Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Lincolnshire Sustainability and Transformation Partnership

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**24 March 2020**
Subject:	**Social Prescribing Update**

Summary:
This paper updates the Health and Wellbeing Board (HWB) on the Social Prescribing "proof of concept" service that has been running across Lincolnshire since June 2018 and will outline the new service model from the 1st April 2020 along with the recommendations to be able to scale up the approach over the next 4 years, which includes a strategic decision from the Health and Care system to investigate and agree how the model should be funded and commissioned to ensure that the Voluntary, Charity and Social Enterprise (VCSE) sector is able to develop sustainable ways to support the service.

Actions Required:
The Health and Wellbeing Board is asked to note the impact and outcomes of the Social Prescribing service during the proof of concept period and comment and advise on the recommendations outlined in the report to scale up the service offer across the Neighbourhoods and Primary Care networks (PCN's)

1. Background

National and Local Context

Social prescribing is about enabling people to become more involved in community life, to improve their health and well-being. It is not a new concept, it may be known by a different name such as care navigation, community connectors, and local area coordination. In Lincolnshire the focus has been to commission services which are able to offer healthy life style support, prevention and low level community and social interventions, such as the Wellbeing Lincs, One You and Carers First services all of which have aspects of social prescribing as part of their offer.

However in 2016/17 social prescribing and community support was becoming seen as a key driver for the NHS to help shift the focus from a medicalised, reactive and urgent response model

to a more proactive, personalised and community based asset rich approach which is embedded in primary care and neighbourhoods.

The evidence base for social prescribing has been and continues to develop and demonstrate impact such as;

- In a recent 2019 Royal College GP survey, 59% of family doctors think that social prescribing can help reduce workload.

- An evidence review, from the University of Westminster, found that studies report an average drop of 28% in demand on GP services following a referral to a social prescribing service.

Social prescribing has now become a key priority for the health and care systems over the last 12 months following the publication of the NHS Universal Personalised Care, where it is identified as one of the six components of the comprehensive model and one of the key drivers in the NHS Long Term Plan (LTP).

NHS England and Improvement (NHSEI) are hoping to see over 1000 social prescribing link workers recruited to in England, during 2020/2021 and have included the posts in the PCN additional roles reimbursable scheme which has included fully funded social prescribing link workers as one of the 10 roles that should be embedded in PCN's over the next 4 years.

Social prescribing has been included in the PCN Direct Enhanced Service (DES) for 2020/2021 with all PCN's being required to offer a service from 1st April 2020.

2. PART A

a) Local Response - 2018 – 2020

In 2017, the HWB awarded non-recurrent funding of £369,016 to the neighbourhood working programme to support the development of a social prescribing / community connector's concept in Lincolnshire which was aligned to health and primary care services.

The proof of concept commenced in the summer of 2018 in Gainsborough and was co designed and delivered by Voluntary Centre Services (VCS). The impact at a neighbourhood level was almost immediate, and was extended across the county with additional short term funding from GP Federations, CCG's and Better Care Funding (BCF).

VCS and Lincolnshire Community Voluntary Services (LCVS) have been the two providers who have been working in partnership with each other and key stakeholders to develop, design and deliver the model.

The total funding supported the employment of 18 whole time equivalent (WTE) Social Prescribing Link Workers (including senior roles), equating to 23 posts – see below

Post	**Number of posts (WTE)**
Link Workers (Supporting individuals across the Care Navigation / social prescribing spectrum)	13.3
Coordinators (responsible for referral management, administration, coordination of the activity for link workers)	2.5
Management, supervision & strategic lead (A mixture of a dedicated post in LCVS and a realigning and expansion of current roles in VCS)	2

The posts were not evenly distributed across the county due to funding arrangements at the time, e.g.: Boston Neighbourhood have had 2 Link workers whereas East Lindsey has only had access to 0.6 wte..

In October 2019 Lincolnshire successfully put in a bid to NHSE/I for funding to transform community mental health services. A key component of the bid was being able to offer a social prescribing service to people with severe and enduring mental health conditions. A pragmatic approach was taken and the CCG subcontracted LCVS and VCS to develop and enhance the establish model further to include a mental health offer. The funding available will support additional Social Prescribing link workers, supervisory support, co-production of a digital platform and funding for VCSE development.

b) The Model (see appendix a)

The model is built around a localised team, embedded within neighbourhood working, PCN's and the Mental Health Community Transformation Project. The team consists of a Link Worker supported by an element of coordination and admin support, and a Social Prescribing Lead offering management, supervision and a strategic steer for the local area; offering all the benefits of a managed and coordinated service.

The model is based on procedures and guidelines that ensure consistent good practice across the county but with the added flexibility and track record of coproduction and co-design that makes sure local issues are fully recognised.

The coordinated team operates as part of the core neighbourhood team delivering a local social prescribing service in line with national good practice, embedding the following components:

- Easy referral from all local agencies including primary care.
- Workforce development
- Common outcomes framework
- What matters to me (creating a personalised plan)
- Support for community groups
- Collaborative commissioning and partnership working

The offer might be in GP surgeries in the form of clinics, local community venues or at individuals' homes depending on the agreed local need.

This provision adopts the Lincolnshire model for care navigation and social prescribing embedding the three levels of support, using the principles and competencies of care navigation within the Health Education England (HEE) competency framework.

Level 1
I know what I need help with
I would like some advice on where to access activities in my local area

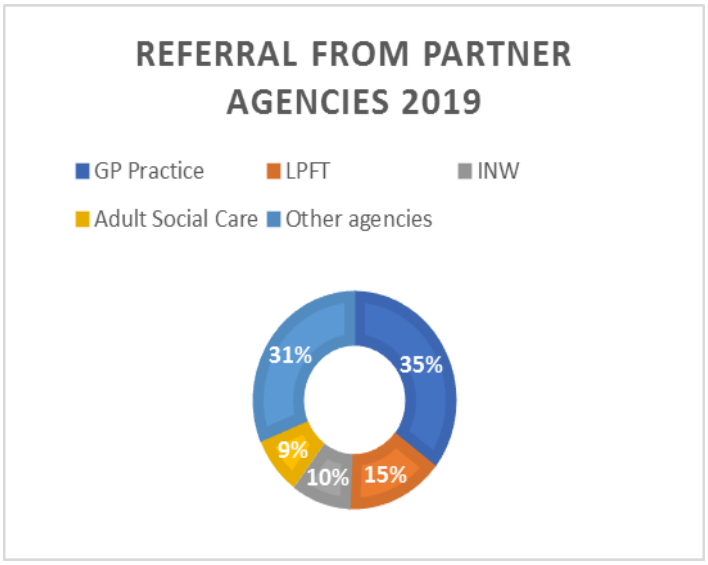
Level 2
I need some guidance to know what might help and where I can find it
I would like some help to think about what my goals are and some advice on how to access activities in my local area.

Level 3
I need practical support to get me started
I would like some help to think about my goals and someone to support me whilst I begin to move towards them.

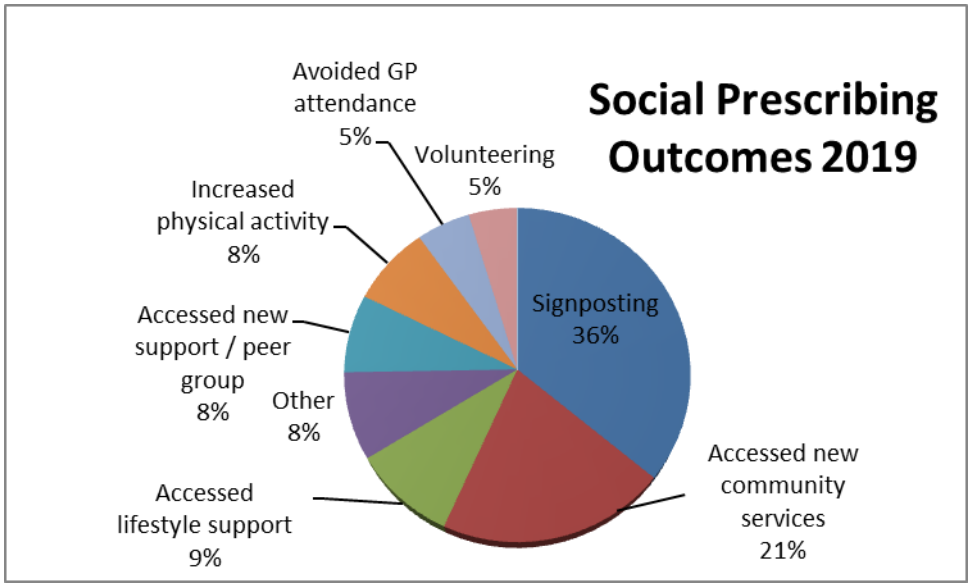
The link workers during the proof of concept were not given individual targets. Each area moved at a different pace depending on the development of the neighbourhood teams, recruitment and retention of link workers, the awareness of the service, whilst generating as many appropriate referrals as possible plus integrating staff within neighbourhood teams and supporting and growing the community groups and activities within the service referral networks.

C1) Outcomes and Impact

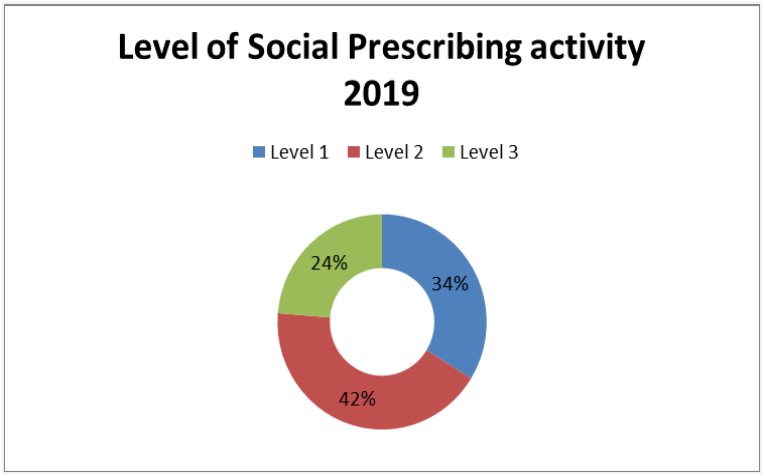
*To note: NHSE trajectories for Lincolnshire 19/20 were set between 762 and 1524 referrals, to present date (01.04.19 – 03.03.20); the social prescribing service has received **1613** referrals, exceeding the higher band.*



Referrals have been received from a wide range of 28 partner agencies. The majority have been from Primary Care.



Since the beginning of the county-wide roll out of the model in October 2018 the service has received 2058 referrals and supported over **1,700 people** and has evidenced demonstrable impacts on people's health, wellbeing and increased social inclusion through cultural, recreational and sports activities, befriending, resolving financial issues, volunteering and greater community participation.



The providers have recorded in excess of 2314 activities against participant records with a mean average duration for each activity of 26 minutes. That's over 1000 hours of direct and indirect support provided by the social prescribing team.

This support has sat alongside the time that link workers have spent developing relationships with colleagues, referrers and community organizations.

C2) Impact on People

616 cases were successfully closed during 2019 with over 94% participants reporting positive outcomes.

Feedback from Sleaford participant reflected on social prescribing; ***"I've been supported by lots of professionals over the years, but no-one has taken time to help me set goals for myself that I believe I can achieve in the way you have".***

Appendix B describes the case of an individual who really valued their social prescribing experience.

Appendix C illustrates participant feedback & impact on health and wellbeing of 35 participants, a sample caseload (sample, from when, how many, what level), participants have indicated that as a result of the support they have received through the social prescribing service, their physical health, safety, emotional health and empowerment have improved.

C3) Impact on the community

The social prescribing referral network continues to grow with participants supported to access over 500 different local groups and services.

C4) Measuring Social Value

Social Return on Investment (SROI) is a way of developing a value for less tangible outcomes delivered through the social prescribing service. SROI provides a more rounded view of what is being achieved (including the broader outcomes in addition to meeting the targets, outputs and outcomes). Through external support and the nationally accredited Social Value Engine, we can evidence that the social prescribing service generates **£8.07 of social value for every £1 invested**.

C5) Impact on the Health and Care System

During the 'proof of concept' it has been challenging to demonstrate impact at system level due to the relatively small numbers of people the service has been supporting, however as the model

expands over the next 4 years, there is an expectation that Social Prescribing will be able to demonstrate an impact on the Health and care system.

D1) The Lessons learnt

Throughout the proof of concept a number of key lessons have been learnt and will be considered during the next phase of the social prescribing service.

D2) Workforce

Recruitment across the county has always been a challenge and recruiting link workers is no exception. Getting the right candidates with the skills and competencies is a struggle especially for in Boston, Skegness and Coast neighbourhoods so working with the PCN's and neighbourhoods has been particularly important to understand methods and approaches that could be used.

With the number of Link workers projected to increase, recruitment to posts could be challenging in parts of the county.

One solution would be to develop a "Social Prescriber Apprenticeship pathway" This idea is currently been developed into a business case by LCVS and VCS.

Exploring a range of employers as host organisations is also being considered as a way of localising the offer and widening the opportunities for people to apply.

D3) IM&T Infrastructure

The current recording system (V- BASE) was developed to meet the demands of one neighbourhood team (Gainsborough) with a few social prescribers; the system ask is increasing. As the project has grown the proof of concept has identified weaknesses within the database that need to be addressed

- The current system offers no read across to other systems such as Mosaic or the Care Portal.
- The application is not user friendly and the current data confidence is lower than required.
- Information Governance and data sharing remains a challenge for the VCSE to be able to access and see relevant information about the people they are working with. Precedents have been set in Lincolnshire and options are currently being explored to find a solution.

Investment in a countywide system is needed, meeting the demands of an increasing workforce including community development teams and a wider stakeholder group. Any new system needs to be sustainable and have capacity for growth as well as being able to deal with the increased complexities and requirements of system reporting.

D4) Commissioned Services

Although when the Social Prescribing service first commenced there was a concern that this would impact on commissioned services or vice versa. There is further work to do to understand the synergy between the offers, and how the processes could be aligned, on the ground the staff work really well together making sure people get to the right service at the right time.

D5) Primary Care Engagement

It has been crucial over the last 12 months to engage where possible with Primary Care. This has been challenging with different levels of support, interest and understanding of social prescribing. Where there has been engagement GP's and Practice managers have encouraged the service

through social media (**See appendix D**), leafleting, offering space for clinics in surgeries and or being an advocate for social prescribing.

This will continue to be key area of engagement of the next 12 months.

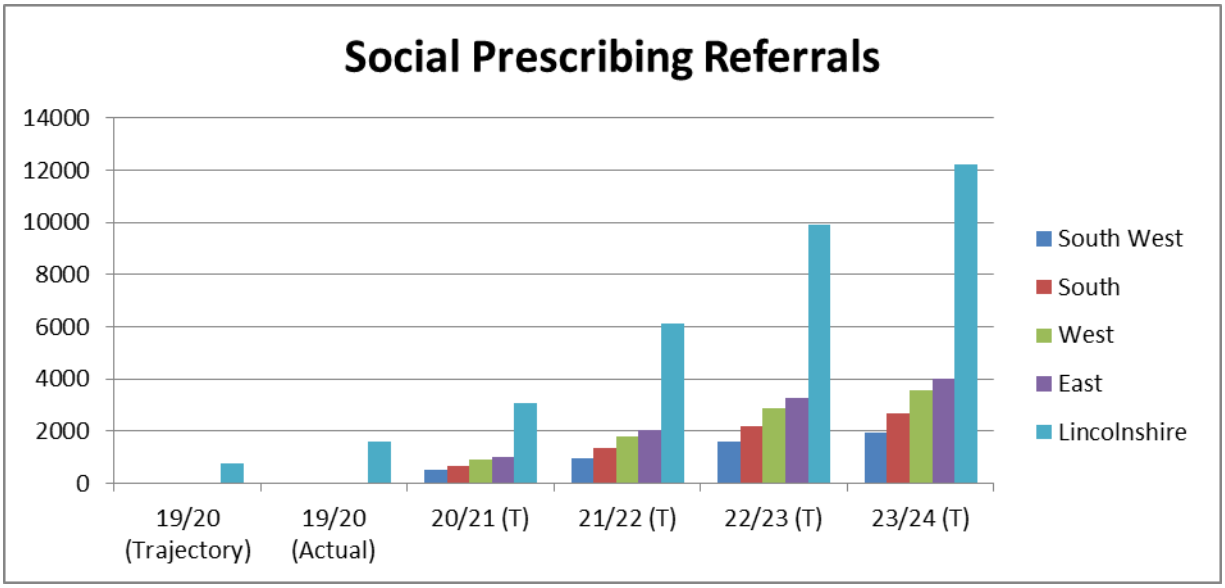
D6) VCSE Funding

The PCN funding will only fund link worker posts, plus a small amount for the coordination and management of the service and should not be used for community asset building or VCSE funding. NHS England are aware of the sectors concerns and are discussing the challenge nationally, however for Lincolnshire this leaves a significant risk that as the service expands over the next 3 years, an agreed approach to commissioning / funding a vibrant and flourishing VCSE will be required.

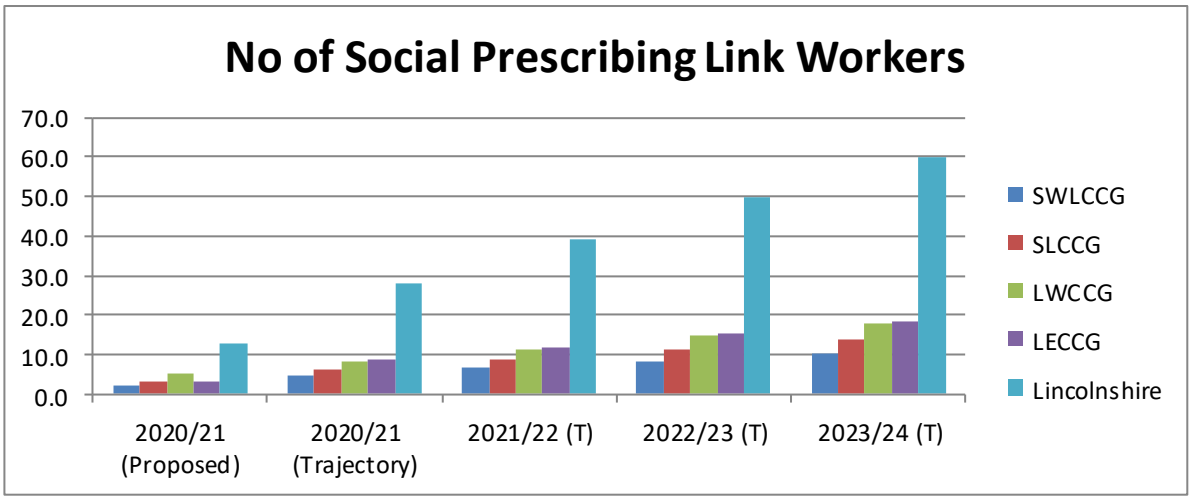
This should be seen as a system risk, which includes health, social care and the VCSE as jointly responsible for developing a sustainable financial model that will be flexible enough to meet the ever changing world of social prescribing.

Part B: Lincolnshire's Ambition 2020 onwards

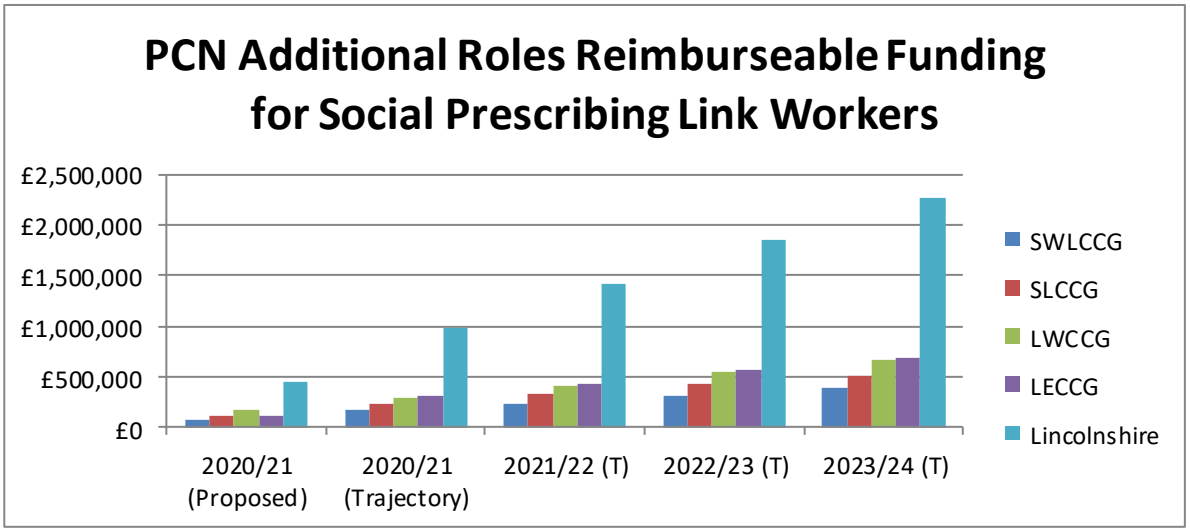
A) What are the expectations of Social Prescribing in Lincolnshire's Long Term plan?



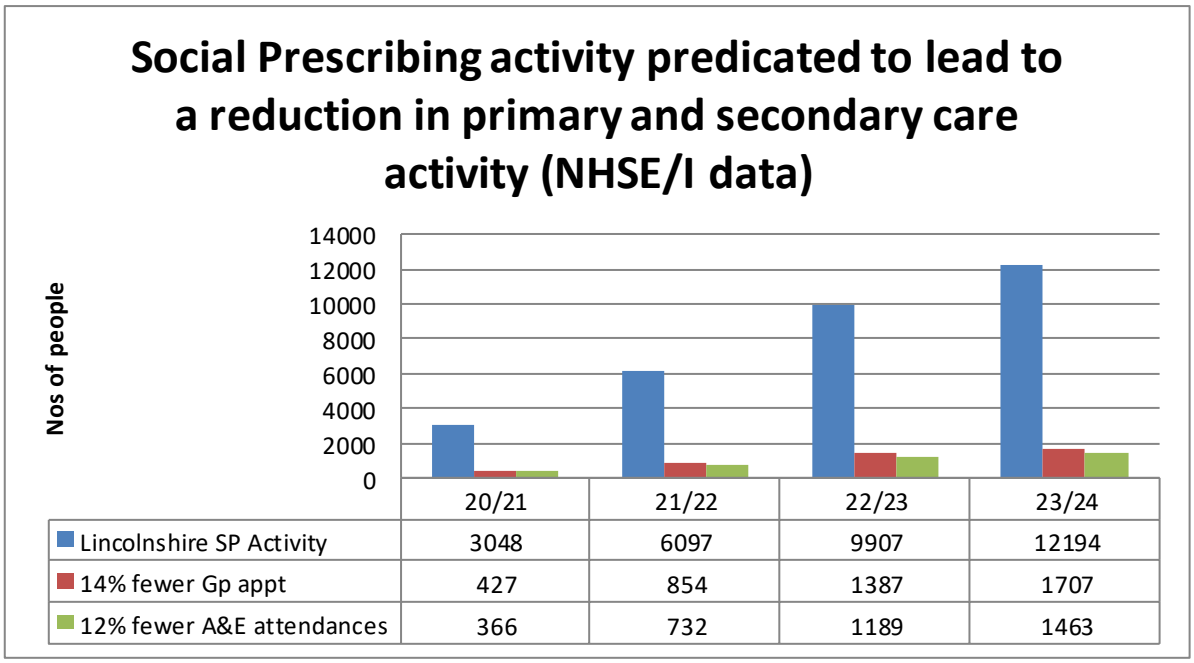
By 23/24 at least 12,194 people will have been referred to Social Prescribing.



13 PCN's will have access to 60 Social Prescribing link workers



The additional roles reimbursable scheme potentially brings in a significant amount of funding into social prescribing over the next 4 years - £2,260,000



	20/21	21/22	22/23	23/24
Lincolnshire SP Activity	3048	6097	9907	12194
14% fewer Gp appt	427	854	1387	1707
12% fewer A&E attendances	366	732	1189	1463

NHSE/I evidence indicates that social prescribing should reduce GP contacts and A&E attendances for those who access the service by 14% and 12% respect – this is what it could look like for Lincolnshire

B) Lincolnshire's ambition

Building on the success and taking the learning of the ever evolving social prescribing model that has been developed over the last 18 months the Lincolnshire Social Prescribing working group which is made up of colleagues from across the health and care sector are extending their ambition and vision for what the offer could be for the people of Lincolnshire.

This has been further endorsed by the 13 PCN's who have all agreed to subcontract LCVS and VCS to recruit at least 1 Social Prescribing link worker / PCN with an expectation that this will increase over the year. Plus the additional 2 Mental Health Link workers for Boston, Grantham, Gainsborough and Lincoln City south who will come into post from the 1st April 2020.

Lincolnshire's aim is to continue to develop the current model to include a co-produced, digitally enabled social prescribing offer at the heart of communities that will support local populations. It will have a virtual offer and will join the various commissioned and non-regulatory services together, within a funding envelope that will enable local community services (VCSE) to thrive and flourish – meeting the requirements of local populations 2020 onwards.

There are 6 strands to this ambition; **(see appendix E)**

1. **Information and Advice (level 1)**
2. **Embedding social prescribing into Primary Care and Mental Health (Level 2 & 3)**
3. **The Digital Platform – already in development**
4. **A simple way to access – to included commissioned services**
5. **Support for community groups**
6. **Integrated Volunteering Approach**

C) 20/21 Costs for PCN Social Prescribing link workers

CCG	PCN 2020/21 (Proposed)	100%(£35,389) Contribution 2020/21 (Proposed)	Total with 14 link worker in PCN	Contribution towards admin and management (shortfalls) on proposed
SWLCCG	2.0	£70,778	£74,422	£3,644
SLCCG	3.0	£106,167	£111,633	£5,466
LWCCG	5.0	£176,945	£192,170	£15,225
LECCG	4.0	£141,556	£148,844	£7,288
Lincolnshire	14.0	£495,446	£527,069	**£31,623**

All the PCN's will be drawing down the full contribution available for social prescribing link workers, which covers salary, on costs and some management and coordination costs. However there is currently a £31,623 cost pressure on the providers which is being negotiated with CCG's at time of this report. However NHSE regional trajectories for Lincolnshire expect PCN's to have recruited to 28 Social Prescribing link workers by the end of 20/21. If this is achieved, the economies of scale that can be applied will remove the risk to the Providers altogether and potentially build in some community capacity building particularly when we move into years 3 & 4.

CCG	PCN 2020/21 (20/21 Lincs actual target)	100%(£35,389) Contribution 2020/21 (Target)		Contribution towards admin and management (shortfalls) on proposed
SWLCCG	5	£176,945	Across the 3	-2295
SLCCG	6	£212,334		-2754
LWCCG	8	£283,112		12438
LECCG	9	£318,501		-4131
Lincolnshire	28	£990,892		

Community Mental Health costs are being managed through the Community Mental Health Transformation fund, however where there are opportunities to reduce on costs and management costs across the providers this is being done.

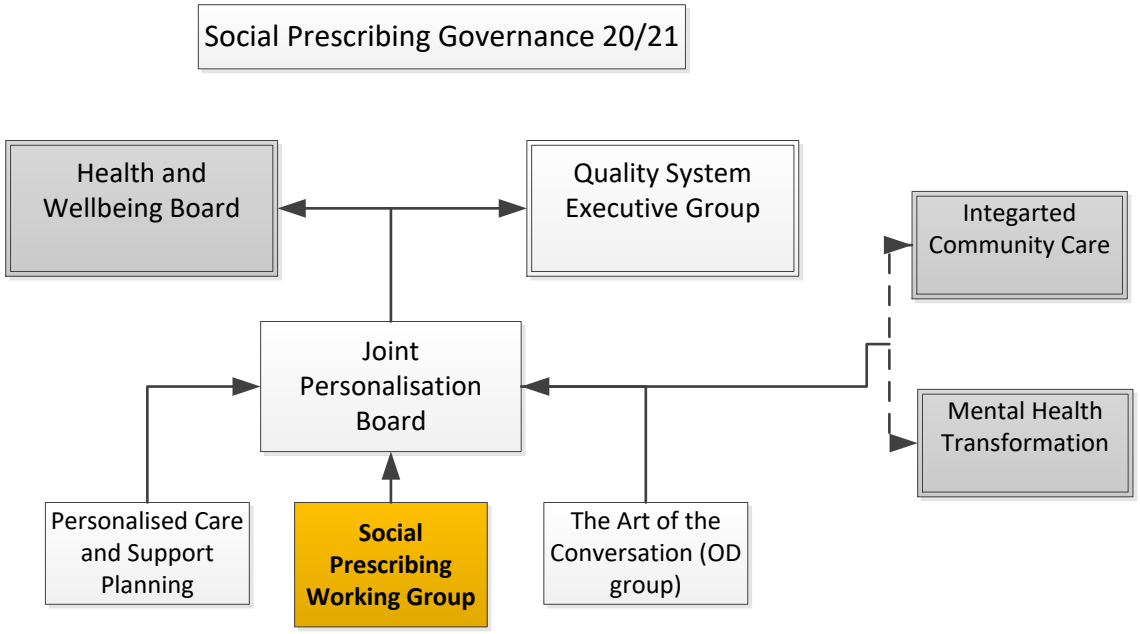
D) Measuring the impact of social prescribing from April 2020

The outcome of social prescribing covers the following three key areas;

- **Impact on the person** - How a person's wellbeing has improved, whether they are less lonely, whether they feel more in control and have a better quality of life.
    - This will be measured through the use of the Outcome Star which is currently being trialled with both providers and the introduction of the Patient Activation Measure (PAM's) which is being recommended by NHSE/I however there are some reservations about the effectiveness of the tool with a number of cohorts.
- **Impact on the community groups** – The Voluntary Engagement Team (VET) will be the central point of contact with the VCSE, and using the web portal, https://lincsvoluntarysectorportal.org.uk/ forums, and the annual conference to understand the state of the VCSE sector. NHS England and partners will support local areas to introduce a regular 'confidence' survey of local community groups, to identify development needs, test whether groups are fully involved and supported to receive appropriate social prescribing referrals.

- **Impact on the health and care system** –
  The national evidence is being aligned to a 14% reduction in GP visits and a 12% reduction at A&E for those individuals who have actively participated in Social Prescribing and or connected back into their community.

E) Governance arrangements



The first joint personalisation board will take place on the 25th March 2020. The Social Prescribing working group has been operating since April 2019 with the following membership;

- LCC - Public Health
- LCC – Adult Care
- Clinical Commissioning Group
- Primary Care Networks
- Lincolnshire STP
- Lincoln University
- Strategic Co production Group
- LPFT
- Neighbourhood Leads
- LCVS
- VCS
- Voluntary Engagement Team
-

The Social Prescribing project currently does not have an identified Senior Responsible Officer or a dedicated programme / project manager.

Part 3 Conclusion

Through the national agenda, the building evidence case and high profile of Social Prescribing it is clear to say that building resilient communities, supporting people to connect for the first time or reconnect with hobbies, interests and understanding what's important to them is a key priority for the health and care system.

In Lincolnshire we have made a really good start with an established model and offer that has already exceeded the higher level NHSE/I expectations for 19/20, and has been able to demonstrate significant positive impact on peoples health and wellbeing over the last 18 months.

The service will be available to all Primary Care Networks from the 1st April with an added mental health enhancement in 4 areas.

It is worth noting there is an added challenge and opportunity with two new roles being included in the PCN 'additional roles reimbursable funding'; health coaches and care coordinators, both aligned to social prescribing and fully funded. This will need to be considered in the discussion and decisions that are made at PCN level as the model develops over time.

As the report describes there is a real ambition to build on the established model through co production and design with PCN's and people, starting with the digital platform to be able to reach more people virtually so they feel connected and supported but on their own terms.

However for the Lincolnshire ambition to be realised the following recommendations are being made to the Health and Care system.

1. An SRO for Social Prescribing needs to be identified
2. Dedicated capacity and resource is required to bring the six strands of the ambition together over the next 12 months.
3. A Clinical Director for Social Prescribing needs to be agreed
4. A facilitated strategic discussion is required across the Health and Care system to address the main lesson learnt; ***the need for a sustainable financial model for the VCSE that will be flexible enough to meet their ever changing world and that of social prescribing.***
5. To explore the IM&T requirements of an expanding social prescribing model as the current system is not fit for purpose and has impacted on the level of data and information that can be easily retrieved and analysed.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS).

4. Consultation

Not applicable

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Detailed delivery model based on NHSE model
Appendix B	Case Study
Appendix C	Participation outcomes
Appendix D	Social Media Coverage
Appendix E	The ambition for 2020 onwards

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use in the preparation of this report.

This report was written by Kirsteen Redmile, who can be contacted on (01522 307315) or (kirsteen.redmile1@nhs.net)

Detailed Delivery Model **Appendix A**

Easy referral from all local agencies

- Simple and effective telephone and secure email referral process, facilitating multi agency and self-referral.
- Easy referrals directly into practice based social prescribing clinics, facilitated by the Link Workers.
- Multi agency referrals directly through the Integrated Neighbourhood Working (INW) multi-disciplinary

Collaborative commission and partnership working

- Facilitating cross sector partnership, networking and engagement events.
- Pro-active partnership working through INW with local services and partnerships including the Wellbeing Service and Integrated Lifestyle Support Service.
- Supporting all partners to come together to create stronger and more resilient local communities building on community assets.

Workforce development

- Raising awareness and enhancing the knowledge of staff teams to ensure relevant referrals through embedding the principles of care navigation.
- Providing robust line management, peer supervision and clinical support.
- Providing access to a range of training and professional development opportunities and resources through the National Association of Link Workers network.

Support for community groups

- Support and expand the existing network of over 500 community and voluntary groups to grow, develop and sustain their services and impact.
- Identify gaps in provision and stimulate the development of new ideas and services.
- Developing robust quality assurance using the five core principles of Welcoming & Accessible, Safe, Well Governed, Supporting People to Grow and Making a Difference to Wellbeing.

What matters to me (Create a personalised plan)

- Personalised support to individuals, their families and carers to take control of their wellbeing, through a holistic approach, based on the persons priorities.
- Co-producing a simple personalised care and support plan.
- Supporting and connecting people to community groups and services.

Common outcomes framework

- Single, centralised management information system capturing all patient data and activity for Lincolnshire feeding into the INW outcomes framework.
- Embedding tools to measure the distance travelled and qualitative impact on individuals, including PAM.
- Utilising the Social Value Engine to evidence the impact and return on investment.

Social Prescribing Case Study **Appendix B**

MB was referred into social prescribing by his OT at Grantham Hospital. He described himself as "very lost and bored after my brain injury and not sure how I was going to build my life again".

MB wanted to be more involved in his local community and more structured to enable him to move forward. He wanted help to set some goals and, with the support of his Social Prescribing Link Worker, decided to:

- Get into volunteering to help others to learn and supporting charities.
- Increase his computer skills and qualifications.
- Get involved in a local social group to meet new people and make new friends.
- Become involved with new community opportunities as are established.

With his Link Worker's encouragement, he started looking at options to reach his goals. Over time he has developed the confidence to do this independently.

This has helped him get into learning and increased interaction within his local community. He is now attending a social group, completed a computer skills training course, completed a cookery course and started volunteering every week at a local British Heart Foundation Charity Shop.

The changes in MB's health, wellbeing and long-term outlook are significant;

- VB reports increased confidence and self-esteem.
- His mood and wellbeing have improved.
- He has increased social activities and has structure to his week.
- He is learning how to look after himself better and is ready to move on in life.

The Social Prescribing Link Worker helped MB to find, contact, arrange meetings and try new groups and services. She supported him to attend initial meetings with his chosen groups so that he could build confidence to become involved independently.

MB says, *"I am developing my resilience in my life alongside living with my impairment. I realise I may be able to achieve paid employment in the future."*

Appendix C

Participant feedback & impact on health and wellbeing 35 participants

Through a sample caseload (sample, from when, how many, what level) , participants have indicated that as a result of the support they have received through the social prescribing service, their physical health, safety, emotional health and empowerment have improved as follows:

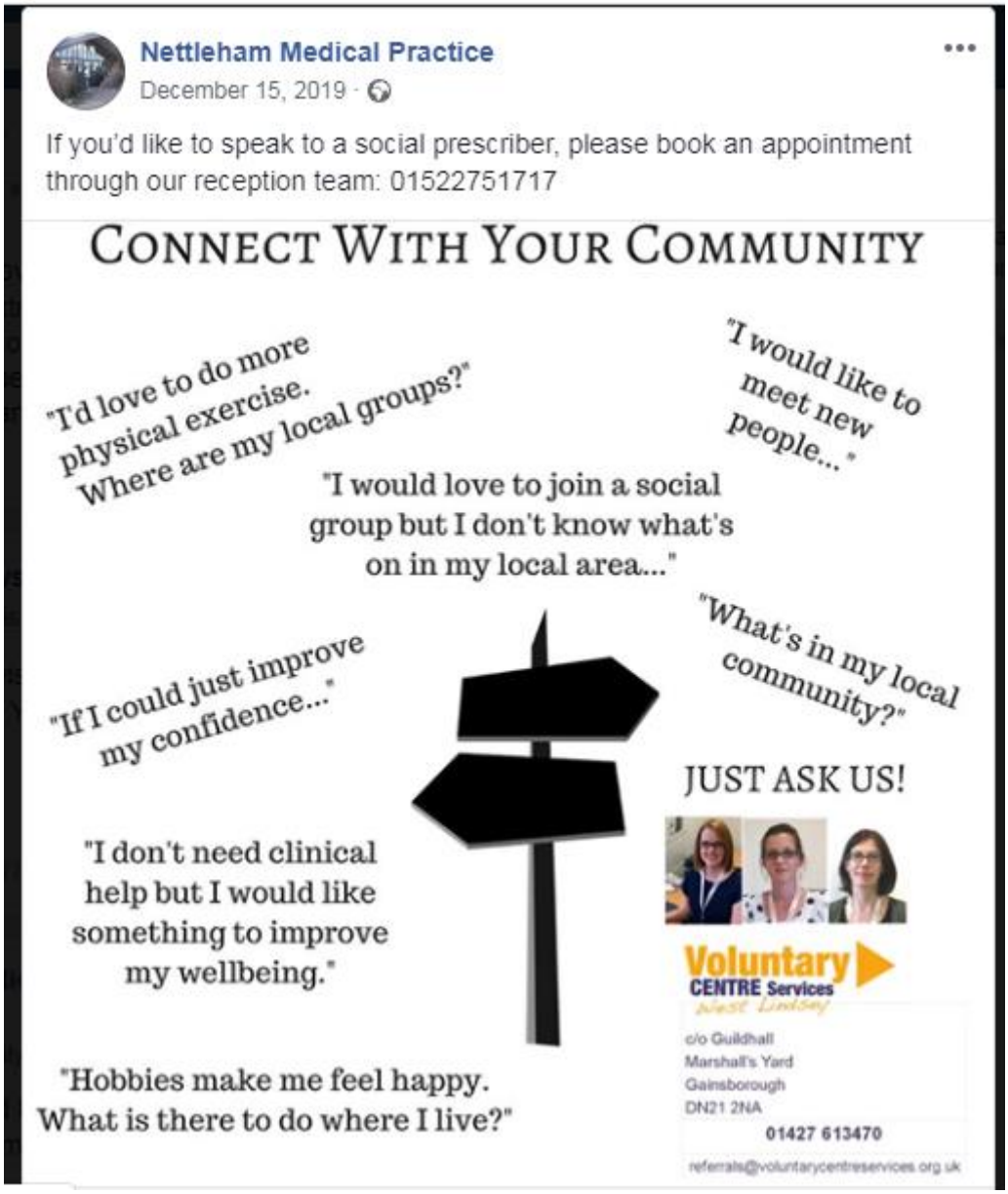
- 78% spend more time in their community
- 89% have more people that they can talk to
- 85% are visiting more groups and activities

- 62% find it easier to manage their physical health
- 74% take better care of themselves
- 62% participating in more physical activities
- 66% feel more confident moving around
- 73% are less worried about falling

- 78% feel more hopeful
- 64% feel their sense of self-esteem has improved
- 70% overall emotional wellbeing has improved

- 71% have a better understanding of the situation
- 78% find it easier to set goals
- 75% achieve the goals they set themselves
- 74% are more confident to try new things
- 68% feel more in control of their lives

Social Media Activity – Facebook

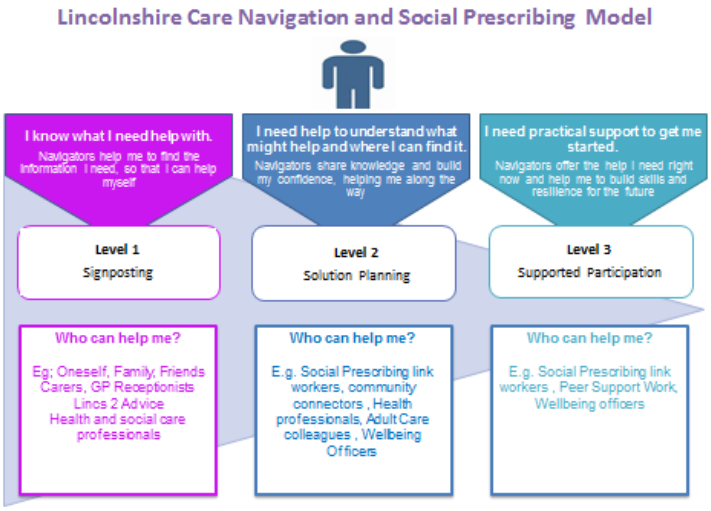


Appendix E

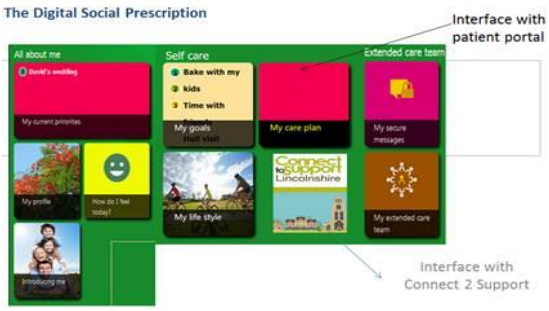
What is Lincolnshire's ambition for Social Prescribing 2020 onwards?

Lincolnshire's ambition is to have a co-produced, digitally enabled social prescribing offer at the heart of Primary Care Networks and communities that will support local populations. It will have a virtual offer and will join the various commissioned and non-regulatory services together, within a funding envelope that will enable local community services (VCSE) to thrive and flourish – meeting the requirements of local populations 2020 onwards.

There are 6 strands to this ambition;



1. **Information and advice (Level 1).** Positioning Connect 2 Support and Lincs 2 Advice as the **first place** people and staff go for information and advice about the local services, what's going on in communities, opportunities to volunteer, purchasing services etc . Individuals will be able to self-service and select through the website or may require Lincs 2 Advice to help people to find the information they need, so they can help themselves.
2. **Embedding Social Prescribing (Level 2 & 3**) in PCN's and Neighbourhoods, which will include the Mental Health aspect of supporting those who have severe or enduring mental health.
3. **The Digital Platform, t**o extend the reach of social prescribing and connecting people to their local communities, we are co-producing with people a digital platform which will support the three levels of care navigation.



Using the digital platforms already available in Lincolnshire; Vitrucare and Connect 2 Support Lincs (library of information and advice), the co-production group will design and test the set/s of tiles that individuals will use to encourage and support self-care and self-management, with social prescribing link workers being available virtually as and when needed.

4. **A simple way to access** local Social Prescribing Services embedded within the PCN. The countywide system will have agreed common set of outcomes, linked into a robust countywide managed IT network (Or IT networks that talk). This model will be closely linked to the commissioned services; clients can be referred into and out of the Commissioned services and the localised social prescribing provision. Link workers will play a pivotal role in ensuring clients are supported into the right service at the right time.
5. **Support for community groups** – Part of the NHSE model for Social Prescribing; Support and expand the existing network of over 500 community and voluntary groups to grow, develop and sustain their services and impact, Identify gaps in provision and stimulate the development of new ideas and services, developing robust quality assurance using the five core principles of Welcoming & Accessible, Safe, Well Governed, Supporting People to Grow and Making a Difference to Wellbeing.
6. **Integrated Volunteering Approach** - Voluntary Engagement Team and NHS are currently developing a bid for year 2 funding from NH5E II to embed volunteering in our social prescribing model-to 'Extend the offer of volunteering to individuals who access the service and seek volunteers to be part of the service particularly digital champions to support the digital platform.