

Impact of Covid 19 on Social Prescribing in Devon – final report

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3. Summary and conclusions

Slides are presented with full narrative notes where needed

Background to the SP Evaluation

In September 2019, Devon STP commissioned the University of Plymouth (UoP) to support an 18 month evaluation of Social Prescribing (SP) across its footprint. A research team from the University was established and the project named 'DESSPER'. The Principle Investigator was Dr Julian Elston, Senior Research Fellow and Researcher in Residence.

Debra Westlake, a Research Fellow at (UoP), was contracted by Devon STP (now ICS – the partnership of providers and commissioners who plan health and care services) from January 2020 to July 2021 as a Researcher in Residence on the Social Prescribing Evaluation.

The three key tasks for the role were to:

- 1) Map out the characteristics of projects and programmes carrying out social prescribing in Devon at that point in time
- 2) Support the evaluation of social prescribing programmes
- 3) Aid quality improvement through sharing learning with sites

The project also aimed to understand issues with setting up and delivering social

prescribing programmes (implementation issues) and sought to work with providers to improve the quality of their services and capability to evaluate their programmes.

When the pandemic arrived the mapping exercise had been completed and written up as a draft interim report [\[insert hyperlink\]](#), (summary below).

In March 2021, our research questions were modified to include a further objective: to investigate the impact of Covid 19 on SP in Devon. The project research questions are listed on the next slide.

The summary findings and recommendations in this report build on those in the interim mapping report. They explore how the commissioning and delivery of SP can be strengthened in light of the adaptations or innovations made under Covid.

The summary of the mapping report findings relevant to the current report are:

There are a wide range of programmes identifying with the social prescribing label across the Devon. These are broadly organised around local council boundaries and, increasingly around Primary Care Networks (PCNs). The majority of programmes are delivered or supported by a very diverse, pro-active and vibrant voluntary sector bounded by their locality, although increasingly some PCNs, the Royal Devon and Exeter NHS Trust and Torbay and South Devon NHS FT are also providing or commissioning services.

Mixed economy of funding

- ❖ All 31 PCNs have appointed at least one social prescribing link worker (and increasingly a team of link workers or mixed skill set of link workers, health and wellbeing coaches and mental health workers). A small majority (19/31) are managed by the voluntary sector or a mixed economy of VCSE and PCN management, particularly where social prescribing has been established for some time. This is helping to ensure PCN link workers are well-placed to connect people to resources in their communities as well as learn from the voluntary sector experience and take advantage of their link workers support mechanisms.

Heterogeneity of provision

- ❖ Even the more mature programmes in Devon are operating in varying ways, often with different approaches or emphasis, each with their unique strengths reflecting their origin. There is significant variation between localities in relation to how they are contracted, organised and managed, who is referred to them, the level and nature of engagement by the social prescriber and how they connect people to the wider community. Where there appear to be similarities due to social prescribers having similar titles, on closer inquiry their roles, functions and activities often

differ considerably i.e. Community Connectors in Exeter have a holistic social prescribing function, identifying what is the right fit for the individual and then working alongside them to engage with activities, whereas in North Devon Community Connectors have a community development role. In some areas, social prescribing roles also overlap with the role of local community developers, who are also working to build community groups, assets and resources in response to local peoples' needs and are sometimes also working with individuals. This often includes those referred by social prescribers.

Social prescribing as community development

- ❖ This lack of consistency is in part a result of programmes striving to follow the place-based principles of social prescribing, evolving in response to their local context, but also from having to label programmes as 'SP' to attract funding. It is also partly due to a lack of a common understanding or agreement of what social prescribing is (between providers and SP funders like the STP or DCC improved Better Care Fund (iBCF)), and whether it is seen as part of community development. This in turn will influence what is seen as a key element or constituent of social prescribing that needs to be in place to deliver an effective programme. This has resulted in contrasting approaches. In Torbay, for example, social prescribers work closely with neighbourhood community builders (serving 10,000 people) who seek to support community assets building from the 'bottom up', in what they call a 'social prescribing eco-system'. In North Devon, SP is located within the One Northern Devon partnership structure which is focused on addressing health inequalities. This enables a broad range of statutory and non-statutory stakeholders to support SP programmes around each of the six One Devon communities, facilitating the resolution of operational issues strategically. By way of contrast, some PCN programmes view social prescribing solely in terms of a link worker (not a pathway), operating with a narrower vision of how to engage with services users (short time-limit, sometimes medicalised) resulting essentially in a 'light touch' service (signposting). PCN contracted social prescribing link workers are mainly focused on their practice or network population (serving ~35,000) and are generally seen as having a very limited role in growing community assets to address unmet needs, which causes some frustration to SPs who are searching for resources and experiences for service users. Where this is the case, in this report will refer to them as social prescribing link workers rather than social prescribers to make this distinction clear.

Research Questions – Covid impact.

A. *How is the delivery of social prescribing changed by or adapting to the current situation under Covid-19, with reference to baseline mapping work undertaken pre-Covid.* Time frame: March 2020-21

B. Sub questions

- *What are the challenges that SP implementation has faced and how are the challenges being overcome?*
- *What have been the challenges and opportunities for the stakeholder organisations (VCSE, strategic partnerships, other organisations?)*
- *What will the opportunities and innovations be as we move forward?*

Recognising the impact of the Covid crisis, the Social Prescribing Evaluation Group amended the research team's protocol to include a series of questions to understand its impact on the organisation and delivery of social prescribing. These were:

A. Aim of re-purposed Covid evaluation: *How is the delivery of social prescribing changed by or adapting to the current situation under Covid-19* (with reference to baseline mapping work undertaken pre-Covid). Time frame: March 2020-21

B. Sub questions

- What are the challenges that SP implementation has faced and how are the challenges being overcome?
- What have been the challenges and opportunities for the stakeholder organisations (VCSE, strategic partnerships, other organisations?)
- What will the opportunities and innovations be as we move forward?

This adaptation enabled the research team to continue its work supporting the evaluation and implementation of SP across the system, by iteratively feeding back its findings to local system providers and leaders, as well as regional and national leaders.

The findings from this revised protocol are reported in this presentation.

Key terms and acronyms/glossary

SP = social prescribing or Social Prescriber – we have used this generic term to describe the breadth of role titles and responsibilities across Devon.

SPLW = social prescribing link worker – the title given to the role commonly carried out in GP surgeries, particularly where the worker is directly contracted by primary care (rather than VCSE or other organisation)

C-19 = Covid 19 virus

VCSE = Voluntary, Community, Social Enterprise Sectors

PCN = Primary Care Network

MH = mental health

SNOMED codes = (Systematized Nomenclature of Medicine -- Clinical Terms) structured clinical vocabulary for use in a primary care patient electronic health record.

LCT = long-term condition

As noted in Slide 2, we use SP or social prescribing as a generic term to describe the breadth of role titles and responsibilities across Devon, and SPLW or social prescribing link workers to describe the title given to social prescribers working in GP surgeries, particularly where the worker is directly contracted by primary care (rather than VCSE or other organisation).

Executive summary (1) – SP Pathway

Covid has impacted every area of the social prescribing pathway and the VCSE infrastructure that enables it. It has accelerated and highlighted pre-existing barriers and facilitators; shown the merits of flexibility in the VCSE, but also united organisations behind a common purpose.

1. ACCESS

Who receives social prescribing

- Referrals and caseloads *fell* where there was a 'boundaried' model of eligibility, restricting types of referrals. Directly contracted SPLWs were more likely to be asked to engage in C-19 specific work and to receive referrals for people with complex needs. This facilitated their role as part of the primary care team, but was felt to be outside their remit by some SPLWs. More clarity is needed on who benefits most from SP, how and why.

2. ENGAGEMENT

What happens in the 1:1 interaction with SP

- Shift from face-to-face to telephone delivery. There was a shift towards more signposting (transactional) interactions due to lack of activities to refer into and the nature of C-19 specific work (welfare checks or calls).
- Conversely, for complex people, 'holding' type mental health support calls (therapeutic) replaced referrals onwards to services or activities.

3. ACTIVITIES

What the SP can refer to

- Availability of activities varied according to place. Absence of face-to-face experiences was a challenge, but some creative solutions were found (online resources, home deliveries of resources, volunteering). These did not suit everyone – again leading to a need to 'hold' some people.

The following two slides present six key findings on how Covid has impacted on social prescribing.

These are grouped around the model of social prescribing we developed in our Interim Report (also see Slide 14) and continued to develop through the second phase of our evaluation. This describes social prescribing as a pathway based around **Access** (referral), **Engagement** (with the social prescriber) and linking to **Activities** (or community groups or resources).

Crucially, it is also supported by a number of **Assets** in the local context that relate to the **Workforce** and the presence of **Community** assets (voluntary organisations and resources etc) as well as links to wider **Partnership** infrastructure that can support its development.

Our evaluation found that Covid has impacted every area of the social prescribing model, including the wider community and partnership assets that enable and support it.

It has highlighted and accelerated pre-existing facilitators and barriers to implementing social prescribing. It has also demonstrated the merits of flexibility as the VCSE responded and adapted to the crisis, and the power of VCSE and statutory organisations

uniting behind a common purpose.

We describe in slides 13 and 14 our suggested model of social prescribing and the impact on Covid on the SP ecosystem. We believe there is a need for a clearer overall delivery model of SP across Devon. There is room for more clarity about which cohorts stand to benefit, how and under which circumstances they would benefit, what should happen when engaging with a social prescriber, and how the availability of services and activities match people's needs (or not).

Nevertheless, our evaluation has identified two proto-typical social prescribing models – Boundaried and Open – which represent operational models at two ends of a continuum.

We have called it the 'Boundaried model' as who can access the service and how long for is clearly defined, often by the SPs themselves or those in primary care and other referral agencies.

Conversely in the 'Open model', referrals are less restricted to certain types of client and there may also be more flexibility about the duration over time and length of contacts with the SP.

Covid appeared to impact differentially on these two models.

Executive summary (2) – SP Assets and Partnerships (context)

4.WORKFORCE Front line social prescribers and community builders

- There are dangers of 'burn out' and disillusionment highlighted by C-19. This is less common in a team supported by clear leadership and supervision and where there are boundaries on the model (referral criteria etc). Induction and training as well as peer support are important but not universal and scarcely funded. Team working between social prescribers and community builders and in local teams (e.g. MDTs) worked better where these relationships existed pre-C-19.

5.COMMUNITY The organisations, systems and practices that enable SP

- Without VCSE activities and organisations there is no social prescribing. C-19 has made this hugely challenging, but the community has stepped up in an agile and flexible way to meet needs. Targeted funding has facilitated this, but there are concerns about sustainability and mission drift post-C-19 for many organisations.

6.PARTNERSHIP Collaborations and networking within and across sectors

- Sustainable partnership working was challenged due to lack of previous income streams, socially distanced operations and immediate, increased crisis demand under C-19. A sense of common purpose facilitated collaboration and levelling of hierarchies in some areas: single point of contact responses are an example of where this has worked well. Areas where there was no pre-existing community infrastructure were less coordinated in their response and less able to seek funding.

This slide presents the second set of our key findings on how Covid has impacted on social prescribing.

Recommendations



Listen, learn

Understand the different models of SP – contexts, barriers and facilitators
Integrate SP as a core programme in Devon ICS



Connect, collaborate

Connect workforce, community, primary care and VCSE: Community of Practice, trusted relationships



Define, communicate

What SP can and cannot do. Community building is part of SP. Communicate clearly to referrers, workforce, citizens.



Fund

Sustainable, strategic assets: pooled budgets, community infrastructure for SP; workforce development



Measure

Framework and apps for data collection and analysis: Who receives SP and why, outcomes

Using the key findings from this and the interim report, the DESSPER team developed some provisional recommendations. Devon Social Prescribing Executive Group were then invited to co-produce these recommendations with us and to make an actionable plan from them. This slide presents the outcome of this work, grouped together under five headings with the following slide showing the actions and responsibilities.

The five broad recommendations were :

Listen and learn

- Understand the different models of social prescribing (the Ecosystem) and its contexts (barriers, facilitators to how and why it works or doesn't work)
- Integrate SP as a core programme in Devon ICS
- Learn from Covid: the power of working together with common purpose, accelerating and levelling of personal and organisational hierarchies, the resulting gaps that are revealed - community assets and vulnerability of VCSE post Covid.

Connect and Collaborate (both virtually and face-to-face)

- Connect up assets – workforce, community, systems - to share practice
- Recognise the need to develop trusting relationships and teams across sectors (primary care, VCSE) and with local communities:

- Those who need SP most are those who are least likely to engage.
- Support for SP in primary care is variable, and SP is misunderstood. Primary care must be involved more systemically in developing solutions, not just the SP 'champions'.
- Involve local authorities and social care – there are parallels with ventures in councils and community that could be explored more systematically.
- Community building is an essential part of social prescribing. Without community activities, SP cannot happen

Define and communicate

- Define what social prescribing can and cannot do; describe the 'places' and boundaries and communicate this to referrers
- Develop a shared language that is communicated to a) referrers, b) citizens, and c) workforce

Fund

- As we emerge from the worst phase of the pandemic, referrals and demand are likely to increase. Strategic funding needs to be made available for sustainable community infrastructure, so that activities are available for SP to connect into. Funding could be pooled across statutory organisations and departments to help achieve this in a coherent way
- Workforce development needs to be adequately funded to support digital access, training, supervision, induction, pay scales in order to maintain a healthy workforce that can cope with the demands on them.

Measure

- We need to understand more about who is receiving SP in Devon and why, what are the mechanisms ('active ingredients' or facilitators) and outcomes and whether inequalities are being addressed by SP
- Projects are all asking for support in defining what measures to collect and for what purposes, so the value of SP can be demonstrated beyond assumed impacts on statutory activity (i.e. social return on investments) . Devon ICS should consider giving guidance via a *framework for evaluation* that will support systems/people in data collection, retrieval and analysis (e.g. CRMs, apps could be purchased at an ICS level).

Recommendations – actions and responsibilities

No.	Theme	Recommendations from SP Exec	Recommendations from DESSPER team	Who to action
1	Listen, learn	SP to be an integrated element of ICS with core funding allocated.	Active engagement and leadership of ICS/CCG and involvement of primary care, adult social care and Devon Partnership Trust	
2	Listen, learn	Recognise dynamic, evolving nature of SP.	Develop a <i>flexible</i> framework that defines core principles and theory of SP (aims, outcomes and scope) and its measurement. Framework to be <i>adaptable</i> to local contexts/circumstances.	ICS? Co-produce with key leaders in statutory and VCSE as well as front line staff and people with lived experience
3	Listen, learn	Increase ICS understanding of SP by presentation of the report to key influencers (ICS and partnership board, finance directors)	Involve primary care at a strategic and local level	
4	Connect, collaborate	Build trust with communities: recognise that those who most need SP often do not know about it	Involve primary care/ public health / mental health services in identifying need within communities. Also recognising what level of 'readiness' and mental health state to include in referrals	
5	Define, communicate	Communicate with DPT and LA about increased complexity of referrals and develop pathways/strategies	Framework of core principles to be communicated. Explore how it interacts with statutory and non-statutory agencies	
6	Fund, support	Core ICS funding for SP	Co-commissioning of SP with a dedicated fund would allow meaningful model of SP according to health needs of population. Strategic funding of VCSE as activities (community building) to connect into in the SP pathway	
7	Measure	Modify what is measured to suit what has been learned about SP (Listen, Learn) and new ways of statutory and VCSE thinking in a post Covid world.	Further qualitative research into cost savings of people receiving SP and causal mechanisms of how these are achieved.	
8	Measure	Centralised funding of Joy app as one way to capture data/case management/directory of services		DH to speak to digital lead in CCG. Unclear who is to action discussion on what is measured and how

As part of our iterative feedback cycles and co-produced analysis, we fed back our summarised findings and five themed areas of recommendations from the DESSPER team to the ICS SP Executive Group in May and June 2021 and invited them to reflect on these recommendations and indicate how they might be implemented.

We posed the following questions to the group:

- Who should be around the table or involved in discussions of these recommendations?
- What are the actions?
- Who is responsible for the actions?

The table presented in this slide summarises their responses according to our themed headings.

Not all areas were discussed or decisions made, in which case cells are left blank for future thinking.

The table includes the DESSPER team's responses and further thoughts on implementation of findings.

PART 2. APPENDIX OF FINDINGS

2. Appendix to Summary report

The following slides represent our full, final report to the SP Executive Group at Devon ICS and include:

1. Evaluation methods used, including data collection and analysis **(slides 11-12)**.
2. Summary of key findings and analysis expressed in our Interim Report (Jan – Aug 2020): presentation of the Social Prescribing Eco-system model **(slides 13-17)**.
3. Findings from the revised evaluation of the impact of Covid-19 on SP in Devon (Mar 2020– April 2021) **(slides 18-38)**.
4. Impact of the Researcher-in-Residence model **(slides 39-40)**.
5. Narrative summary **(slides 41-44)**.
6. Conclusions **(slide 45)**.

Evaluation method - using mixed methods and data sources – RiR model¹

Qualitative data collected from 80 anonymised SPs in a variety of roles and organisations		N=
– Emails / comms from individuals		67
– Reports / PowerPoint presentations (VCSE and PCN)		11
– Meeting minutes		7
– Interviews with VCSE stakeholder conducted by RiR		9
– Team's notes, observations and reflections from naturally occurring conversations and meetings (e.g. front-line peer support)		28
Total		122

Quantitative data – routinely collect data		N=
– SNOMED codes at CCG level		31 PCNs
– Other GP/SP records		Limited case studies
– VCSE reporting from own records		11 reports

Survey data (Covid specific) – April/May 2020		N=
SP respondents (front-line n=46, managers n=6)		52

¹ [Gradinger, 2019](#)

Evaluation method

This evaluation used university-employed **Researchers in Residence** (RiR), based in Devon CCG (and elsewhere across the system), to work with front-line staff, managers and public representatives to support service evaluation, identify good practice and implementation issues in order to share this knowledge widely to inform service improvement and strategic development of SP. This approach is an innovative, nationally emerging way to improve services, combining local knowledge and evidence (Gradinger, 2019)

(<https://www.ingentaconnect.com/content/tpp/ep/2019/00000015/00000002/art00003;jsessionid=246e04b2ucxwa.x-ic-live-02>)

The RiRs have engaged with a wide range of stakeholders from across the system, including SP programmes (VSCE, PCN and others), through facilitating SP conferences, co-designing workshops and training events, attending link worker peer-support groups and networks, and contributing to STP, VSCE and Academic Health Sciences Network meetings. The data, documents and observations collected through this engagement and its systematic analysis form the basis of the findings of the interim report.

Covid study

Data for the Covid study were collected and analysed using the Researcher-in-Residence model which involves development of trusting relationships and reciprocal exchanges

with those involved in commissioning and delivering SP across Devon. This included providing advice and support to system leaders and individual practitioners, based on perceptions and experiences from a range of stakeholders across the system (managers, front-line and executive) combined with other types of data. Data were collected from naturally occurring environments such as meetings, conversations, observations and workshops. Field notes are made about these meetings, capturing pertinent verbatim quotes that illustrate key points.

- For this study selected VCSE stakeholders, suggested by the SP Exec group, were interviewed about the impact of C-19 on their organisations, using a semi-structured interview schedule which was agreed with the stakeholders. Interviews were recorded and typed up as notes.
- **The data set used in our analysis is taken from our interactions with more than 80 stakeholders across Devon.** These were anonymised in our analysis and report in order to uphold confidentiality and prevent attribution.
- Data about the impact of C-19 on SP also came from **a survey of front line workers in April/May 2020. The report can be found here:**
- ([https://www.plymouth.ac.uk/uploads/production/document/path/16/16832/Finding s from a Rapid Evaluation Survey of Front Line Social prescribers .DW.JE 21.05.20 01 w notes.pdf](https://www.plymouth.ac.uk/uploads/production/document/path/16/16832/Finding%20s%20from%20a%20Rapid%20Evaluation%20Survey%20of%20Front%20Line%20Social%20prescribers%20.DW.JE%2021.05.20%2001%20w%20notes.pdf)).
- Secondary data from project reports on SP and email exchanges were also included in our analysis. These data were mostly non-Covid specific, but included implications for Covid.
- We followed the course of Covid throughout the year March 2020 to April 2021.

Methodology

This slide shows the data included in our analysis and on which the findings of this report were based. Our data were largely qualitative as this was the most appropriate for answering the research questions in Slide 3. We have also included quantitative data to substantiate the points made by the qualitative data analysis, where available.

We used a mixture of primary and secondary data sources, as shown in the three tables.

Although we collated diverse data sources, there were notable absences. These were largely due to challenges accessing data (practical or information governance related) and also to the nature of our role, which was to embed ourselves as researchers and support evaluation throughout the Devon-side system, rather than as primary researchers collecting data. Covid also constrained the embedded role. In compliance with public health guidelines, the RiR worked exclusively from home throughout and conducted all meetings via teleconferencing and email. While good relationships were maintained or developed with teams and individual SPs, this was not always possible during a resource-constrained time.

What was not included:

- Primary electronic health and social care service data (patient records, linked data sets with primary, secondary care service usage, costings)
- Primary quantitative data from all projects or SPLWs included in the study to substantiate perceptions and comments made in naturally occurring meetings (e.g. SPs have said: 'referrals have gone up' 'there has been a rise in mental health problems'.
- Community building activity – no systematic primary data collection from front-line workers or organisational leaders working specifically and exclusively in this area and with the explicit job title of 'community builder'. However, community builders attended some naturally occurring peer support meetings and fed into discussions, some SPs have a joint CB role, community development leads attended some VCSE meetings. Their comments are incorporated as data
- Statutory organisations' reports
- Data on SP with children (rather than adults) – this innovative type of work was under development in some areas, but not offered throughout Devon. As such we were not able to compare different programmes or have a sense of impact on them before and during Covid

Other notable data absences

- Quantitative process and activity data from projects (e.g. PCNs). Where there are absences in the data to substantiate key points, we have pointed this out and suggested what data would be helpful. Requests were made to projects and individual SPLWs for quantitative data but it was not always available or was in an unanalysed format.
- The voice of general practice/primary care and other statutory services (e.g. mental health, social care). It was difficult to engage people not known to the research team and the impact of Covid on colleagues in primary care meant the possibilities to meet with them were limited. It is important to address this for future learning.
- The voice of the service user is absent for similar reasons to the above point and because of limitations on researcher time in this current project.

Approach to analysis

Qualitative analysis was based on following iterative, overlapping steps:

1. Detailed, deductive and inductive double-coding in NVIVO/Excel, based on a coding framework agreed by the team
2. Thematic framework analysis of emergent codes, with memos and draft narratives
3. Further inductive/deductive framework analysis
4. Subsequent analysis and theory building sessions
5. A workshop extracting recommendations based on overall micro/meso/macro framing, using MIRO online platform – the whole DESSPER research team
6. Co-production of the findings and recommendations with the Devon SP Exec group (using EasyRetro online tool)
7. Co-production of actionable recommendations with the Devon SP Exec group, June 2021

Survey analysis:

1. Survey data collected via an online survey tool
2. Analysed in Excel, producing descriptive charts and tables
3. Thematic analysis of free text in Excel
4. Presented to all stakeholders at meetings - refining of analysis and recommendations

Our approach to qualitative and quantitative data analysis is shown in this slide.

In relation to the qualitative analysis, all data were imported into a research data management software called NVIVO then analysed deductively in relation to the research questions and inductively to identify emerging themes. These were compared with our model of social prescribing to further its development as an aid to understand social prescribing.

Excel spreadsheets were used to compare and contrast data from different sources to check the validity of the findings, using a process called triangulation. Findings are evidenced by using anonymised quotes or with reference to anonymised examples.

The analytic process was dynamic, iterative and overlapping with emerging findings and analysed themes fed back to the local system (at all levels) and to national leaders in a process of continuous learning cycles. So, for example, the survey data findings were fed back to the Devon SP Executive Group as well as the South West Academic Health Science Network (including national stakeholders from NHSE SP team), shortly after the survey was conducted.

We invited stakeholders to reflect on our findings to refine them and make further recommendations, which subsequently became part of the findings presented in this report.

What is Social Prescribing?

Definitions across Devon:

“Social prescribing is a way of enhancing health and wellbeing, by encouraging/supporting people to access non medical community services, returning to employment, volunteering etc. [...] People with loneliness, social isolation, mental health issues, physical health and fitness barriers will all benefit.”

“A service that is embedded in your GP surgery alongside your GP and other practice staff, that aims to connect you to community services and activities that may help improve your health and wellbeing. Reasons for referral include e.g. isolation, bereavement, debt, housing, work, training, support groups, general health”

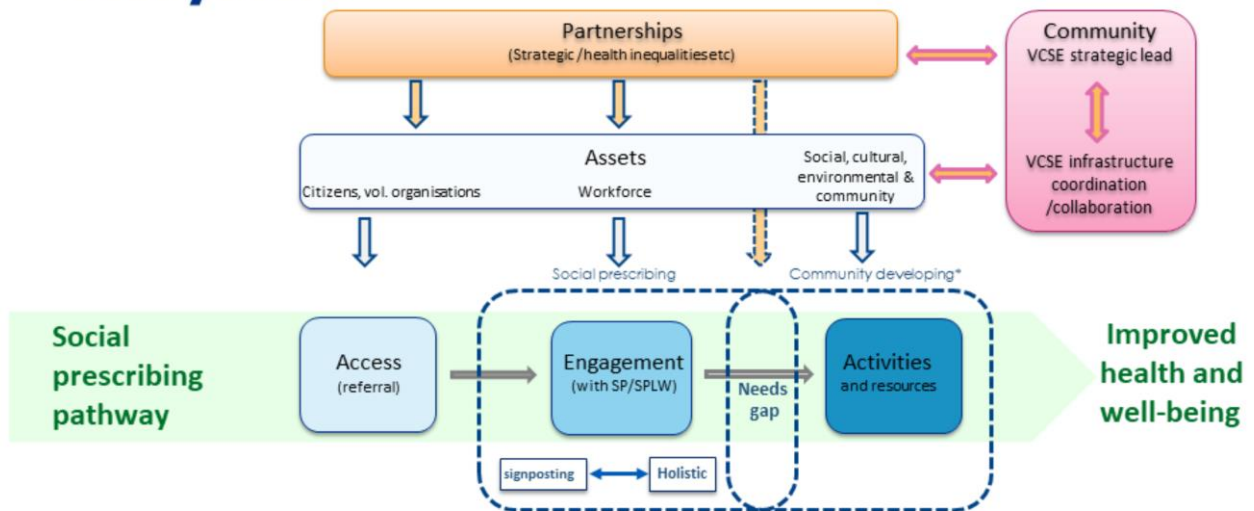
(Extracts from two projects' information leaflets about their services)

As there is no single definition of SP in the research literature, we have included these definitions used by two of our local projects, one based in GP surgeries and one contracted by a different organisation. As highlighted in our interim report, definitions of SP and terminology vary across Devon.

In essence, social prescribing is based on a bio-psycho-social model of health. It recognises that many health needs have social determinants and that connecting people to relevant local (community and voluntary sector) activities can be beneficial and that this may complement or have better outcomes than traditional medical prescribing.

Connecting people is usually done by being referred to a Social Prescriber (often now called a Link worker) who talks to the person about what they feel might help them and supports them to make a plan. This can be a simple signposting activity but more often than not involves developing a relationship with them to devise a shared plan of goals or activities.

Model of the social prescribing ecosystem²



This slide shows the social prescribing framework or ‘Eco-system model’ which includes the components of the SP pathway. This was developed by the research team following the first phase of the evaluation (report delivered in March/April 2020 [hyperlink] and with reference to the literature on SP (Husk et al, 2019 (<https://bjgp.org/content/69/678/6.short>); Elston et al, 2018 (<https://pubmed.ncbi.nlm.nih.gov/31547895/>)). A version of this model was presented at the 3rd International Social Prescribing conference (Salford, March 2021) (see 6 minute video at 16m:25s on <https://vimeo.com/522021070/2325e6cdc1>)

The literature is largely concentrated on the steps of the SP pathway, in which the individual is supported by a social prescriber to identify non-medical (usually social) goals and to connect to activities or resources in the community. Our model identifies three steps to this pathway:

1. **Access** – describes how different groups of people enter into a SP pathway. This is usually by referral (e.g. from a GP, adult social care, self). Some projects have a ‘*Boundaried*’ model (e.g. will not accept referrals for people who have severe mental health problems or are in a crisis) whilst others have a more open door approach or ‘*Open*’ model and will take anyone referred

2. **Engagement** – describes the interaction between a person and the SP. We found this varied significantly between programmes, resulting in some programmes delivering a more *signposting* service rather than a *holistic*, person-centred transformative-type of engagement. We will go into this in more detail as our analysis shows the key mechanisms of SP comes about through this relationship.

3. **Activities** – these are the experiences, resources or activities that are identified as part of the goals developed with a person.

Social prescribing and community building

Our findings showed that there were key overlaps between social prescribing and community developing, and in some areas front-line SP roles also included elements of community building in order to find solutions for local people. Social prescribers often also identify an unmet need and develop solutions themselves to meet this need, for example, by setting up groups or motivating community organisations to respond to specific client needs. Community developing required a different skill set and focus to SP. In some areas, community developing had a ‘bottom up’ dimension, focused on empowering individuals and communities to support themselves, rather than just connecting. This area is an increasingly important area of research.

Assets (community)

Our evaluation also showed that equally important are the community assets – including VCSE organisations and community-led activities – which wrap around the SP pathway and provide the necessary structure within which the pathway can operate. Without these community assets there would be no SP. Some areas had community development workers to support the growth and development of community assets, but many did not.

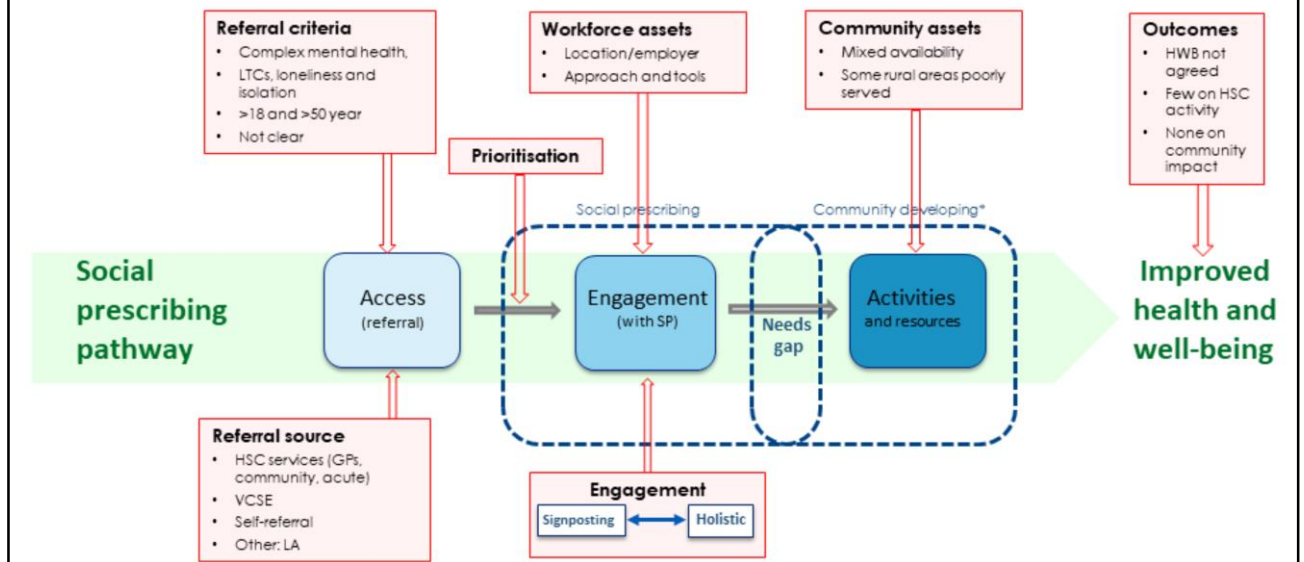
Assets (workforce)

Our evaluation also noted the crucial role of the workforce, an essential asset that needs to be supported, trained and developed – this is commonly a SP, but in some services also may include other members of the community or collaborations of organisations including voluntary sector and statutory sector. In areas where there were less communities assets some SPs moved to fill these ‘community building’ functions, particularly if they identified the same gap in needs for several clients. This required a different skill set and focus to SP and impacted on front-line staff’s capacity to delivery SP.

Partnerships

In some areas, SP programmes had links to wider strategic partnerships, such as multi-agency health inequalities partnerships at a town and/or area level. This provided a forum for strategic partners to work together to solve implementation issues and programme sustainability, and potentially to address ‘needs’ identified by SP programmes. Having links to strategic partnerships adds potential to address health inequalities arising from the varying base of community assets that exists between areas i.e. some rural areas have fewer assets or are more of a challenge to access due to transport.

Model of the Social Prescribing ecosystem



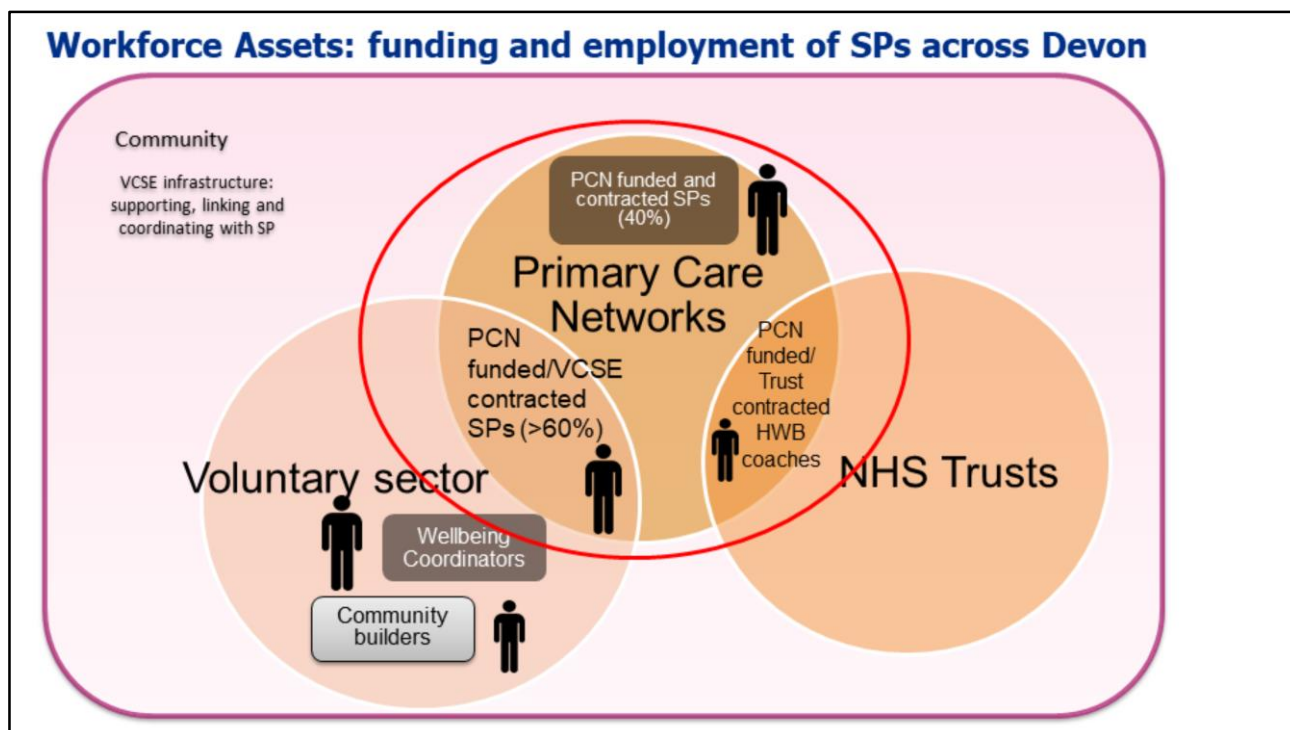
This slide summarises some of the key differences our analysis found in relation to the SP ecosystem model across greater Devon, reported in our Interim Report. This enabled us to understand how social prescribing programmes are working and the factors that might influence their impact on improving health and well-being.

Briefly, we found:

- Diversity in the criteria for who can be referred, as well as which organisations or professionals can make referrals (including if someone can self refer or not)
- Who was prioritised to get access to the service – which had implications for caseload and waiting listing
- Differences in workforce relating to who employed link workers and where they worked, in primary care or the community, and their conditions of work
- Differences in how SPs were engaging with those referred, the tools they used and for how long, impacting on the nature of engagement i.e. varying from a more medical, signposting model to a more transformative, holistic, person-centred approach.
- Differences in the roles link workers were undertaking, with some engaged in building community assets or resources, or working to develop group activities where they did

not previously exist

- The availability and access to community activities also varied significantly, with some rural communities having poor access. This is important as people referred to link workers in communities with fewer assets are less likely to demonstrate improved health and well-being outcomes.
- Finally, different programmes were using different Health and Well-being (HWB) outcome measures to capture their impact, making comparisons of different programmes and delivery models difficult. Few programmes had looked at the impact of SP on Health and Social Care (HSC) activity and none had considered the impact of SP on the community.



This slide summarises who employs SPs and how they are funded across Devon. This was mapped fully in our Interim Report [\[hyperlink\]](#).

We have included this slide as our analysis shows that employing organisation is an important context to how Covid has impacted on SP programmes, as well as how front-line SPs were able to respond to the pandemic.

Devon hosts its SP practitioners in different sectors according to funding and employment contracts. Of the 31 PCNs in Devon, over half have sub-contracted management of their SPs to local voluntary sector organisations. The funding from PCNs does not typically cover all the on-costs for these staff members, which are made up from other sources within the host organisation.

There are 5 main sectors for SP employment in Devon.

Of the SP practitioners who are **funded** through the NHS scheme via the Primary Care Networks (in red ring), there are 4 main sectors:

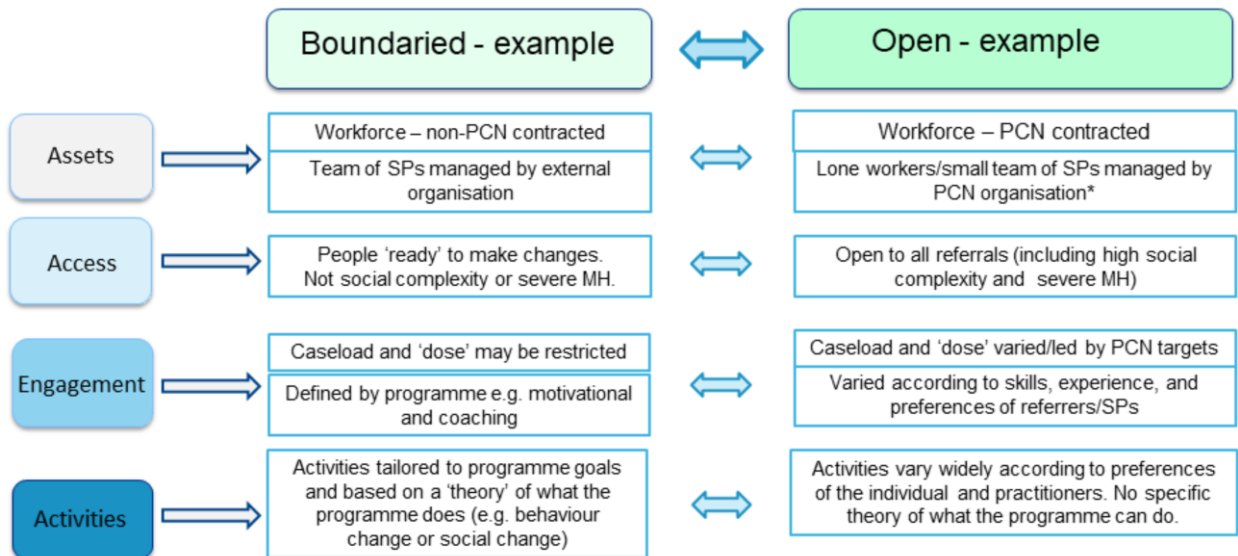
1. PCN SPs sub-contracted to VCSE organisations (some 60% of all PCNs).
2. In one locality where there was no coordinated VCSE umbrella organisation, the 3

PCNs sub-contracted their SP service to an NHS trust, based on a Health and Wellbeing (HWB) coaching model.

3. The remaining PCNs have directly contracted SP link workers to work in their practices.
4. More recently some PCNs have introduced a mixed model of contracting where *some* SPs are sub-contracted from the VCSE and *others* are directly employed by the PCN. In some surgeries there are VCSE employed SPLWs and PCN contracted Health and Wellbeing (HWB) coaches on different salary scales.
5. The remaining sector are those localities still providing Wellbeing Advisors/Coordinators and Community Builders who are NOT funded by the NHS scheme. These continue to receive funding from a variety of sources (including NHS Trusts, iBCF, National Lottery and other grant funding) and overlap with PCN funded SPs.

We know that the VCSE sector continues to provide much of the infrastructure that enables practitioners to work in this way through development of activities for SPs to refer into.

Continua of SP delivery in primary care: 'Boundaried' to 'Open' models*



* at April 2021

In our interim report we noted that SP models operate along a continuum; we have refined these models further into two extremes: the 'Boundaried' and 'Open' models of delivery.

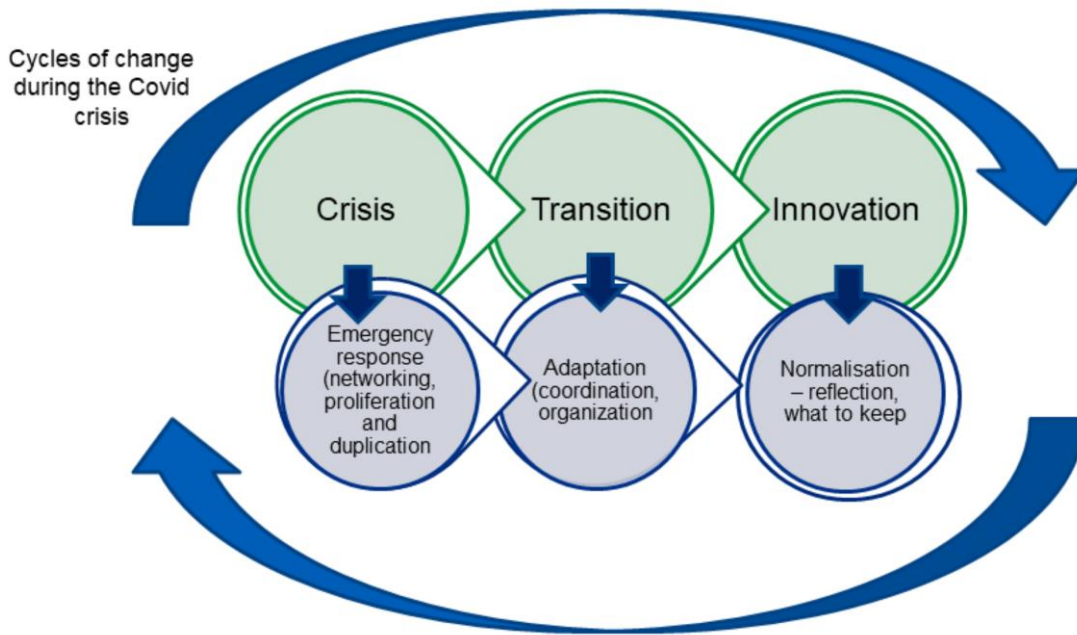
This slide show how operational characteristics or features of the models vary along four continua in Devon, in relation to the assets (workforce) and the SP pathway (access, engagement and activities).

These two models can be thought of as 'archetypes'. We are NOT suggesting that these extremes represent particular projects or programmes in Devon; these are amalgamations of the characteristics we have observed. We will go on to give examples that demonstrate some of these characteristics, which illustrate the continua. We will also demonstrate how Covid has differentially impacted them.

Our social prescribing eco-system model shows that these characteristics do not occur in isolation. They are driven and influenced by the contexts and conditions shown in Slide 13 and 14. These conditions operate to influence how the programme is delivered in a given PCN or VCSE organisation or area of Devon.

These contexts explain how the variability in delivery has occurred and why Covid may have impacted delivery differently in different areas, as we discuss in the next slide.

The Covid crisis and the cycles of change for SP

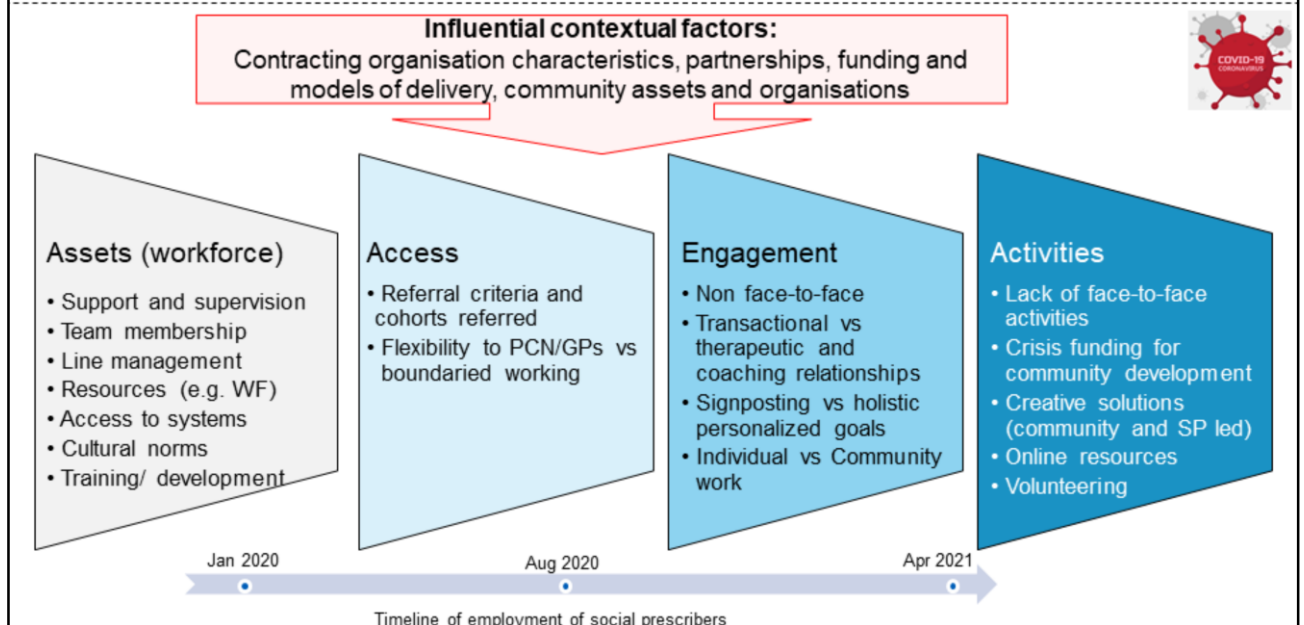


We now turn to the findings of the revised evaluation which followed the course of the Covid crisis through the year March 2020 to April 2021.

It would be inaccurate to talk about 'Covid' as though it were one context or 'phase' or that changes had been made in a linear way during the last year. From the data we have conceptualised this as repeated cycles of change with one cycle of transition and innovation followed by a further crisis leading to another cycle.

Our qualitative data demonstrated that the sense of constantly anticipating spikes and changes and making adjustments to practice caused a lot of stress and exhaustion in the SP workforce, as in other front-line services, during this time.

How were SP models impacted by the Covid crisis?



This slide summarises the pandemic's impact on key elements of the eco-system model: workforce assets and the SP pathway (access, engagement and activities).

Contextual factors

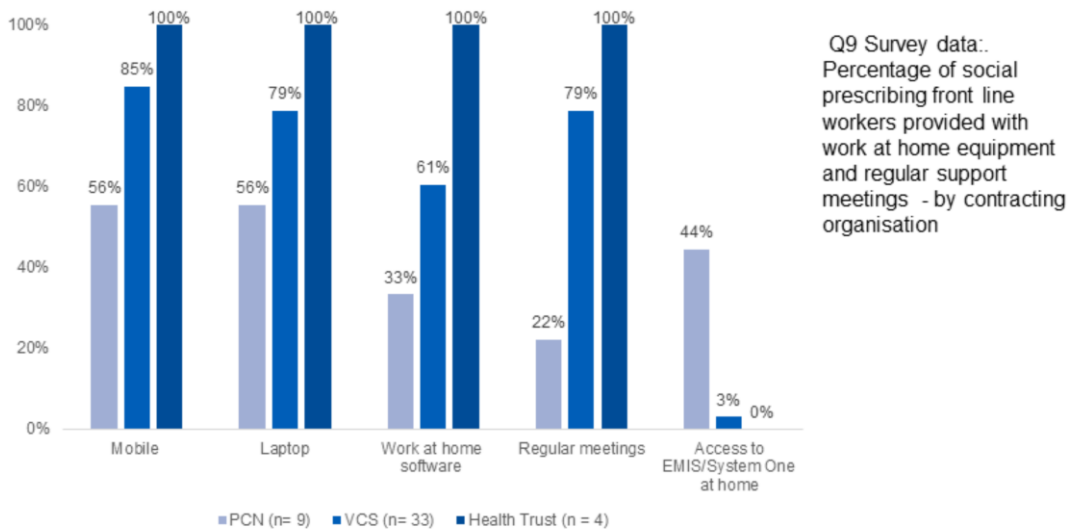
We will look at these areas individually in the following slides, but it is important to also mention the wider *contextual factors* (in the red box) that we identified as influencing key elements of the SP pathway albeit in different ways - the nature of contracting organisation characteristics, partnerships, funding and models of delivery, community assets and organisations.

The impacts of these contexts will be further explored below but, as an example, in areas where pre-Covid there was a high level of community partnership with a rich and thriving voluntary sector, rapid re-purposing to meet Covid needs was possible, with creative local solutions developed for those who were isolating or vulnerable. The rapid set up of single point of contact helplines which worked alongside SPs is an illustration of this coordinated response.

Employment characteristics, as well as the timeline of employment, were also an important context. At the time of the first lockdown in March 2020, SP practitioners had been appointed in all the Devon PCNs, however some were very new in post. Our

findings showed that working practices, role boundaries and relationships with primary care colleagues were only beginning to be established. For those employed during summer 2020 many were not familiar with what 'normal' SP was, having worked in crisis and responsive mode only.

Impact on Assets (workforce) during the Crisis phase – survey data April 2020



In April 2020, the research team surveyed all front-line social prescribers (and some managers) across Devon with 52 respondents, representing all PCNs and localities. The survey asked a series of questions about the impact of the Covid pandemic and lockdown on their work during **April/May2020** (the Crisis phase).

This slide shows responses to Q9, which asked social prescribers what equipment they had been provided with in order to enable them to work effectively from home (or in some cases GP surgeries).

It shows that there was a difference in what was provided to SPs according to the organisations by which they were managed: PCN, VSCE or NHS Trust

In summary:

- PCN directly-contracted SP link workers were (at this crisis phase) provided with less work at home equipment, and were much less likely to have regular support meetings than those Social Prescribers sub-contracted from the voluntary sector (working as link workers in GP practices) or working directly for the voluntary sector in other settings.
- The NHS Trust sub-contracted SPs were all immediately provided with work-at-home

equipment and supported by regular team meetings and individual supervision, but did not have access to SystmOne either at home or in surgery.

- Only 40% of PCN-contracted staff had remote access to EMIS or SystmOne software. Therefore, some were having to go into surgeries to gain access to patient records.
- 3% of sub-contracted (VCSE) SPs had access to EMIS or SystmOne from home or surgery.

Although the differences in provision of equipment were largely addressed by March 2021 (Innovation phase), there were still some PCN-contracted SPLWs who were using their personal telephones for communication and who did not have remote access to GP electronic health records when working remotely.

The importance of the workforce feeling connected to their teams, and supported by their managers, cannot be overstated, as some remote-working SPLWs reported experiencing isolation and burn out, particularly those newly employed SPs working alone in GP practices or from home.

We were able to report our survey data to NHS England (via the national evaluation team for social prescribing and the national GP Lead for social prescribing). Dissemination of our findings supported the case for extra payments to PCNs to support social prescribing as part of the pandemic response, so that SPs could continue to work effectively.

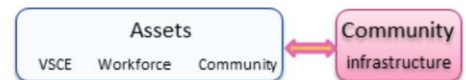
The survey also found that:

- 20% of all front line link workers had no mobile phone or laptop provide
- 40% (at least) had no licensed video conferencing platforms provided (e.g. Zoom, MS Teams)
- 20% had no regular meetings with their teams/supervisor
- 90% had no access to electronic patient health records systems, such as SystmOne or EMIS, from home
- 80% of VCSE managed SPs had regular support and/or supervision meetings compared to 20% of PCN managed.
- Creativity and ingenuity were evident, often through the use of personal resources e.g. the use of personal phones for WhatsApp groups, calls etc.

During the crisis phase at the beginning of the pandemic it was clear that the VCSE had pre-existing structures in place to support their workforce (such as regular meetings and supervision). This enabled the sector to support SPs effectively, as they moved quickly to remote working during the Crisis phase. The agility of the VCSE and their capacity to provide support to the SP workforce and respond to an unprecedented crisis was a

defining feature of the early pandemic.

Workforce assets: Community infrastructure and Community Building (CB) activities



Collaborations

- Rapid response in communities with pre-existing coordinated CB/SP roles

Creative response

- New CB/SP collaborations (VCSE/PCN) forged to source non face-to-face activities

Needs gap

- SPs take on CB activity where no CB roles

Role diversity and duplication

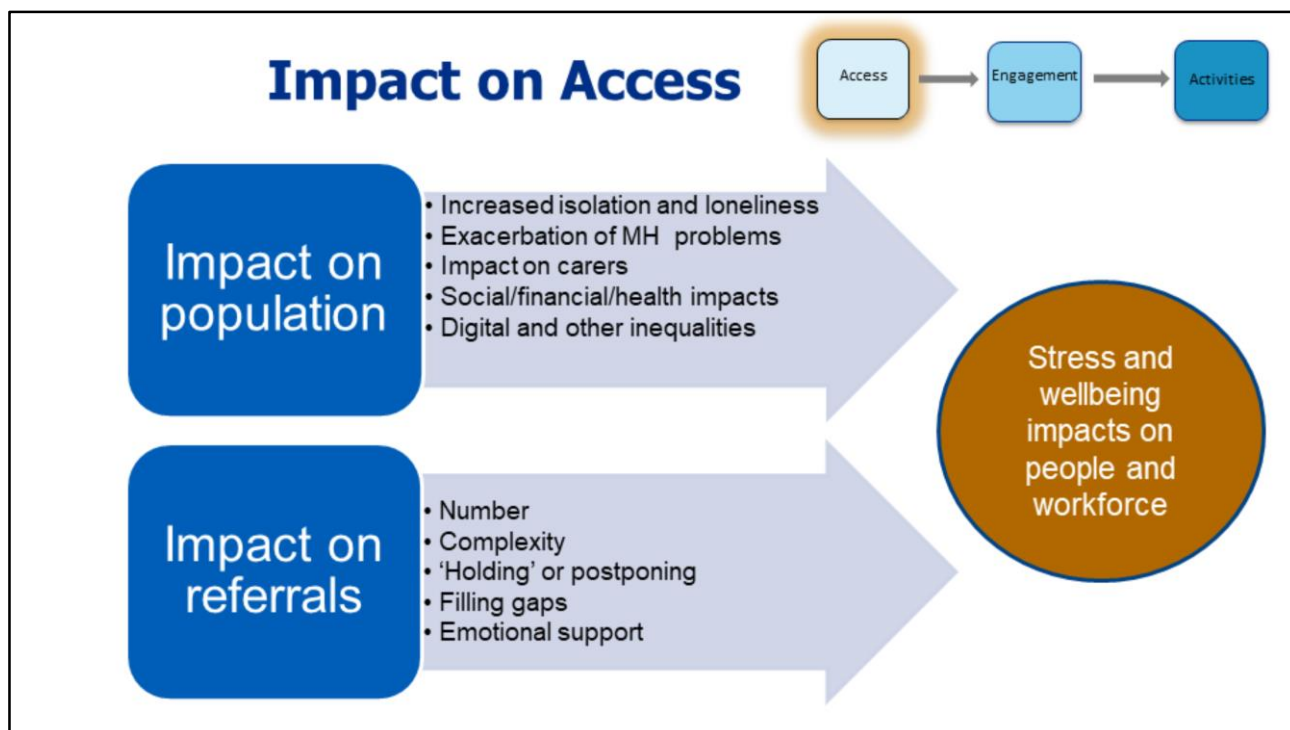
- VCSE SP and PCN SP roles became more diverse, which led to duplication of effort in some areas

This slide reflects on the demands that Covid placed on the system, highlighting the importance of assets (workforce roles) and community infrastructure, such as the presence of Community Builders (CBs), in coping with the crisis and being able to respond by generating new activities. This was dependent on pre-existing VCSE/PCN relationships and partnerships pre-Covid, as discussed in Slide 14. This slide describes the different ways in which areas across Devon were able to respond.

- In communities with established community builders (CBs) these were deployed in a collaborative way with SPs to meet demands of the pandemic
- Overlap between CB/SP roles increased with a need to find alternatives to face-to-face activities. SPs co-ordinated informally with the VCSE in their communities and nationally – often online - to find creative solutions
- However, when a needs gap was highlighted in areas where there was no access to CB, SPs often took on the role of finding activity solutions (for example, online and national sites for activities such as counselling and MH support).
- Covid highlighted the divide between VCSE and SPs in PCNs in some areas and led to duplication of response during the *crisis* phase – for example in duplication of Covid-specific activities such as welfare checks for vulnerable people.

It is important to conclude that in May 2021 during the *Innovation phase*, bridges were being built in some areas without a pre-existing collaborative relationship

between CB and SP as it was recognised that a divide between VCSE and primary care offers in SP were unhelpful for the community and that the future lies in collaborations at the community level.



This slide examines the impact of Covid on the 'Access' element of the SP pathway.

Access describes how certain cohorts of people come into a SP pathway: those who are referred to, or receive, SP and why.

Our analysis showed there was an impact on referrals but also the well-being of the wider population and, consequently, those referred

Impact on population

A number of reports from organisations across Devon – Living Options (Direct Engagement Support) [hyperlinks], CAB, Wellbeing Exeter, Torbay – provided data on the impact of Covid on the population. These showed:

- Increased isolation – anxiety and loneliness, sense of disconnection (especially among protected groups and the vulnerable)
- Exacerbation of previous mental health problems (e.g. severe and enduring conditions, trauma) and an increased chance of falling through the gaps or remaining on long waiting lists
- Impacts on carers e.g. lack of respite (DES reports Nov 2020)
- Lack of solutions to social/financial and health impacts of Covid (CAB report, 2021)
- Digital inequalities which magnified lack of access or difficulty in accessing services and activities

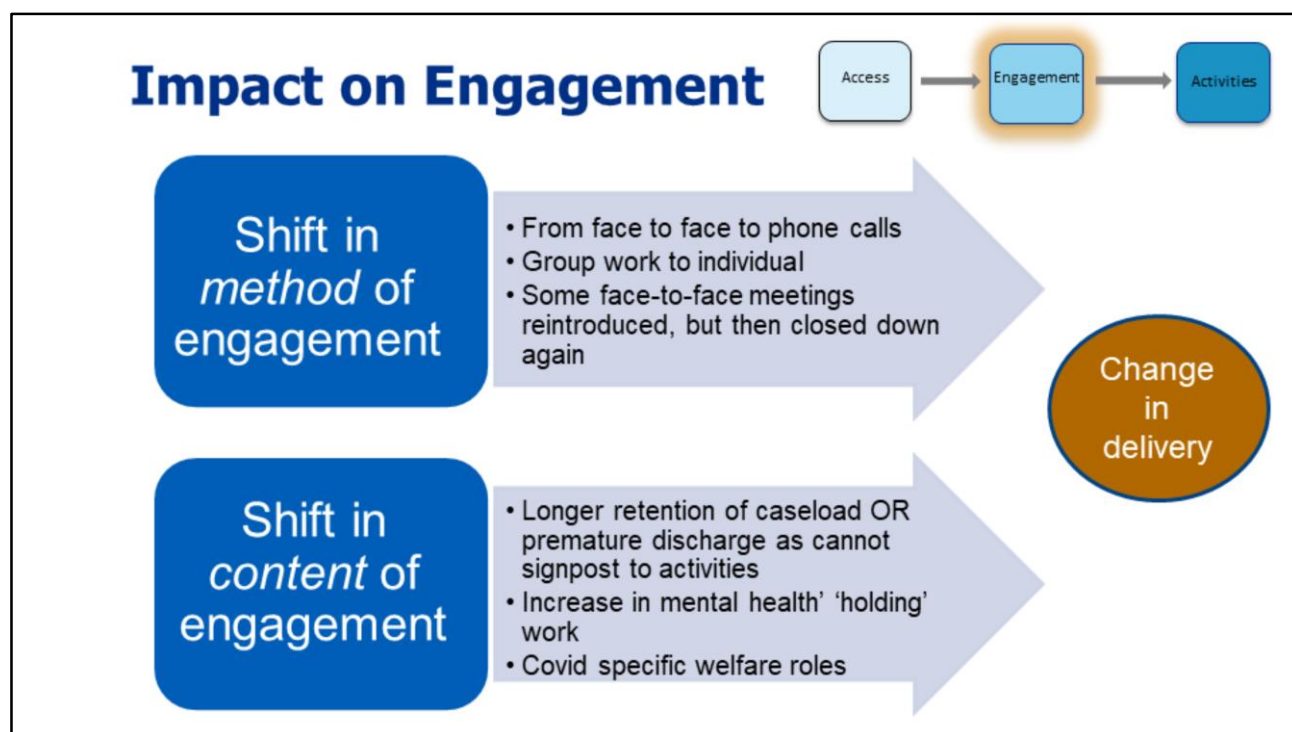
Impact on referrals

This situation, along with the influence of Covid on delivery of statutory and voluntary services, resulted in impacts on:

- Number: impact on numbers of referrals was dependent on model of SP (e.g. Boundaried vs Open – these different impacts are further explored in case study slides 29-35)
- Increased complexity of referrals (e.g. severe and enduring mental health, isolation, financial hardship).
- Expectations of referrers. SP was seen as 'filling the gaps' left by statutory services.
- Retention of clients for longer with SP providing a 'holding' function OR premature discharge of referees as no face-to-face solutions were available with the expectation that clients would postpone their goals until activities opened up again (e.g. exercise solutions)
- Increase in emotional support/counselling type work, resulting in lengthy phone conversations

Data evidence:

- *The impact of COVID 19 and the third lockdown on people's mental health and wellbeing was highlighted across all the protected characteristic groups. Again loneliness, isolation, anxiety, fatigue and the inability or difficulty to access services and activities is having a detrimental effect on individuals' wellbeing, mental health as well as their socio- economic situation. People are struggling with the lack of face to face contact [...] There was initially a sense of national togetherness at the beginning of the pandemic. The third lockdown has brought a sense of COVID 19 fatigue.* (Summary feedback from Devon Engagement Service Partners/Service Users regarding COVID 19. Leila Manion Feb2021) [hyperlink]



This slide examines the impact of Covid on the 'Engagement' element of the SP pathway.

Engagement is defined as what happens in the 1:1 interaction with a SP, and includes the *method* of contact (e.g. phone call, face to face, virtual) and the *content or intention* of these interactions.

In our interim report we showed how SPs engagement with those referred can vary along a continuum from simple, transactional signposting to services or activities to a holistic, transformative conversation where the intervention also becomes the conversation that happens with the SP - these conversations are person-centred and focussed on defining shared goals and a plan for the client.

Our subsequent analysis showed that Covid has had a major impact on the *method* and *content* of how SPs engage and interact with people, both are outlined below:

Method of engagement

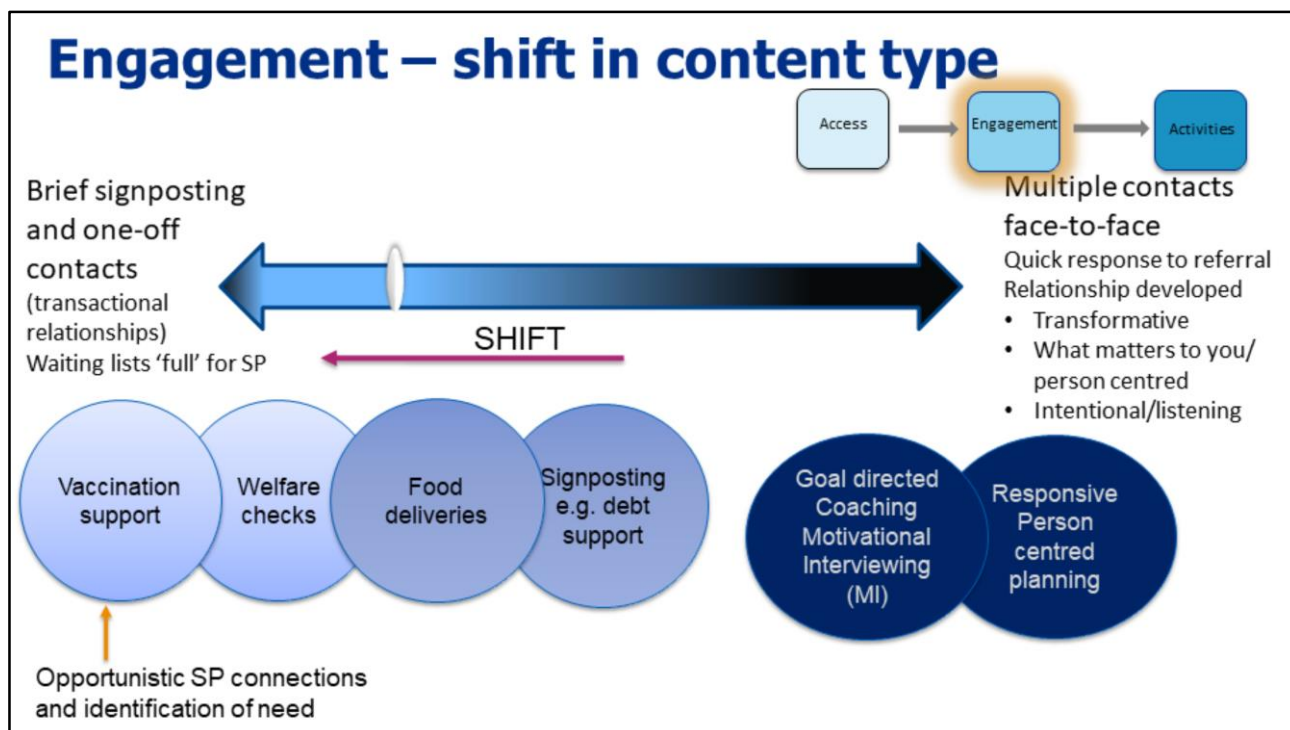
A number of SP programmes quickly shifted to using video conferencing (e.g. Zoom or MTeams) as a means to interact with clients. In general, however, SPs stated they adapted to the needs of their clients. For many, to be contacted by telephone was a preference, but in a number of cases this choice was limited due to their lack of digital access. Sometimes lack of digital access also applied to practitioners, and resulted in

limiting the choices of their clients.

Content of engagement

The *content* of engagement was also impacted by Covid, depending on the model of SP adopted by any one project or front-line SP (for example, whether there were boundaried criteria about who could be referred to the service and what type of work was done with the person during their engagement with SPs).

For PCN contracted SPs, there was a drift towards more signposting (transactional) interactions for some cohorts due to lack of activities to refer to and the nature of C-19 specific work (welfare checks or calls). Conversely, for people with complex needs, 'holding' type mental health support calls (therapeutic) replaced referrals onwards to services or activities – these type of 'holding' conversations were more typical in non-PCN employed staff, but could also happen with PCN workers, if they felt this was part of their role.



This slide shows in more detail how SPs engagement work shifted in response to the Covid crisis, transitioning into a slightly different model of engaging with clients.

As noted in Slide 14, engagement prior to the Covid pandemic varied broadly across SP programmes, with some services more rooted in the signposting, transactional model (shown on the left-side of this slide) and other in the more holistic, transformative model (shown on the right-side of this slide).

Overall, there was a shift in engagement work towards brief one-off contacts (e.g. to signpost people to welfare support and organisations offering food deliveries) rather than deliver a more person-centred 'what matters to you', coaching approach to engagement.

This shift appeared to be more prevalent in SPLWs directly employed by PCNs, rather than those that were sub-contracted/contracted by the VSCE sector.

Directly-employed PCN SPs

Where SPs were directly contracted by PCNs, there was frequently a shift to more medicalised roles (cooperating with the primary care team in the Covid crisis phase by carrying out welfare checks and vaccination admin) rather than the inherently social and personal model as operationalised by VCSE employees (both SPs subcontracted from the

PCNs and Wellbeing Coordinators etc).

Some SP team leaders saw this as an opportunity to enhance and reinforce their status as primary care team members *'all doing it together'* and considered it a *'privilege'* to collaborate with the vaccination effort, speaking in war time metaphors of *'rallying'* the response to a common enemy. It was also noted that working at vaccination centres highlighted unmet needs in the population – particularly with the first vaccinated cohorts of the elderly, some of whom had become isolated and lonely.

However, this view was not shared by all PCN-contracted SPs, who often balanced pre-existing complex caseloads (including people who often needed increasingly intensive support during Covid) with these brief more signposting contacts/welfare checks. This resulted in some PCN-contracted SPs feeling over-burdened by these competing demands and experiencing professional isolation, at least until more members of the SP team had been appointed to help with demand, as these quotes illustrate:

*"There are definitely positives of working at the vaccination centre which I've found to be meeting/networking with colleagues from my surgeries and other surgeries across Devon. This has been especially helpful as I started during the pandemic and hadn't met many people in person so it has definitely helped my profile within the PCN. It is also a lovely positive atmosphere with a great team mentality even though the days can be long and very repetitive. Unfortunately though there are quite a few negatives in supporting at the vaccination centre; being a new social prescriber and now working at the vac centre is giving me a lot less time to focus on SP and my development. **I already had a large caseload before I started supporting and because we didn't stop taking referrals/referrals didn't slow down, my caseload has grown even more in size and has meant we have had to start a waiting list. We've advised GP's to tell patients to expect quite a wait to be contacted but it has definitely put the pressure on our service.** We are sometimes finding that by the time we have contacted new referrals their case has worsened and has been escalated further due to crisis etc which could have been prevented if support was offered faster."* (SP_80)

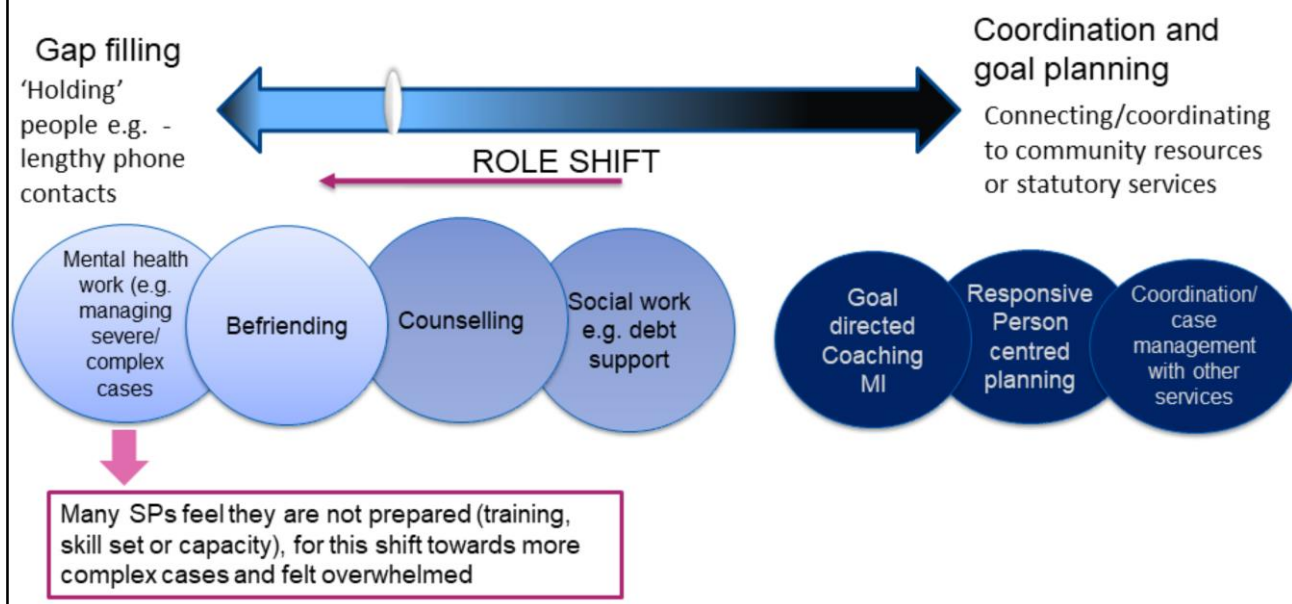
"The situation has been wholly mis-handled in my opinion. We have been used to plug a gap in administration and queue marshalling at the vaccination centre since December, sometimes working 2 days a week there. Unfortunately I tried to raise this with our 'lead' but she refused to push back on it on our behalf. I think it reflects generally how unseen and undervalued social prescribing is. The use of any 'patient facing' staff to be administrators seems an extremely odd decision, when there are many administrators in every practice who could have been utilized and would have been more efficient." (SP_76)

VSCE employed SPs

Voluntary sector employees were more able to embed their work in known relationships within the community and combine their work with individuals alongside the development of community resources and the response to lockdown (such as coordinating volunteers to make food and prescription deliveries). A VSCE lead (VSCE_81) also pointed out that differing contractual arrangements between Wellbeing Coordinators (VSCE employed SPs) and SPs (PCN-funded, both PCN and VSCE-contracted) in terms of

caseload targets were also important drivers of the nature of engagement. For example, in his PCN area, the requirement that practices refer 1.2% of their list size to SP implied a caseload of some 300 patients to 3 front-line staff. By comparison, 6 VCSE Wellbeing coordinators in the same geographical area had a joint caseload of 250 individuals – less than half the caseload. The implication is that the amount of time spent with an individual patient is limited by caseload targets and this in turn undermined the nature of engagement and the ability to hold a ‘what matters to you’ conversation - the theory of change that sits behind the model of social prescribing. Workarounds in some PCNs included recording Covid-specific transactional activities in the target caseload (such as making welfare phone calls to a large list of shielding patients). This then freed up more time for individuals who needed time and support.

Engagement – shifts relating to MH referrals



This slide looks at the shift in the type of people referred into the service, leading to a concomitant shift in the content of engagement in SP interactions.

SP front-line workers reported a change in the content or type of work done around mental health (MH) and other high-risk areas like child protection and domestic violence. Pressures relating to the Covid lockdown also served to increase the complexity of these referrals. Many severe MH cases had no referral routes into statutory services, so they were referred to SP programmes or what one SP described as ‘the last chance saloon’ (SP_49).

While most SP practitioners felt it was appropriate to their role to engage with the basic social needs of someone with complex MH problems, they were wary of holding cases in ‘crisis’, which they saw as ‘gap filling’ and a shift away from their usual role of coordination and goal planning. As they noted, they were managing people who would normally be the responsibility of the statutory MH crisis team (field notes SP peer support group meeting March 2021).

Where there were no clear boundaries in relation to who could be referred into the service, front-line practitioners found themselves ‘holding’ onto or supporting people with significant and severe mental illness, including suicidal ideation. This resulted in lengthy and sometimes distressing phone calls, often taken by SPs in their home

environment, and without adequate support or supervision.

Many SPs reported that they did not feel prepared for this shift in needs (training, capacity or skill set) and felt overwhelmed. Some felt they needed to be 'protected' from these referrals by their service instituting a more boundaried referral offer.

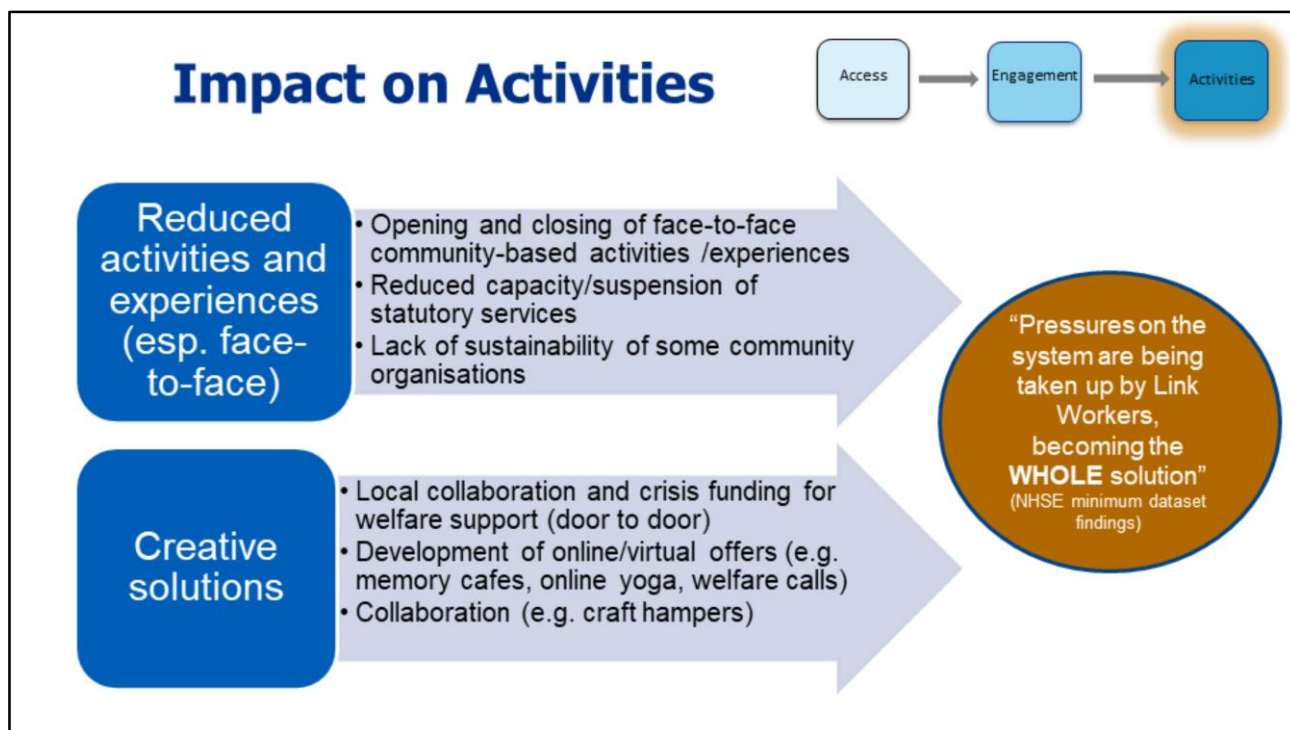
Reflecting on this shift, the research team felt that it is important for SP leaders to consider what level of complexity is 'too complex' for the SP workforce, and to negotiate with primary care about their expectations in relation to referring these type of cases, if the well-being of workforce is to be protected.

Data references

"I think some of the MH referrals are inappropriate as we get referrals for people who have previously been suicidal (might only have been 6 months ago) and I don't feel equipped for this."

(Email communication_ SP 68 Mar2021)

"Complexity of referrals increased under C-19 but was pre-existing[...]From my viewpoint, I would say that some referrals are definitely inappropriate. There needs to be clear guidelines and expectations set out to the funders and referring parties (each being different as we have different responsibilities in our roles. Then at least there will be a clearer framework for everyone.'" (SP 65)



This slide looks at how the activities and community resources (sometimes called ‘prescriptions’) that SP services would generally connect people into in their local area changed during Covid, and how SP services responded to lockdown by creating new activities and solutions to try and meet peoples’ needs.

Reduced activities

One major change for those working in SP was the lack of face-to-face community activities and experiences to connect people into and reduced, or changed, capacity in statutory services (e.g. GP appointments restricted/ freeze on secondary referrals). DEVA reported that a number of VCSE organisations had to close permanently, leading to gaps for vulnerable age groups (e.g. Age Concern groups in mid Devon). During the initial *crisis phase* SP was focused on immediate needs such as welfare checks and making contact, but the *transition phase* soon came when people realised that they would need to adapt their way of working and develop new ways of working. SPs found themselves at the sharp end of these frozen services as they were left becoming ‘the whole solution’ when onward referral or connection to activities was not possible. This is illustrated by the ‘gap filling’ or ‘holding’ role described in the previous slide (25) i.e. C-19 caused a blockage at the activity stage of the SP pathway, resulting in the engagement stage *becoming* the intervention in itself.

Digital inequalities

The lack of availability of traditional, face-to-face activities, however, provided a stimulus to create online solutions. As a result, during the *transition phase*, most SP activities moved online. This led to SP front-line and managers in the VCSE sector voicing concerns about a number of clients not having digital access e.g. to software such as Zoom or MS Teams or hardware (computers or broadband access), resulting in digital exclusion often in communities already subject to significant health inequalities. *'Up-to-date equipment and broadband speed have also been highlighted as significant barriers particularly in rural areas.'* DEVA 2021

Digital exclusion did not just apply to clients, but also to front-line SPs. For example, where PCN-employed practitioners were not seen as part of a primary care team, their access to digital resources was less than for other members of staff. This contrasted with PCN sub-contracted and other practitioners employed by the VCSE whose organisations tended to make up for this shortfall in equipment or digital access by providing resources from their own budgets.

In short, C-19 has seen the proliferation of online offers, but data about the take-up is unclear. Some offers were reported to have poor take up (e.g. online weight management), but others were over subscribed (Building Better Futures course). Other examples included setting up community support through mutual aid groups (SP 49). Wellbeing coaches in mid-Devon started online groups – craft group and book club – *'maybe clients can run themselves afterwards'*, and mental health courses (peer support field notes 2021). VCSE groups also gave examples of Zoom groups replacing dementia cafes, that were surprisingly successfully (ED_54). As a response digital coordinators were reportedly employed in at least two localities.

Creative solutions

Across Devon, creative solutions were found either by SPs themselves, or by SPs in collaboration with the VCSE sector. SP peer support groups provided important fora for sharing of non face-to-face solutions. Some examples of creative solutions or innovations are presented below, taken from our fieldnotes:

'meals on wheels rather than a lunch club: from 20 befriending/25 people in lunch club (physical disability, Dementia; 140 phone calls a week (daily calls); how to get social when not on internet (conference call every 11am and 2:30 regular activity – doing crosswords, reminiscing session, quizzes, bingo, poetry – 'feel like being out'; knowing people/on-going relationship and therefore trust to have this; future potential of this service innovation) (Field notes_VCSE_Wellbeing meeting_July2020)

The SP for three surgeries within one PCN collated EMIS data about services referred into in the time period April-Oct 2020 during the first lockdown (*crisis and innovation phases*). Analysis of the proportion of social 'prescription' types were:

- 30% - online 'learning/activities and support
- 18% - Covid support (via a single point of contact Covid helpline in their locality)

- 10% - mental health crisis support
- 18% - other types of mental health support (e.g. counselling) provided by local and national organisations

Where signposting or connecting to experiences and activities was identified as the person's key need, many creative solutions were found to replace this opportunity. While role titles suggest that front-line staff are either SPs or CBs, in North Devon there were examples of PCN-funded roles that straddled these two functions and in practice the boundaries are frequently blurred as SPs look for solutions for their clients. For example, one PCN-contracted SPLW, alongside local VCSE organisations, initiated the development of a craft hamper to be delivered to referred individuals. SPs also broadened their reach by developing support for universal practice populations by producing materials such as a 'lockdown leaflet', highlighting local and national support/services, and are doing three versions of this which will be practice specific in terms of local activities.'(SP 51). Another SP commented that individual solutions for her clients often did not precisely match, or fell through the gaps, of VCSE provision, so she stimulated the formation of local community assets for onward 'prescription'.

Case study: impact of C-19 on engagement and activities



This slide presents a case study of how Covid impacted on SP services (in relation to engagement and activities) and the outcome for clients.

An 88 year-old woman was referred to her local SP service for social support and connection to a befriending service in January 2020. When the SP met her, s/he learnt that she was struggling with feelings of depression, loneliness and isolation, and had a progressive cancer diagnosis. She lived in a small first floor flat of sheltered accommodation, with a building manager on site.

The SP made 3 home visits prior to the Covid pandemic. During each visit, the client expressed how lonely and depressed she felt, despite attending certain groups. She said that, particularly in the evenings, no one wanted to leave their flats, even to chat over a cup of tea. She explained that she had moved from a city in the Southwest, on her family's advice, and that her car had been taken away following a memory test. She felt she had lost her independence and her previous ability to drive and visit friends. She was very homesick for the city in which she had lived.

The SP was concerned about the impact of social isolation on her mental health as well as some unresolved health issues i.e. the client's repeated requests for help with incontinence and other medical issues. The SP contacted her physiotherapist several times, with no response. S/he also phoned the incontinence service, who would only

accept GP referrals. Just before the first COVID-19 lockdown, the SP exchanged emails with her GP, who confirmed that the client was receiving GP support for her physical difficulties.

SP felt that 'while I was still able to visit this client, I could listen to her – be 'a space' for her – over a cup of tea, even though her issues were not resolvable. I contacted Independent Age, who said they would send a befriender, but my client said it was her real friends she missed.'

During lockdown and beyond, SP was unable to reach her by phone and she was not connected to the internet, so she wrote her several greetings cards, each time enclosing information about wellbeing in her area, in order to keep a link with her and remind her who I was.

Impact of actions

Towards end of 2020, the SP was contacted by client's daughter – the client had recently passed away. Her daughter had found the cards the SP had written and wanted to express gratitude for the SP's role. She said that, in her last two weeks in hospital, her mother had been happier than she had seen her for a long time. Her daughter said she felt that this was connected to her being surrounded by people – nurses, doctors and relatives – having her needs met, and no longer feeling isolated, lonely and depressed.

Case study: reflections and learning

SP reflections:

Client's needs were already difficult to address by SP but could offer helpful contact pre C-19

Post C-19, this support was no longer possible as no flexibility / creative thinking over face to face meetings allowed

Physical health needs should not outweigh mental health needs



What can we learn?:

WBC's creative approach to maintaining contact was important but this alone was not enough

Mental health needs increased under C-19 but support deprioritized despite significant negative consequences

It is easier to identify and respond to a physical health crisis than a mental health crisis

This slide presents reflections on this case study and what we can learned from this.

- Mental health could have been given equal status to frailty, where appropriate, such as in this client's case.
- The SP felt this case study is illustrative of Wellbeing work at its most restrictive, due partly and understandably to Covid-19 guidelines. For some clients it has always been possible to have socially distant meetings and phone calls. However for this client, living with memory impairment, in sheltered accommodation during the Covid-19 restrictions, she could have easily 'dropped off the radar' given the challenges of contacting her at a time when visits inside homes were prohibited by guidelines, and there was no outside area in which to meet this client.
- However, if mental health issues were considered of equal importance as physical health in national guidance, then there could have been more flexibility to visiting rules. There was a very spacious lounge and several sitting areas on the ground floor of the client's accommodation with windows that could have been opened for ventilation. The SP had hoped that such options to be explored, going forward. By 2021, guidelines had changed allowing Wellbeing Teams to replace some former home visits with standing outside the homes of those clients who were too frail to leave (when the weather or circumstances did not allow for meeting outside or in a

garden). This enabled a brief check-in, to keep the contact and the communication flowing. However, the set-up of sheltered accommodation meant that this was often not possible. Since the time of this case, the guidelines have changed and now allow SPs to do home visits in extreme cases where appropriate, with PPE in place. This means that a situation where the SP cannot visit their client with similar issues is unlikely to occur in future.

Learning

- This case shows how C-19 exacerbated pre-existing issues of loneliness and isolation. For this client, the importance of contact with her old friends had already been minimised with focus on maintaining her physical health in sheltered accommodation.
- These issues were difficult for the SP to address even pre-Covid, but her contact with this client was, nevertheless supportive in itself.
- However under C-19, even greater priority was given to physical health which directed the restrictive rules around visiting, despite the significantly negative impact of these restrictions on clients' mental health.
- Social prescribing is a move towards redressing the existing prioritisation of physical health over mental health and emotional wellbeing despite physical and practical challenges often presented

Impact of Covid on the two types of SP delivery model found across greater Devon: 'Boundaried' and 'Open'

The following slides explore in more detail how C-19 has impacted on two different delivery models of SP and why this might be the case.

- Case study 1: Boundaried model
- Case study 2: Open model

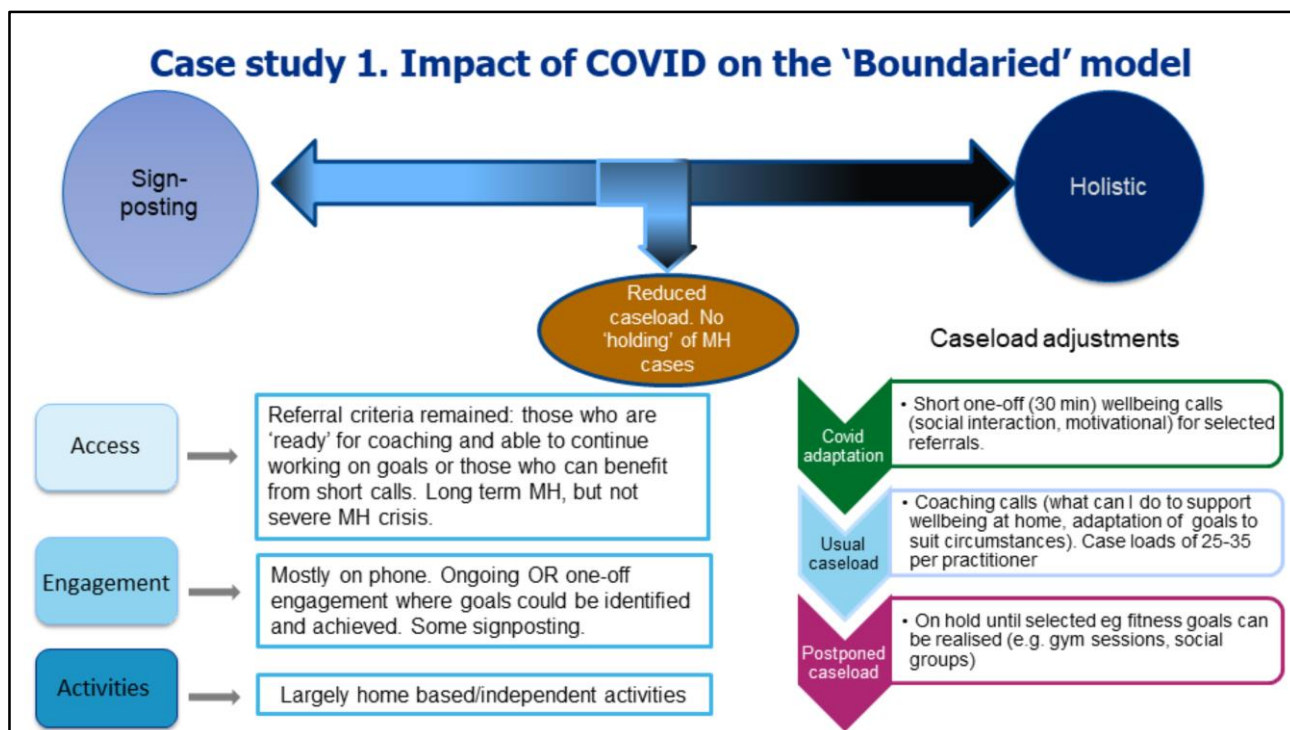
In Slide 17 we noted that there are broadly two types of SP delivery models in greater Devon that vary in relation to a number of operational characteristics or features along continua. These relate to the *assets (workforce)* and the SP pathway (*access, engagement and activities*).

These two models can be thought of as 'archetypes'. As stated in slide 17, we are NOT suggesting that these extremes represent particular projects or programmes in Devon; these are amalgamations of the characteristics we have observed. So, for example, in relation to *engagement* we have found services where this can vary from simple signposting to others which deliver a more holistic therapeutic way of interacting with the person. Sometimes both characteristics are demonstrated within the same service. Indeed, some projects emphasised that flexibility is required to meet the varying needs of its client group and that signposting may be appropriate for one person, whereas a holistic conversation and goal setting is more appropriate for another.

"A good social prescribing scheme needs to offer all of them (points on the engagement continuum) from signposting to a strengths-based conversation'. Some SPs are more comfortable with one than the other. 'Need to offer what's right for the individual at the time its right for that individual'. Describes 'active signposting' to 'full on'." (Field notes conversation with VCSE leader_59).

The following slides consider two exemplar cases from Devon which contrast different approaches to delivering SP: a 'Boundaried' to an 'Open' model of SP. **It is important to state that this is a schematic to illustrate the range of practice rather than a judgement of what is 'better' or a recommendation.**

However, there are some core principles of SP implementation, and the research team have suggested development of a co-produced framework for looking at these.



This slide presents how C-19 impacted on the Boundaried model in relation to *access*, *engagement* and *activities* and the implications for caseload and the nature of engagement based on our SP ecosystem model.

This case study is based on a service with the follow characteristics (as of March 2020-21)

- Sole SP offer in a region of Devon covering three PCNs
- Project funded by PCNs but sub-contracted to another organisation for admin, management and supervision
- Lead supervises a team of front-line staff who carry a caseload of approx. 25-35 each (number of caseload dependent on type of engagement required by clients –e.g. frequency of calls/intensity of support – balanced against team capacity)
- front-line staff are called Health and Well-Being coaches (HWB coach) and approach is motivational

Boundaried delivery model

This project uses a boundaried approach to delivery characterised by an explicit logic that the model of SP works better with some people than others: this is defined as people who are not in any type of crisis situation and who are 'ready and motivated' to make significant changes in their lives '

changes' (extract from service leaflet) .

The model has clearly defined referral criteria that are communicated to referrers. Referrals not deemed appropriate can be declined. Its project narrative is based on a philosophy of empowerment and self-management of health and wellbeing and discourages dependency on the project workers by limiting number of sessions. Conversations are grounded in a motivational interviewing approach which facilitates clients to determine for themselves whether they are ready for this type of work. The outcomes are anticipated to be behavioural changes (such as increase in social and physical activity) leading to a sense of increased wellbeing, as well as more distal outcomes such as reduction in usage of traditional health services or medication.

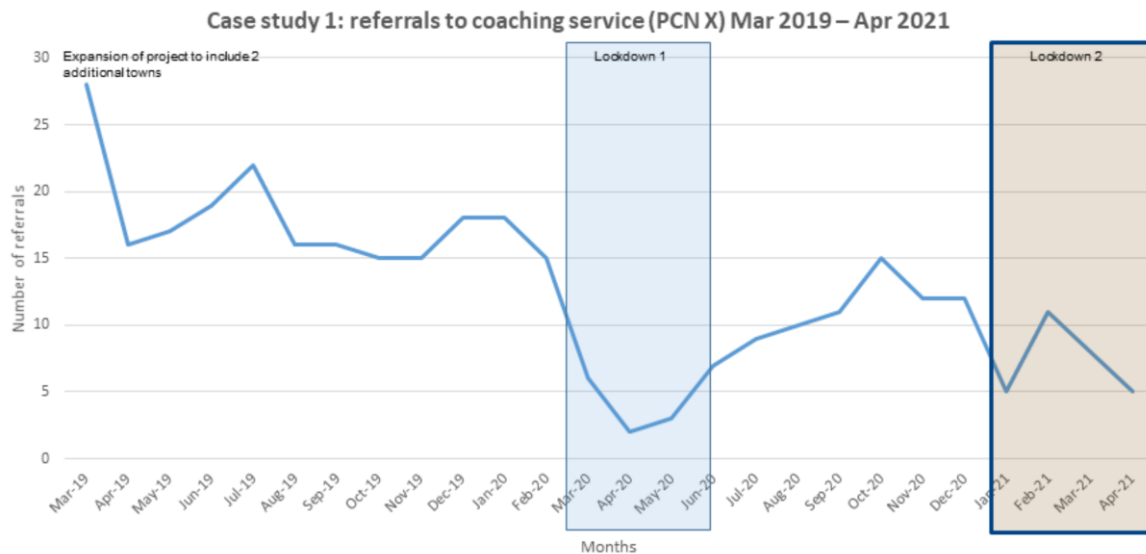
"As a service we have to be aware of what we are and what we are not – mental health cross over – have referred people to specialist services like Talkworks, if we can't meet that need through coaching - as we are not a mental health support service" (Researcher notes from team leader interview, SP79, June 2020).

This does not mean that the service does not recognise the links between mental and physical health and wellbeing. Indeed, the well-being benefits of trusting relationships developed with front-line staff were evident from client feedback and it was clear that the coaches' listening and engagement work covered many aspects of a client's life. The engagement with clients was also limited or 'bounded' by time and frequency, a principle explained to clients at the outset (6-8 one hour contacts over a flexible time period). As elsewhere, the service switched from face-to-face to a telephone call engagement during Covid.

Covid presented a severe limitation on the content of engagement since many goals usually set for clients could not be realised (such as group walking, attendance at gym or exercise classes). The service modified *access* in the three ways listed in the slide. Initially, in the *crisis phase* the project accepted referrals for short one-off wellbeing calls to suggest, for example, ways to structure the person's day to reduce feelings of isolation or boredom (these were not the shielded population and did not comprise the majority of case load). These calls were discontinued during the *transition phase*. For existing caseloads, creative adaptations to usual goals were made. For example, coaches suggesting walking targets according to Covid guidelines with one other person, and on-line methods of social interaction. For others, it was decided to 'postpone' or put goals on hold that were intrinsically tied to group or social activities and either or both client and worker felt that these were better realised once restrictions were lifted.

No shift was experienced by this project into mental health crisis work – what some projects term 'holding' - although supportive, coaching calls were offered to existing caseload where this was thought to be beneficial to their overall mental health and wellbeing. Similarly there was no shift into Covid-response work such as supporting vaccination clinics or welfare checks. This could be attributed to the clear mission and vision for this project's work. This approach was supported and endorsed by its leadership.

Covid impact on the 'Boundaried' model: number of referrals



The slide shows the number of referrals for the Boundaried model in one PCN during the two financial years 2019-21. These numbers were supplied by the project themselves. It shows referral fell during both the March 2020 and Jan 2021 Covid lockdowns.

This could be attributed to impacts of Covid on the referring organisation. For example, in primary care few patients were seen face-to-face, so they were less likely to get referrals to SP.

However, as suggested in the previous slide, this was also due to the model of social prescribing, and the service's boundaried offered with clear but more restrictive criteria for *access* to the service. In addition, those existing or new referrals whose goals were not achievable as a consequence of the pandemic restrictions, were not taken on or postponed for re-entry into the scheme at a later date when activities may have opened up again.

Case study 1: Service users' experience of the 'Boundaried' model

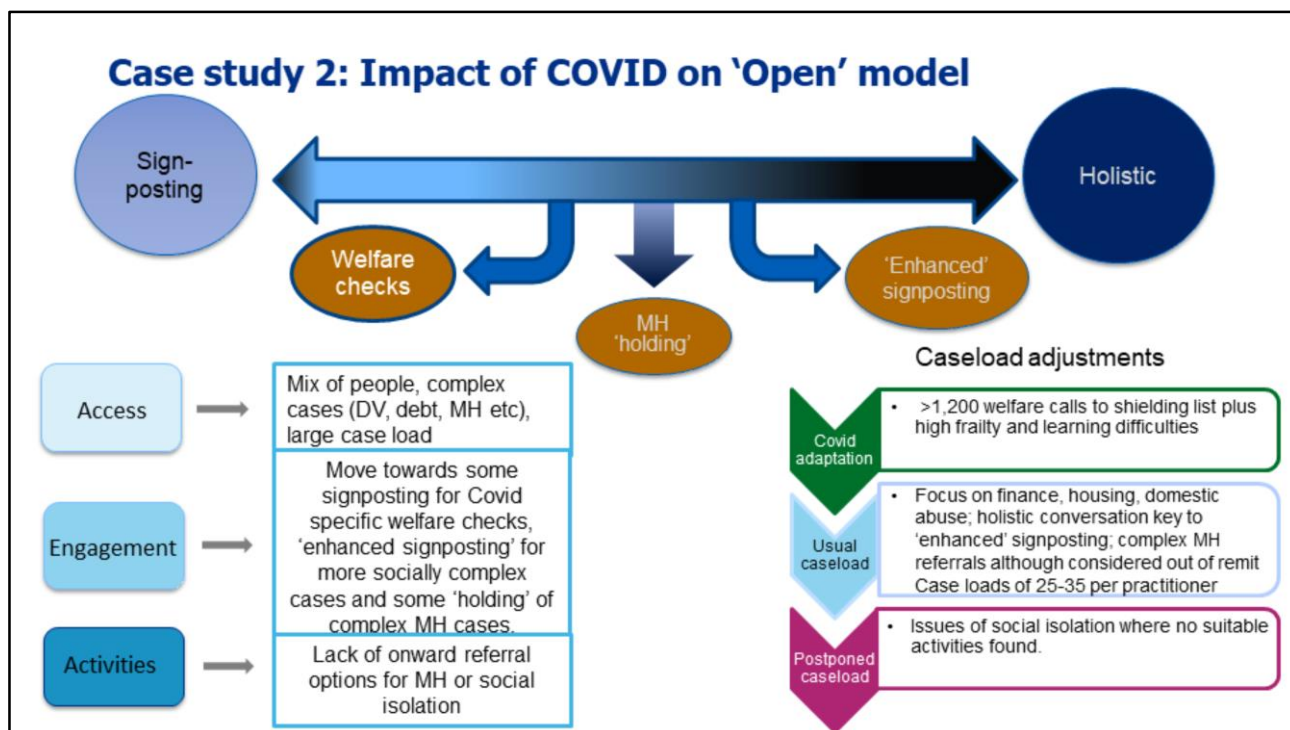
Theme	Data reference (Service user feedback)
Impacts of the service • SP interaction with primary care – reciprocal outcomes • Mental health benefits and reduction in medication • Increase in self-belief and self management	<i>I have obviously gained more faith in my GP practice as a result of this scheme. Were it not for the scheme I would have been taking antidepressants and riding the depression out until its end. (P5 on completion of full course)</i>
Mechanisms of action • Goal setting • Encouragement and support • Empowerment	<i>I was given the right amount of encouragement and support in identifying my goals and achievements. I came away from every appointment believing I can follow up with my plans and achieve them. (P5 on completion of full course)</i>
Impact of Covid • Lack of services or activities	<i>I now feel confident to use some of the services being offered by my GP. However due to the pandemic unable to visit. (P8 on completion of full course)</i>
Importance of referral criteria • Readiness for the service • Identification of mental health needs	<i>I am not ready for this type of support. I need psychological help. Therapy! Possibly, (will continue) when it is in the right order. Counselling first then wellbeing. (P103 – initial visit only did not continue course)</i>

This slide shows a preliminary thematic analysis of service user feedback in relation to different aspects of the service and its impact on individuals. It is based on a collaborative qualitative analysis currently being undertaken by the SP lead and team of SP coaches, guided by the RiR . In general, the project had a high-level of satisfaction from anonymised client feedback forms.

Themes examined here are :

1. Impacts of the service: The data show that the project has important outcomes relating to reduction in use of medication and services as well as increasing well-being (self-belief, motivation and self management).
2. Mechanisms of action: The clients' experience is organised thematically in relation to the way the service works (its theory of change or mechanisms) i.e. goal setting, encouragement and support, and the sharing of power by the front-line staff which engenders empowerment.
3. Impact of Covid: clients found activities or services that would formerly have been identified or 'prescribed' were not available due to Covid, such that some goals could not be achieved.

4. Importance of referral criteria: Data were also collected from people referred, who had an initial meeting, but who did not continue into the 'full' programme of goal-directed coaching. The final quote is taken from someone who declined to continue beyond an initial contact as it was identified in conversation with her SP that her current needs meant she was not able to benefit from the project. This decision reflects the rationale of the project: it is a service that works with people who experience mild/long-term mental health problems, but cannot offer a formalised intervention for mental health, such as CBT, counselling etc. Where these needs are identified they are signposted to more appropriate services.



This slide presents how C-19 impacted on the Open model in relation to *access*, *engagement* and *activities* and the implications for caseload and the nature of engagement based on our SP ecosystem model.

This case study is based on a service with the following characteristics (as of March 2020-21):

- Sole SP offer in one PCN
- SPs are PCN-funded and contracted. PCN provides admin, management and non-clinical supervision (clinical supervision externally sourced)
- Initially a single worker who became team leader. Team lead supervises a team of 2 front-line staff, with a caseload of approx. 22-35 people each
- front-line staff are called SP Link Workers

Open delivery model

This model is characterised by its flexibility to the working practices of different surgeries in the PCN. Referrals come from GPs and are largely negotiated with individual surgeries.

In the example of case study 2, the crisis phase of the pandemic came at a time of early development of primary care based SP services. It was more difficult for the (initially) lone SP worker to set referral boundaries and a largely responsive model that

accommodated the needs of the PCN was adopted. Referrals characteristics were, therefore, broad and varied. As time went on and a team was employed, the lead SP began to draw some boundaries (and produced documents to share referral criteria and offer with referrers and people who might be referred). However, unlike the Boundaried model, the Open model, exemplified in features of this case study, gives access to people with complex needs, domestic violence, debt and homelessness.

'A real mix of people really, lots of social isolation, financial issues comes up a lot, domestic abuse, low mood and anxiety also a lot, homelessness'.

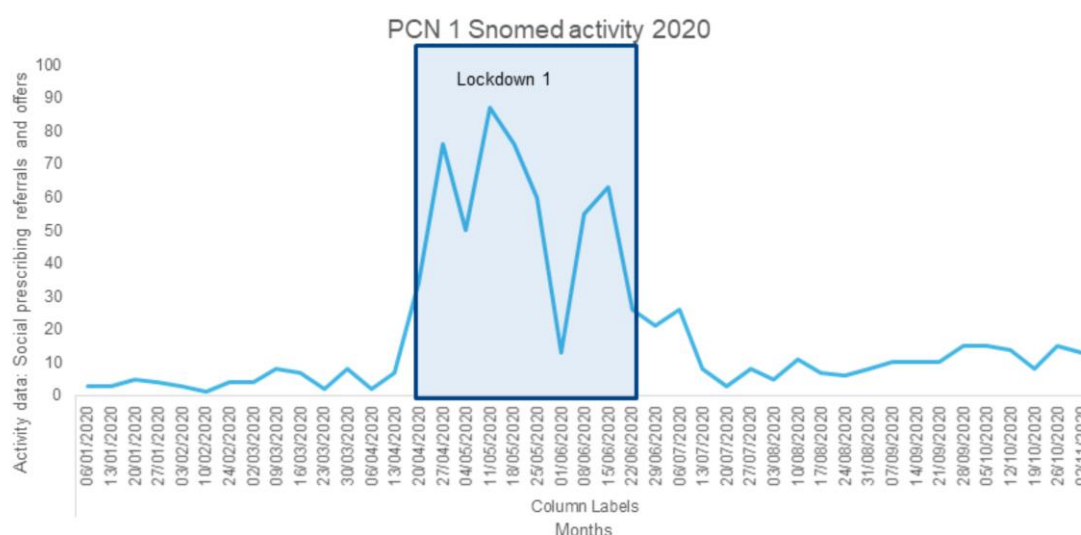
This continued throughout lockdown, with the addition of shielded list on top (SP2: 13/10/2020)

The lead SP is mental health trained (RMN). Perhaps as a consequence of this, she has received referrals for people in crisis, despite pointing out that she and her team were not supported to offer this work. This was exacerbated by Covid since her experience was that few services were available to meet the needs of those with complex mental health issues. *'I also get complex mental health and those people who have recently been suicidalI accept these for social issues as I'm RMN trained but I've informed my service there is very little I can find for mental health' (13/10/2020).* This led to some 'holding' work for these cases.

This service also offered some Covid-specific (adapted) work with shielding lists. This resulted in a significant shift for a proportion of her working hours towards a more signposting or transactional interaction, not coherent with the theory or model of SP generally adopted by this SP, for whom trusted relationships are key to *engagement*. *'We've had to call all the shielding list which started off at 564 and with additions went to 1200...I'm still playing catch up with the additions that appear to come each week. We don't do an MI conversation, just a welfare check really for most, we do have to be cautious of time and pressure, however the more complex queries come to me which might be a more guided discussion as needed' (03/06/2020)*

However for the majority of this team's clients, the lead SP described how an 'enhanced signposting' is often required, as to understand people's needs in order to identify relevant services takes time and engagement. This SP feels it is difficult to know to what extent Covid has affected the team's offer as she started only a few months before Covid. She was initially recruited to work on a more boundaried model in which those experiencing social isolation were the target cohort. The shift towards greater complexity was in motion prior to Covid and appears to be ongoing. The main effect of lockdown was that the team were less able to address those clients with social isolation, but as their referral criteria was broad and focused on issues for which other support services still continued, the majority of their work continued as it had before, albeit via telephone or Zoom rather than face-to-face.

Case study 2 – primary care employer with 'Open' model



Data for this slide were extracted by the research team from SNOMED data recorded by patient electronic health records in general practice for this PCN. The slide shows that the number of referrals for the 'Open' model increased significantly during the first lockdown (Apr-Jun 2020), fell but then remained at a slightly higher level than pre-lockdown to Nov 2020. SNOMED data were not available to us beyond Nov 2020 so we are not able to look at impact during the second lockdown of Dec 2020.

The increase in SP activity following the first lockdown represents work doing welfare checks on patients on the 'Shielding' list for the practices, rather than 'full' social prescribing.

This activity was coded as 'declined social prescribing' in SNOMED codes since people did not enter the programme for SP and as such were not regarded as part of the usual caseload where a sustained intervention takes place over 6-8 months and a relationship is built up with the practitioner. The data show that there was a significant shift in engagement for this PCN SP to a more signposting interaction in this cohort of people, who would not necessarily previously have been exposed to social prescribing.

We will discuss the differential impact of Covid according to these models further in the next slides.

Summary observations: Comparing Covid impact on different models of SP

Access	- Referral types (e.g. Covid specific/complexity/MH) - Referral numbers
Engagement	Content – what happened in the interactions – shifts to signposting, 'holding' or postponement
Activities	- Both models – lack of activities/ services - Particular impact on people experiencing social isolation
Assets	- Teams, relationships, time - Employing organisation, Community assets, VCSE infrastructure
Outcomes	- Lack of evidence to compare outcomes - Balance of inclusion and workforce wellbeing

This slides shows how different models of SP had a different response to Covid in relation to who accessed the service, the nature of that engagement, activities undertaken and assets

- *Access*: This resulted in different numbers and types of referrals and brought benefit to slightly different populations with different needs.
- *Engagement*: The Open model focussed on social determinants of health, rather than 'readiness' to change (Boundaried), and also shifted engagement towards simple signposting due to Covid adaptations, such as vaccination and shielding work.
- *Activities*: It was particularly challenging to find solutions for those experiencing isolation or having fitness goals
- *Assets*: The assets available to SP formed important workforce and community contexts that served to influence the structure and delivery of SP:
 - Pre-existing relationships with employing organisation impacted on how the elements of the pathway were configured under Covid. For example, where employed by PCNs, SPs were more likely to adjust their offer according to the pressures on primary care brought about by the pandemic. This worked in

favour of team-building with primary care colleagues and meeting the pandemic needs, but caused extra stress in management of pre-existing caseload numbers and was felt by some to dilute the 'theory' or model of what SP can or should do

- Working with people with high levels of social or mental health complexity was more inclusive in the Open model. However, this also brought tensions in relation to workforce well-being since regular supervision was not widely available
- Temporal factors – how long the service had been established and SPs had been employed were important factors in determining what SPs could do to respond
- Local characteristics were also key factors – for example, the presence and strength of community assets, VCSE infrastructure and partnerships

Outcomes: It is not possible to say which is model of SP (e.g. Boundaried or Open) was more beneficial to clients as we were not able to compare outcomes across these models.

The following slides will look in more detail at the local context – the VCSE sector assets and partnerships in different areas and how these were impacted by, and responded to, the pandemic.

Impact on VSCE sector: response, relations and infrastructure

Adaptations and opportunities

Agile adaption

Agility and adaptability of VCSE, local response (helplines/coordination), recognition of VCSE role

Levelling

Hierarchies reduced, more inter-silo working, partnerships, decreased bureaucracy

Accelerating

Digital solutions and innovation, WFH, communication, team working, funding flows

Creativity and good will

Collaboration and convergence, peer support, solution focused, flexibility in response

Potential unintended consequences

Shifting focus

Potential for 'mission creep', funding sustainability?

Sustainability

Multiple organizations, duplication, VCSE and SP replace statutory services

Widening of gaps/fractures

Digital and social exclusion, trusted relationships less easily formed not face-to-face, sustainability of funding?

Loss of boundaries and identity

Shift in models – e.g. away from face-to-face, less responsive to needs, blurring of role, 'filling gaps'

This slide gives a summary of themes we identified about the impact of Covid on the VSCE sector: how it responded, the nature of relationships with others and the impact on its infrastructure.

Impacts were grouped into potential positive innovations as well as unintended consequences of Covid on the sector, both thematically grouped under four (different) headings.

Adaptation and opportunities

As shown already in the previous slides there were a number of adaptations by the VSCE sector (SP services) as well as opportunities to engage differently with system partners and local communities. Some of the innovations the SP system might want to keep. Four key themes arose in relation to its *Agility adaption* in response to a sudden change in context, in some cases setting up a single point of access within days of the first lockdown. This contrasted with the NHS volunteers programme that took months to get established. This resulted in increased recognition of the VCSE role by commissioners and statutory providers.

The VSCE also reported a *Levelling* of relationships with statutory organisations with a willingness to work in more equal partnerships and less bureaucratic ways. It resulted in an *Acceleration* of new, innovative ways of engaging with the public/clients, access to

funding and the creation of online activities. There were many examples of *Creativity and good will* and collaboration with other organisations, including working with the shielded patients and vaccine programme, which was outside their remit and funding realm.

Potential unintended consequences

However, these were some potential unintended consequences; some immediate and others potentially longer term. These need to be recognised. The willingness to respond to the pandemic led to worries about a *shifting focus* or ‘mission creep’ and threats to funding sustainability for VSCE organisations. Although funds were available to support the VSCE Covid response, a number of traditional funding streams and fund raising activities were not possible during lockdown. This raised a number of existential concerns about the future *sustainability* of the sector. At the same time there were concerns about lack of coordination and duplication of services, and that the VSCE could end up by default replacing statutory services or that *boundaries* or roles were blurred, for example, in relation to supporting people with significant MH issues, moving the sector away from its original purpose and ‘filling gaps’ in statutory service provision. The VSCE were also keen to be involved in recovery planning, recognising that they are often the closest organisations to their communities, understanding the impact of Covid on them and their needs, but to engage requires further funding. Finally, there was also a concern that the rapid shift to digital undertaken by its services could actually widen digital and social exclusion and undermine the effectiveness of SP.

It is important to plan for the effects of these potential outcomes in building sustainability of funding and partnerships, digital future proofing for the excluded and to further consider developing a common agreed set of principles about the scope of SP and its boundaries, taking into account employing organisation characteristics.

Data references

“We have provided support with risk assessments, interpreting the changing guidelines, training, support, guidance, and reassurance.” DEVA report April 2021

“My own personal concern is that the role of VCSE during Covid-19 has been recognised by all – of course it really stepped up to the mark – but at cost to the organisations to some extent; I am fearful that the statutory sector think that response is sustainable from organisations and clearly it isn’t.” (VCSE manager 23. July 2020)

Covid support effort has brought people (community) and local VSC together in relation to people needs (values focused): *“Covid has connected us back to our community – repurposing our services was putting it back out into community – 236 community supporters volunteered in 7 days – e.g. providing hot meals. People who didn’t know about us have said ‘we knew you were up the hill, never knew what you did (until now)’ – people became part of our family.”* (VCSE leader 60)

Covid encourages joint working between statutory and VCSE, VCSE/PCN: *“More integration of approach where people were working in silos – people see how much they need each other – communication barriers have come down –having conversations we wouldn’t have had.”* (VCSE leader 56)

Covid impact on partnership working between organisations and teams:

Partnership responses under Covid

Common purpose and collaboration

Covid response accelerated sense of common intention and collaborative working

Trust and power sharing

Increase in equality between partners.

Reciprocity

Exchange of resources and flexible working for mutual benefit

Community mobilisation

VCSE mobilization of community and agile community response

Key facilitators for successful partnership

VCSE infrastructure

Vertical and horizontal networking and knowledge of communities, leadership and strategic thinking

Sustainable and pooled funding

Reduces competition and increases collaboration

Flexibility of approach

Working outside of silos and at pace, sharing power

Maturity of relationships and trust

Contextual factors – time, pre-existing strategic partnerships and relationships

This slide gives a summary of the impact of Covid on partnership working between VCSE and statutory sectors. In general the pandemic stimulated a greater degree of partnership working than had been seen previously, although local variation occurred depending on pre-existing factors and facilitators such as relationships and maturity of trust between organisations.

Partnership responses

- *Common purpose and collaboration:* the Covid response generated a strong sense of common purpose, working together to mitigate the impact of the crisis
- *Trust and power sharing:* There was much *good-will* and *trust* from the VCSE as they quickly adapted services to meet immediate needs as well as participate in the vaccination programme often without resources or funding secured, but on the expectation that they would follow. There were reports of *power sharing* relations with less hierarchy and bureaucracy and more equality between partners and how they worked together (e.g. in local teams in primary care or communities as well as at a STP/ICS level). The VCSE shared its knowledge of and ability to mobilise communities, a resource much needed by statutory organisations.

- *Reciprocity*: there were examples of some organisations – statutory and non statutory - working together in a mutually beneficial way . PCN contracted SPs also working flexibly and reciprocally with primary care colleagues to facilitate responses for the shielding and towards the vaccination effort. There was an informal acknowledgement that this willingness to adjust delivery model at a time of demands on primary care workforce enabled SPs to feel part of the team, which could have benefits for future working. However, there was also an acknowledgement for some that a similar phenomenon of ‘mission creep’ could result , such that it may be difficult to return to pre-Covid delivery models.
- *Community mobilisation* : This was facilitated by having some VSCE strategic infrastructure in place, which could engage, identify and negotiate funding streams (albeit short-term in nature) and resolve issues presented by Covid.

Nevertheless, it was reported that coordination could have been stronger with other statutory partners (DPT/CCG/PCNs). SPs reported that their work was being hindered by the inability to refer to some clinical pathways (particularly mental health) and poor access to IT systems/equipment.

Facilitators for partnership working learned from Covid: key variations in maturity of VCSE and partnerships with CCG: geography matters

- *VSCE infrastructure* – where there was a well-established infrastructure, it enabled vertical and horizontal networking and coordination of the Covid response at town, locality and area levels: towns or localities with a more mature infrastructure, and where there was also trust with statutory partners, reported they were more able to mobilise promptly and coordinate their response to their communities’ needs (adapting SP services, innovating single point of access, but also food banks, delivery services etc). In one area, this led the CCG working with the VSCE sector to coordinate their support for vulnerable populations (recognising the value of its networks/contacts). In another, lack of an umbrella VSCE organisation (and trust between some partners), led to disengagement and smaller VSCE networks charting their own course separately.
- In some areas, the VSCE reported that collaborative working had reportedly led to greater sharing of resources and *reduced competition* for limited funding resources.

Covid exposing tensions in SP Ecosystems



In conclusion, Covid has accelerated many pre-existing issues and tensions within the SP Ecosystem model, outlined in our interim report. These issues relate to the SP pathway (access-engagement-activity) and also the wider SP ecosystem i.e. where SP is located or who is the employing organisation and the wider community infrastructure that sits around the pathway. Understanding and resolving these tensions is crucial if SP programmes are to be provided equally and sustainably across Devon, and their impact on individuals and communities is to be similar.

Tension between VSCE and PCN SP systems

This report has shown that under Covid the differences in SPs employed in PCN and SPs employed by other organisations seem to be more exaggerated now than reported in our interim report, with SPs often holding different caseloads, different types of referees, different approaches to engagement and weaker links with the community assets.

As we now move to the recovery phase of the pandemic, commissioners may consider how this potential divide is addressed at the strategic and operational levels. Our suggestion would be greater representation of PCNs at the SP Executive Group as well as the funding of Communities of Practice to allow all SPs, regardless of employer, to come together and share issues, best practice and learning. This will help ensure that a two-tier system does not evolve.

Tension between individual well-being and community building

As noted in our interim report, the effectiveness of social prescribing is dependent on the presence and strength of community building. In some areas, where community building was weak, SPs were undertaking this role to fill the gap (reducing their capacity). As the system recovers from Covid, commissioners will need to consider which model of SP they are willing to support moving forward – a version of the Boundaried or Open model, combined with flexibility along the suggested continua to allow response to individuals and place. This decision will impact on who benefits from SP, as well as how community building can be better linked to SP programmes and financially supported alongside it, so that there is sufficient capacity and variety of community assets on offer to meet most peoples' SP needs. This is likely to require linking with Social Care/Community Development commissioners in the local authority and mental health commissioners or service providers. This will also influence the training, support and supervision SPs will require.

Unless these two key tensions are addressed, delivery of SP across Devon is likely to remain varied and inconsistent in content and provision.

Impact of the RiR role during Covid

National impact

- Timely findings fed to SP Institute (AHSN) and NHSE = increased funding for WFH)
- Reciprocal learning re evaluation (NHSE national minimum dataset collaboration)

Local systems

- Feedback improvement cycles e.g. need for Communities of Practice
- SP Exec co-production of recommendations post-Covid

"I relayed messages following your report on the issue of link workers not having sufficient resources – particularly telephones/laptops and often access to the surgery computer system [...] I think it is true to say that the extra £3,000 per link worker was partly a result of these discussions"

*Dr Michael Dixon,
National GP Lead for SP*

The embedded researcher role has had important impacts on policy and delivery during the 18 months of the contract, which coincided with an unforeseen and unprecedented change in working practice.

The role was quickly repurposed to virtual working. The team has continued to work as embedded researchers on the social prescribing project, building and maintaining relationships with commissioners, leaders, front-line staff and projects across Devon and delivering to external and self-imposed deadlines with minimal supervision.

We have developed an extensive network of project contacts, supported front-line staff by coordinating peer support mechanisms so they can share practice under Covid conditions and learned how to effectively disseminate findings virtually with impact.

We have maintained an active role on various key executive and operational groups including the ICS Social Prescribing Executive Group, SW AHSN Social Prescribing Institute insights group, Devon VCSE Reference group, NHS England minimum dataset co-design group.

Researcher in Residence impacts – national and local

Thank you so much for your support and input to the sessions and for the support and information for the social prescribers up here in North Devon

Community connector/builder and peer support facilitator

'Debra's role has been invaluable in offering our team the opportunity to carry out thematic analysis on our client feedback - Debra's approach has meant **we have felt empowered as a team to action the analysis ourselves** [...]. Debra has also been able to link us into various forums, resources and conferences that we would have otherwise most likely not known about, due to her overarching knowledge of initiatives in the area – **the links have been hugely beneficial for networking and the ongoing development of our project and coaches**. We are hugely grateful for her time and input.'

SP Team lead

"I have close contact with the NHS England Personalised Care Team, Department of Health and at ministerial level. I am thus able to advise on issues and challenges at the front-line. **I relayed messages following your report on the issue of link workers not having sufficient resources** – particularly telephones/laptops and often access to the surgery computer system and was able to advise on other challenges facing link workers and the financial pressures on the VCSE sector, where it was taking on the management of link workers. **I think it is true to say that the extra £3,000 per link worker was partly a result of these discussions**"

Dr Michael Dixon, Chair Devon ICS SP Executive Group, Chair College of Medicine, Co-Chair National Social Prescribing Network

'your expertise has been pivotal in driving Social prescribing forward but also service improvement.'

SP Link Worker

This slide shows some of the feedback from people the research team engaged with whilst embedded within the health and social care system.

PART 3. SUMMARY AND CONCLUSIONS

Summary slide - 1

- SP aims to improve health, wellbeing and employment; supporting people who are lonely, isolated, with MH issues or LTC to access non-medical community services.
- SP is a pathway (access, engagement and activities), including both workforce and community assets set in a wider context of community infrastructure and strategic partnerships.
- SP programmes across Devon exist along the continua of assets (workforce), access, engagement and activities and are mostly hosted by either VSCE or PCNs.
- Covid impacted on all these features (types of referral and needs; shift to video or telephone engagement and the creation of online activities). Different SP programmes responded in different ways.
- In the crisis response phase, VCSE-hosted programmes responded more quickly to workforce needs, with more rapid adaption to pandemic working.
- Barriers to delivery during the pandemic included a lack of: equipment, peer support, management and supervision and integration with primary care IT systems. These were most acute in directly-contracted PCN programmes.

The following three slides represent a summary of our findings from the overall DESSPER evaluation project , including the shifting context of Covid impacts.

Summary slide - 2

- Two models of SP were identified across Devon - Boundaried and Open – which responded differently to the crisis, although many programmes displayed features of both models
- Boundaried models are more typical in non-directly-contracted PCN services.
- Boundaried models prioritised those cases 'ready for change' and delivered one-off wellbeing calls. Caseloads reduced overall.
- Open models shifted to more complex cases, more signposting, and engaged in welfare checks and vaccination rollout.
- Whilst we did not conduct comparative work, it is possible the Boundaried model excluded those with higher levels of health and social needs, but may be more protective of staff wellbeing.
- Regardless of model, staff training, support and supervision need to be prioritised.

Summary slide -3

- Covid demonstrates the agility and creativity of the VCSE and has resulted in closer and more equitable partnership working with statutory services.
- Communities with greater levels of infrastructure responded more quickly to the crisis, mobilising local resources in a more coherent and coordinated way whilst being more able to link with strategic partners
- This agility comes at cost to the VCSE. There have been changes in priorities, blurring of previous roles, and greater financial vulnerability as a result of over-commitment through goodwill.

Conclusions

- The different models of SP have developed over time organically and in response to local contexts – one of which is the pandemic
- Covid has highlighted tensions in the SP system between contracting organisations and the models of SP that they foster. It has also highlighted the importance of a vibrant VCSE that is agile and sustainable and can support the SP pathway. The presence of existing community assets was key to the Covid response.
- It is time to consider how the future of SP implementation is best delivered in Devon by comparing the merits of different models (Boundaried/Open), type of contracting (PCN, VCSE, other), teams and support mechanisms (including funding) and how community building and infrastructure can be developed equitably across Devon to facilitate SP work and the Covid recovery

A final word...

“Now is the time. The pandemic has required the VCSE sector, along with its partners, to enact, in new ways, and often very rapidly, **long-sought changes and insights**. It has also thrown into relief problems [...] the crisis has unblocked what had seemed like insuperable obstacles, improving communication, speeding things up, removing silos. In others, as one commentator put it *‘the cracks happened where we’ve always had cracks’*. We feel that there is so much to learn, and much to preserve, from our experience of the last few months. **We cannot afford to let this opportunity pass us by.**” “

Roads to Renewal, Towards Genuine Partnership,
February 2021 (VCSE sector representatives, Devon)



Thanks to Devon STP who commissioned this evaluation and to those link workers, members of staff, managers, commissioners across the Devon health and social care system (VSCE, NHS and LA) for engaging with us and giving their time so generously

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