (E2) Improved social wellbeing in participants (E3) Improved quality of life in participants (E4) Barriers to efficacy/positive outcomes (E5) Facilitators to efficacy/positive outcomes
Maintenance	(M1) Barriers to maintaining service delivery (M2) Facilitators to maintaining service delivery (M3) What is required to maintain delivery of programme? (M4) What new developments have been stimulated? (M5) Wider policy agendas/changes affecting maintenance

"There's a Widows' Group that has just closed. There's a Carers' Group that has closed. There are another two groups locally that have closed. I think the reason why a lot of these groups are closing is because of the lack of volunteers. We're also finding it difficult as a charity. Now with the rising costs of living, lots of people have gone back to work. Working is a priority and unfortunately, volunteering for many people has really taken a backseat." Voluntary Service Provider

As the crisis worsened—in addition to the subsequent challenges of an economic downturn—*Community Connect* experienced a rapid turnover of personnel, leaving the service to be delivered by a skeleton staff for a period of months. Service users reported CWCs' attempts to contact them were sporadic; this was reported both during and following the pandemic. However, certain clients who received contact said they did not need support and were coping well. Service users engaged in the telephone befriending scheme described the 'regular chats' or check-in calls as enjoyable and positive interactions. Other service users conversely felt their support was 'on hold', since they were unable to see a CWC in person or be linked to the services they required. In this state of impermanence, clients' abilities to take action regarding their health were felt to be diminished. The cessation of formal in-person groups and other services signposted through *Community Connect* was noted to be damaging for service users who had made significant progress with their health prior to lockdown. Those less digitally literate clients reported attempting to engage with activities remotely, yet the experience was described as 'frustrating'. Service users also noted that the lack of personal contact affected their engagement with services offered, again impacting upon the efficacy of the programme.

"The emails I was getting were clearly computer generated, which is how it has to be but there was nothing personal. A follow up 'phone call could be seeing that you joined those three classes and asking how you found them. 'Don't feel obliged to do those every week and let's catch up when you want to.' Even asking if I wanted to try something else. To make sure what people pick fits what their needs were. Having a buddy system of people that ring back would be really good." Community Connect Service User

With reference to referrals, certain service provider organisations witnessed an increase in new users during the preliminary stages of the pandemic, while others noted a decrease. CWCs meanwhile reported an increase in complexity of need, including severe and/or enduring mental health issues, domestic abuse, extreme isolation, financial hardship and housing crises during—and more significantly—following the pandemic. Service users were often retained for longer periods, with *Community Connect* described as operating a 'holding' function until clients were able to access other health and social care services. Alternatively, service users were discharged prematurely, since no appropriate services were available to new referrals and/or there were excessively long waiting lists. As the world began to emerge from the impacts of the pandemic, CWCs described the increasing challenge to provide meaningful support, with clients acknowledging the inadequacy of a service attempting to address multiple and complex issues.

"The GP said to me, 'Have you got money problems?' I said everybody has got money problems, unless you're a millionaire! I'm running a small business during a pandemic. There's a lot going on in my life. I didn't really know what to ask for. I needed not to be in pain and I needed to be more able than I was at the time. I have to sleep in the chair because I can't sleep in the bed. Really, what could Community Connect do for me? I know that sounds critical but I've been back to the doctor for this over three years now. I don't tend to get anywhere. I just get put on waiting lists." Community Connect Service User

6.2. Implementation. Following a period of programme interruption, *Community Connect* adapted to online delivery in support of existing and new service users. The service attempted to operate remotely in the first instance; however,

Table 2: Summary of RE-AIM framework analysis.

RE-AIM dimension	Question (s)	Examples from data
Effectiveness	Is the intervention resulting in positive outcomes? What factors are contributing to these outcomes?	*'My partner hadn't had her prescription for 3 months and was taking anti-depressants. She has no money, so wasn't eating properly. No wonder she felt like that! I got her prescription sorted and put her in touch with the food banks. She's like a different person now! I speak to her on the "phone and her tone of voice is high pitched. She's so happy and excited and that makes me feel good too"'.* Volunteer Telephone Befriender *'I think now, where we've had such an increase of referrals, people are being put on wait lists and they're waiting for months before they're actually able to use any service. When it comes to follow-up calls, they're like, "We haven't actually started yet." You struggle with that because you can give someone an appointment, but it's like you haven't really changed things for multiple months.'* Community Wellbeing Coordinator
Implementation	How was the intervention implemented? How and why is the intervention being modified over time?	*'The pandemic has amplified many issues, particularly financial hardship, homelessness, domestic abuse. In common with a lot of mental health and wellbeing support in the borough, the level of need has now become far worse. As a result of trying to be helpful in that space, community connect has been filling some of those gaps through the pandemic but once you get into that space, it creates the expectation that you can just deal with this stuff, no matter what the future holds'.* Service Commissioner *'It's not their fault but there were a few weeks when she didn't call me. I assumed she had tried to call me and I'd missed her. But the message was supposed to get through to me that she needed some time off for personal reasons. I totally understand but the message never got through and I was just left without any support for weeks'.* Community Connect Service User
Maintenance	Is the intervention being implemented (and adapted), after the core delivery period? What is being sustained, discontinued, modified and why?	*'We're continuing beyond lockdown because it has really benefitted people. We've just trained some more volunteers, including Bengali, Portuguese, Senegalese, Serbian and Turkish community members. We're hoping this will enable us to help a far more diverse range of people in need of support during these difficult times'.* Volunteer Coordinator *'Post COVID, a lot of the GPs don't seem to actually know what we can offer. They'll send something through, and we'll contact the client. They might need support but it'll be for something completely different. There's been some cases where it's been like, "This client needs help with moving furniture where they're moving to." That's not something we can help with'.* Community Wellbeing Coordinator

the CWCs reported a lack of resources and/or equipment in order to begin working efficiently from home. Although these differences in the provision of equipment were largely addressed in the first 6 months, CWCs reported using their personal telephones and computers beyond this period. In-person team meetings were halted—apart from two events held outdoors—while CWCs attempted to cope with frequent system and procedural changes in the delivery of *Community Connect*. Online team meetings were then organised; however, CWCs experienced many technical challenges in joining from home, resulting in dislocated discussions and a lack of coherence across the team. Eventually, a hybrid model was employed until restrictions eased and in-person meetings resumed.

> *"We came together on just two occasions. There were a lot of gaps and changes. System changes and procedure changes of how we were doing things. We tried to bring things online through Teams and Zoom. They've decreased as we've switched to a hybrid style of working. The discussion base was lost and we needed to find ways to bring that back. We've now got meetings with MIND and smaller ones with BVSC. It was really needed for the whole team, I would say."* Community Wellbeing Coordinator

CWCs reported challenges engaging with and supporting digitally excluded clients during the pandemic. They attempted to adapt delivery to these service users by posting hard copies of information. However, this intervention was acknowledged to be inaccessible for those with low literacy levels and/or those whose first language was not English. Moreover, CWCs described the difficulties in 'reading' the situation of individual service users via telephone. Unable to conduct in-person consultations proved frustrating for both parties, with CWCs attempting to adapt their practice from day to day, according to the constraints of the pandemic.

> *"I've found myself having to retrain my perception skills. How I listen to people and how I reacted and acted with people. If I'm talking to someone and then all of a sudden you mention something that triggers them. There are so many different signs to pick up on that. I find now, that if I'm talking to someone on the 'phone and there's a period of silence, the next thing I might hear is someone bursting into tears. Whereas that might not happen if you've picked up on the body language. It has completely turned my whole working method upside down."* Community Wellbeing Coordinator

At the beginning of this altered state, the priority was to maintain contact with the most vulnerable clients, with CWCs supporting the delivery of food and/or prescriptions, checking service users understood the Government's COVID-19 guidelines and that individual service users were coping during their imposed isolation. It was recognised the pandemic may have altered clients' lives dramatically, with those individuals doing well prior to lockdown subsequently struggling. CWCs reported maintaining contact with service users was key during this period and suggested certain clients were easier to access via telephone than previously. As such, they reported attempting to balance contact with individual service users presenting high levels of need against maintaining contact with existing and increasing caseloads, often re-contacting those who had been previously discharged. The impacts of the pandemic upon wider health and social care services were also noted to be affecting the implementation of *Community Connect*, resulting in a mismatch between the ambitions to provide personalised provision in an increasingly fractured system.

> *"With home working, I've found myself second guessing all of the time. Am I doing the right thing for this person? I know that Social Services are in a terrible state. I just wish that there was a facility where somebody could have that one-to-one long-term support. You talk to people and they just say, 'I feel like I'm being moved from pillar to post.' That's the phrase they use when somebody comes out of all different services and then moves onto the next one. Because there's no 'one size fits all', people do feel like they're in a washing machine. Nobody's got the time to stand still and say, 'Let's work on you'."* Community Wellbeing Coordinator

In addition to those challenges in communicating with service users during the pandemic, CWCs suggested they were unsure about which community or voluntary services had begun to deliver remotely, expressing difficulties in fulfilling their role when the usual linked services were unavailable. The majority of these partner services were halted during the preliminary months of lockdown—preventing any onward referrals—resulting in a backlog of clients waiting to be supported and, in many cases, an escalation of need. As service provider organisations began to open up, additional challenges were presented with salaried staff and volunteers reticent to return to the workplace. Several voluntary service providers were obliged to close, reducing the range of support CWCs were able to offer clients,

> *"When that all calmed down, there were staffing issues. They either couldn't work or some of them didn't want to work. They didn't feel safe and didn't return. That was a real crisis! Certainly, from the point of view of some of our carers, they really felt 'It's COVID, you're on your own!' There wasn't a replacement for the services we'd previously signposted them to. There still isn't for a lot of people. They've felt very, very let down"*. Voluntary Service Provider

Finally, for the CWCs, the unforeseen changes to their working practices inevitably resulted in personal impacts. A rise in the severity of mental health issues led to longer telephone and/or online consultations with clients, demanding increased time, emotional capacity and skills, with their role shifting to that of mental health counsellor for which they were not necessarily trained; such clients would ordinarily be the responsibility of statutory mental health crisis teams. While most practitioners felt it was appropriate

to engage with the basic social needs of those with complex mental health problems, they were less comfortable with holding cases in crisis, which they saw as a shift away from their usual role of coordination and/or signposting. Without the in-person support of their colleagues or managers, CWCs themselves described feelings of isolation and exhaustion, and more especially, those who were newly employed and/or working alone from home.

6.3. Maintenance. After an extended period of navigating the many programme changes from March 2020 onwards (e.g., a move to remote working for CWCs, the development of a volunteer telephone befriending scheme, a decrease in voluntary service provision, a backlog of referrals held on waiting lists, an increase in service users with complex health and/or mental health conditions, frequent changes in personnel across the team, negotiating a new contractual agreement with commissioners and a relocation of offices), *Community Connect* did not resume full-service delivery until October 2022, following the recruitment of a new Programme Manager and three CWCs.

Due to its positive outcomes—and in response to other comparable voluntary services being closed—it was decided to extend the temporary telephone befriending scheme. However, a recruitment drive for new volunteers became necessary following the end of furloughing and as people returned to work; this in turn resulted in significant periods of waiting prior to service users being matched with suitable volunteers. CWCs meanwhile described how service user needs had multiplied on recommencing delivery, reducing their capacity to support individual cases and maintain the programme.

> *"Recently, I've seen far more clients who have extra needs. They'll come in due to isolation and then they might end up in hospital. They call you from hospital and they need different or more support. It's like you're giving so much time and sometimes you aren't able to do everything that they're asking. You have that guilt that you're not doing enough. Our main roles are to find out what people need and to refer them on but once you've started working with someone, they need more and more. There's a sense that one service isn't enough anymore."* Community Wellbeing Coordinator

Increasing pressures placed upon NHS health and social care services due to impacts of the global pandemic were repeatedly described. In terms of service users, CWCs and service providers reported an escalation in need giving rise to increasing—and often inappropriate—referrals made during the past year. The extreme demands placed upon GPs both during and postpandemic were regularly acknowledged; however, it was suggested certain GPs were not aware of the parameters of *Community Connect*. In addition, changes in primary care consultation systems were noted to have subsequent impacts upon the service and its maintenance.

> *"Elderly people start calling the surgery at 8am and are then held in a queue of sixty-seven other people waiting. Then they don't bother to wait and things escalate. Then it all comes out in one go. A big flood of 'I've got this problem, that problem and another problem'. The GPs are overwhelmed and just think, 'Oh, I don't know what to do, let's refer them to Community Connect'."* Community Wellbeing Coordinator

Commissioners concurred with these findings, while noting the inconsistencies in the current referral processes. An influx of referrals to *Community Connect* from specific GP practices towards the end of the financial year had raised concerns, not least because of the additional burdens it had placed upon the service at a critical time of recalibration (e.g., induction and training of new team members, renewed communication with GPs and allied health professionals and investigating the current status or capacity of voluntary service providers).

> *"We've noticed some erratic social prescribing trends. If this was working properly, you'd expect to see a fairly smooth flow throughout the year. You'd expect somebody to present in primary care and as part of a consultation the GP/ health professional would refer them on to Community Connect. That clearly that isn't happening when you get a whole bunch of referrals that come in February and March. It's a trend and something we are trying to work with our practices to support, to make sure that doesn't happen again in the future."* Service Commissioner

In terms of the long-term maintenance of *Community Connect*, the current contractual agreement with commissioners ends in September 2024. Taking account of the numerous challenges and programme changes experienced since 2020, CWCs repeatedly described the need for a period of stability, enabling them to establish new systems while reconnecting with the increasing numbers of both existing and new service users. In light of the current economic crisis and mounting pressures facing the NHS, concern was naturally voiced as to whether a more permanent state might be expected during the next phase of delivery. Commissioners attested to their continuing support for social prescribing and *Community Connect* more specifically. However, a need to revisit the model with stakeholders and discuss its potential duplication of services was reported, a point worthy of note.

> *"Prior to the procurement process, we brought together a stakeholder group to look at Community Connect and think about the new model. Unfortunately, due to COVID people's attention was diverted. It's our absolute priority that we pick up that conversation again. We need to talk about where social prescribing fits in this new world. I've not heard anybody say that it's not delivering or that it's had its day but at the moment, there is duplication; in terms of the investment but also, how services here are working together."* Service Commissioner

7. Discussion

7.1. An Escalation in Need for Social Prescribing. The long-term impacts of fatigue and stress amongst NHS health and social care personnel on staff sickness and/or turnover are becoming increasingly evident, while negative impacts upon the general population have resulted in a greater demand for services. This in turn has augmented the need for and availability of social prescribing interventions. In addition to the pressures placed upon NHS health and social care workers, social prescribers likewise have experienced expanded caseloads, frequently working in isolation with individuals with increased and/or more severe needs. The issues of lone working felt by the CWCs even before the pandemic—combined with readjusting to new ways of offering support during COVID-19—intensified the challenges facing those working with vulnerable clients, dealing with complex cases of mental health, homelessness and domestic violence. The findings of the present study revealed an escalation in need, alongside the frustrations experienced by the CWCs, resulting in the loss of several key team members at a crucial point in programme delivery.

Recent research refers to the depth and complexities of the link worker position, exacerbated throughout the global pandemic [32–34]. These studies describe the emotional demands of the role, in supporting clients with complex needs [35] particularly in the periods of national lockdown. Morris et al. describe the many adaptations made to services during this time, with social prescribers required to work remotely and/or focus upon COVID-19 advice and support, resulting in increased pressures upon retaining personnel [36–38]. While additional funds have been made available to support the recruitment drive for social prescribers since the pandemic, frequent changes in personnel in programmes across the country reflect a dissatisfaction in the role, as reported by the National Association of Link Workers [39]. Without skilled and experienced social prescribers to deliver both existing and new programmes, how will the needs for services be met in the future? As we emerge from the global pandemic, the demand for and referrals to social prescribing schemes are likely to increase ever more. Strategic funding therefore needs to be made available for sustainable community infrastructure, in order that a wide range of activities are available for programmes to connect into. Similarly, workforce development requires adequate funding to support, for example, digital access, training, supervision, induction for existing and potential personnel delivering social prescribing programmes. Pay scales also need to be realistic in order to maintain a healthy workforce, one able to cope with the demands social prescribers have placed upon them. Importantly, organisations engaged in the design and delivery of social prescribing schemes need to practice a meaningful duty of care of towards both salaried personnel and/or volunteers.

7.2. A Change in Practice for Social Prescribing Services. The immediate impacts of COVID-19 required a rapid shift from face-to-face to remote consulting for primary care and mental health providers. *Community Connect* was similarly affected by this change in practice, resulting in both positive and negative outcomes. Razai et al. note there is strong evidence for the acceptability, safety and effectiveness of telephone and online video consultations in healthcare settings for improving mental health [40]. Video consultations also provide therapeutic presence and visual information, especially helpful for anxious patients who would prefer not to attend in-person consultations [41]. Findings from the present study attest to the efficacy of the interim telephone befriending scheme, with benefits described by service users and volunteers alike. However, social prescribers (CWCs) experienced difficulties in fully realising an individual client's situation and/or needs without in-person contact. McKinstry et al. suggest that although telephone consulting is a familiar tool that has been widely used in primary care for many years, it is limited by the lack of non-verbal cues [42].

Moreover, effective use of video consultations and other web-based technologies is recognised to be limited in resource-poor settings, in populations with low health literacy and in older adults [43]. In addition, the ubiquity of online delivery has multiple implications, including creating greater social and health divisions between the digitally privileged and disadvantaged [44]. In spite of the perceived time—and indeed resource—effectiveness of the shift to remote delivery, service users in the present study described their frustrations at not being able to have regular, in-person contact with providers, suggesting they had felt abandoned by health and social care professionals. Since the pandemic, GP practices engaged in *Community Connect* have maintained a practice of remote consulting, while increasing referrals made to the service, frequently for patients with complex health and/or mental health needs. With these changes in practice set to continue, it is difficult to envisage how such programmes might be sustained to deliver meaningful outcomes, for service users and providers alike.

7.3. The Diminishing of Voluntary Service Organisations. The COVID-19 pandemic has exacerbated the struggles facing VCS organisations to meet social prescribing needs. *Community Connect*'s service provider organisations described challenges in recruiting individuals to sustain delivery and/or experienced severe financial cuts during the pandemic, thereby minimising the effectiveness of the programme and its provision for service users. Although the National Emergencies Trust allocated £5 million funding for local groups responding to the COVID-19 pandemic (e.g., food banks, groups supporting families and children), this funding is unlikely to fully alleviate the crisis facing the sector as a consequence of the pandemic [45]. A recent survey delivered to UK charities by the Institute of Fundraising, the Charity Finance Group and the National Council for Voluntary Organisations reported the sector expected at least £12.4 billion losses in income as a result of COVID-19

[46, 47]. Many organisations have faced budget shortfalls due to high-profile fundraising events being cancelled and/or charity shops closing their doors for significant periods of time during the crisis, with attention redirected to dealing with the immediate, physical impacts of the virus [48]. Irrespective of where an individual social prescribing scheme sits on the spectrum of individual to community models, no one model would be able to fulfil its impact upon population health and wellbeing without adequate community resources.

For social prescribing to function effectively, the VCS must be both able and willing to provide the kinds of support or engagement opportunities required by service users. The VCS sector has experienced more than a decade of reduced social finance, which has undermined its sustainability and capacity to support those individuals referred by social prescribing schemes, even in prepandemic times. Amongst the many challenges of delivering social prescribing during COVID-19, service providers highlight the vulnerability of programmes when VCS sector and linked services are not accessible, an issue widely reported in social prescribing literature both prior to and during the pandemic. The influence of health services' use of VCS organisations to supply social prescribing activities is likely to vary in the future. Those organisations already working with social prescribing programmes might be in higher demand and become better supported than less-established groups. Those able to adapt to the demands of working closely with the NHS (e.g., meeting the increased bureaucratic burden and forming good relationships with social prescribing schemes) may find their services expanding, whereas organisations not in a position to do so may disappear. Once again, without the infrastructure and support of adequately funded and well-resourced VCS organisations, how will social prescribing schemes be delivered in the months and years to come?

7.4. Social Prescribing in a Postpandemic Landscape. The health inequalities witnessed during COVID-19 and the unequal distribution of infection and mortality create cause for concern amongst already vulnerable users of social prescribing interventions [49]. Those individuals who often have complex health conditions that significantly affect their lives were evidenced to experience 'set backs' in their health [50, 51]. As yet, it is unknown to what extent the serious disruption to *Community Connect* during the pandemic might have affected individual service users' longer term engagement, health and wellbeing. However, these conversations with social prescribers, service providers, service users and commissioners suggest the impacts will have rarely been positive.

Recent research conducted by the IPPR's Cross-Party Commission on Health and Prosperity attests to the burgeoning evidence base to support bringing a broader array of interventions into community and primary healthcare settings, including those of social prescribing [52]. However, in spite of the long-held ambition to move care and healthcare resources into community settings, funding for such NHS services increased in real terms by less than 0.5% between 2016/17 and 2022/23. By contrast, acute and ambulatory care funding increased by over 20% [53]. Moreover, UK Health Accounts suggest hospital budgets reached record levels in 2022, while both general practice and preventative service budgets fell, as compared to 2021 levels [54].

The association between economic deprivation and poor health is well established. Unemployment and debt are seen to aggravate mental health problems, as does the impact of isolation from wider work and social networks. The UK population's health has deteriorated during the past 15 years, while it has also become poorer. Alongside the worsening health of the nation, there are deep-seated economic challenges contributing to the population's poor health: low growth, stagnant productivity, depressed wages, falling living standards and, more recently, a decrease in workforce participation rates. The consequences of the COVID-19 pandemic are set to widen existing health inequalities by affecting the most vulnerable, consequently increasing the demands placed upon health and social care services.

In the face of this public health emergency, which has undoubtedly exacerbated the existing shortcomings in population health that social prescribing aims to address, programmes across the country have been presented with major challenges in terms of delivery and development. Challenges which appear set to increase as we realise the longer term impacts of the past years' events. In a post-pandemic landscape, there exists a need for social prescribing to be remodelled to meet these multiple challenges. A social prescribing model that embraces the key principles of universality, inclusion and integration will be vital. Improving population health requires social prescribing to be holistic in its delivery, addressing domains beyond the traditional biomedical model to include health promotion and social determinants. To impact the entire population, it needs to be equitable and accessible to everyone. Fragmentation in care means those less able to manage their own health are more likely to fall through the gaps; therefore, truly integrating social prescribing into the healthcare system would improve accessibility and navigation through services. Crucially, where health systems are integrated, they have an increased ability to adapt in tandem with other services, no matter the unforeseen events that may arise in the future.

7.5. Strengths and Limitations. At the time of writing, this is the first study to apply the RE-AIM framework, in underpinning an evaluation pertaining to social prescribing. Strengths of this discrete case study include the timeliness of this investigation and the use of the RE-AIM framework to explore the three key domains of implementation, maintenance and effectiveness—as impacted by COVID-19—while capturing the diverse perspectives of service users, service providers and commissioners. One of the most challenging issues in applying RE-AIM is understanding the patterns of results and how they might affect generalisability across other studies [55]. Programmes and policies frequently produce different patterns of results across each RE-AIM dimension. An intervention may be highly

successful in its implementation, although less so in its effectiveness. Social prescribing services are by their very nature context specific, thereby affecting their results. However, findings from the present study demonstrate the application of RE-AIM in supporting the design of similar, future studies.

Limitations of the study include the small sample of participants, in attempting to describe the effects of COVID-19, upon one social prescribing programme in real time. In terms of its design, the investigation employed self-report methods (i.e., interviews and discussion group), thereby suffering from those criticisms levied at all comparable investigations and as described in the literature, for example, response bias and/or memory bias, defensiveness and/or social desirability. In addition, the investigation focussed solely on qualitative methods, while the overarching evaluation of *Community Connect* comprises a mixed-methods study, ensuring a more rigorous analysis. Finally, it is presently unclear how the continuing impacts of COVID-19 will affect social prescribing in the longer term, not least in terms of the increasing pressures upon health and social care services.

8. Conclusions

This discrete qualitative study sought to investigate the challenges faced by service providers and service users of social prescribing programmes both during and emerging from the global pandemic. It has described how one specific scheme has been impacted by COVID-19, how social prescribers and service providers have responded, how patient needs have altered and, finally, what questions might have been raised for the development and delivery of social prescribing in a postpandemic landscape. It aims to build upon the findings of several recent comparable studies, while reflecting upon those wider issues affecting social prescribing services across the country, as they attempt to recalibrate during an ongoing state of flux. Findings attest to the challenges and changes in delivery of social prescribing in response to COVID-19. Digital technology has assumed a central role in social prescribing, moving away from its traditional in-person focus. The study also highlights the additional pressures placed upon social prescribing practitioners now engaged in supporting a rising number of individuals with complex health and/or mental health conditions, heavily overburdened statutory services and third-sector organisations attempting to survive in a highly uncertain economic climate.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Conflicts of Interest

The authors declare no conflicts of interest.

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