

Social Prescribing across Devon STP

Mapping and evaluating the implementation of social prescribing

- Interim report - August 2020

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EXECUTIVE SUMMARY

Introduction

- ❖ Social prescribing is a pathway that connects individuals (often those who are lonely, anxious or depressed or are struggling to manage their long-term conditions) to voluntary sector activities, support groups and community resources (advice on employment, housing and debt) as a means to promote health, well-being and independence. Connection is often mediated by referral to a non-clinical link worker who may engage with the person in a holistic, person-centred way or with a 'light touch', sign-posting them to community resources. The level of support provided by the link worker and the activities and support offered can differ between service models.
- ❖ Social prescribing programmes have been established in Devon for at least five years (although arguably for a lot longer than that), and have been supported by a variety of funding sources, including the National Lottery and improved Better Care Fund (iBCF) funding. More recently it has become one of the six strands of the NHS England's Personalised Care agenda, with funding and an ambition to employ Band 5 social prescribing 'link workers' in every GP practice by 2023/24 (NHSE, 2019).
- ❖ Research on social prescribing suggests it also has potential to reduce health and social care activity (as well as health and well-being), but the evidence base is limited due to a number of methodological and practice challenges when evaluating programmes (Husk et al, 2019).

This report

- ❖ In September 2019, Devon Sustainability and Transformation Partnership (STP) commissioned the University of Plymouth to support an 18-month evaluation of Social Prescribing programmes (SP) across its footprint to understand the impact of SP on the local health and care system and the potential for SP. This report presents the interim findings on the project until March 2020, and reflects the situation prior to the pre-COVID-19 lockdown. However, please note that the preliminary work by the Evaluation Team on SP during lockdown suggests that the COVID-19 crisis has exposed or amplified many of the issues raised in this report. We will be reporting on these and how the SP system responded to the crisis in our next report.
- ❖ The aim of Phase 1 of the evaluation was to map and understand social prescribing programmes across Devon, and to identify implementation issues, what is working well and what could be deployed at large scale, and to work with providers to improve the quality and evaluation of their programmes.
- ❖ In doing so, the Evaluation Team sought to address two research questions relating to: (i) what makes SP successful, and; (ii) how can the STP support the development of a high quality and equitable SP services across Devon.

Methods

- ❖ The evaluation used university-employed Researchers in Residence (RIR), based in Devon CCG (and elsewhere across the system), to work with frontline 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.

- ❖ 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 this report.

Findings

Overview across Devon (mapping)

- ❖ 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 (PCN). 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.
- ❖ All 31 PCNs have now appointed a social prescribing link worker with a small majority (18/31) being managed by the voluntary sector, 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.
- ❖ Localities are at different stages of maturity in terms of their social prescribing, with differing approaches to service delivery, their managerial infrastructure and links to wider partnership structures. The most established programmes are in Torbay and South Devon, Exeter and Plymouth. Programmes have been heavily shaped by local context: the strength and depth of the sector, historical relationships with health and social care, and their success in obtaining funding. This comes from a variety of funding sources, often short-term, including the national lottery, NHS FTs, STP funding and iBetter Care Funds (iBCF). East Devon is unique in that all PCNs have subcontracted their SP service from a hospital community trust (RDENHSFT). It is also different to other sub-localities in that while there are a spread of voluntary sector organisations developing social capital in the community, there is no single infrastructure body coordinating VCS activity. Two PCN programmes put themselves forward to work with South West ASHN's [Institute for Social Prescribing](#) developing local case studies (Ilfracombe and South Hams).
- ❖ Comparison between these programmes (and with other programmes outside Devon) has identified good practice and insights in relation to programme

implementation and delivery, and have allowed us to identify gaps in infrastructure, provision and evaluation.

Heterogeneity – when similarities are different

- ❖ Even the more mature programmes 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 sign-post people to activities whereas in North Devon they 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.
- ❖ 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 (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 (sign-posting). 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.

Cohorts served

- ❖ The target cohort for SP is related to programme diversity. We struggled to map and categorise programmes according to NHS England's Care Pyramid. This was because

programmes varied in cohort definition and level of need (which in turn may be influenced by understanding of SP or requirements of the funder e.g. >50 years, having more than one long-term condition, lonely and anxious/depressed, high use of statutory services) and a related issue, the source of referrals i.e. some programmes only take referrals from GPs (partly due to contracting arrangement with PCNs, but not exclusively), while others will take referrals from community services, the voluntary sector or self-referrals. In some programmes, lack of clarity about the target cohort has resulted in a high number of referrals, or referrals of people with very complex health issues which the SP are not trained or skilled to deal with, leaving many feeling overwhelmed (as an example, from April to September 2020, 40% of SP referrals to one Link Worker in South Devon were for mental health needs). A LW in Northern locality estimated that 80% of her current referrals are highly complex. She works with cases ranging from severe psychosis, substance abuse and homelessness to end of life elderly people.

- ❖ Projects funding in the first year was based on the principle of test and learn. This flexible approach resulted in funding of projects supporting population groups in each tier of the Care Pyramid. Our findings show that a strengths-based conversation with an individual at whatever level of the pyramid can reveal a wide range of social, psychological, financial and medical needs, often not apparent to the referrer, but important to address in order for them to make progress.

Triage

- ❖ In response, some programmes have developed a triage process to manage referrals and the level of engagement required. This may occur at a project or VSCE provider programme level on receipt of referrals (as in Exeter) or, as in North Devon, is being developed at a system level to guide referrals to different types of services (although not yet fully trialled).
- ❖ Where there is not an effective triage system in place to manage the high volume of referrals, this has the potential for (negative) consequences i.e. social prescribers are far less able to spend time engaging with users, resulting in a more 'light touch' service - arguably a less impactful approach - or worse, social prescriber 'burn out' as they try to manage their increasing heavy caseloads (without clear expectations as to what these might be). Evidence on caseload is limited, but a review of navigator roles (including social prescribers) by [Bertotti et al. \(2019\)](#) noted that caseloads of '50-80 for patients with complex needs would be a heavy burden'. In Devon, anecdotal reports state that LWs are carrying regular caseloads ranging from 35 to 100 and more, as well as receiving new referrals. This has increased in practices where LWs are being asked to do welfare checks with the shielded under Covid-19. Where there is a lack of social prescriber peer and/or managerial support, this has compounded the issue and led to Link Workers from 3 PCNs (that we know of) where LWs are contracted directly by the PCN, resigning due to burn out and others expressing ambivalence about whether they will continue in their roles. This situation is more prevalent where PCNs have directly employed SP link workers without any connection to a wider programme for SP representing 9% of all PCN LWs and 33% of directly contracted PCN LWs)

Triage, capacity and 'burn out'

- ❖ Access to support structures for social prescribers also varies across localities and programmes. Social prescribers report they are frequently dealing with very complex cases, often people with significant mental health issues in addition to an underlying health or determinant of health need (poor housing, debt, domestic violence etc). In response to local need, this has led to the development of Specialist Social Prescribers, who are trained and have expertise in, for example, domestic violence, dementia, mental health, youth and children or end of life care. These specialists provide advice and support to other SPs. In a number of localities, especially those with established programmes, social prescribers have regular network meetings, supported by a lead practitioner which provide peer support and an opportunity to share practice, discuss difficult cases and learn. In some localities these are now open to sub-contracted PCN SP link workers as well as VSCE social prescribers. CBs are also invited to meetings in North and South Devon networks. Some PCN contracted SP link workers do not have access to peer support. It is important to recognise that PCN funding has been perceived by voluntary sector organisations to be inadequate to provide peer and managerial support for social prescribers. This has been a barrier to some VSCE providers taking on PCN link workers. Other providers are delivering this function, but as a loss-leader, which is not sustainable.

Evaluation of SP and impact

- ❖ VSCE programmes in localities have taken different approaches and use different (IT) systems for collecting process and user outcome data. Some programmes/projects have developed in-house expertise (Exeter) and a desire to evaluate, while others believe it is related to funder KPI requirements rather than of benefit to them (as a means to assess and improve service quality or outcomes). We could not find any examples of outcomes data being used for quality improvement purposes.
- ❖ The data that we are aware of varies in type, quality and completeness. Where a place-based, community capacity model is implemented (by VCS and statutory partnerships) measures are often not adequate. We have limited information about how PCN social prescribing link workers are collecting process and outcomes data, but peer support networks report dissatisfaction with measures suggested by PCNs (such as PAM) and confusion about the type, purpose, system-recording and analysis of any outcomes data collected to the extent that some PCN SP link workers are collecting only referral and process data, but no outcome measures
- ❖ This makes even estimating the total number of people accessing social prescribing across the Devon system last year or completing their 'referral' challenging. In the established VSCE programmes, such as Torbay and South Devon the programme had approximately 1,650 social prescribing referrals a year, with about 700 receiving a longer conversation (2018). Well-being Exeter had a similar number of longer conversations (~670), although slightly less referrals (~930 in 2019) it was similar to Plymouth's programme (~1,100). In Torbay and South Devon 65%-73% of referrals were women. We could not identify data relating to the use of social prescribing services by vulnerable or protected populations.

Individual outcomes

- ❖ In relation to capturing the impact of social prescribing we found a similar picture. A variety of outcomes measures were being used (WEMWBS, ONS4, PAM, Outcomes star, Five Ways to Wellbeing, MYCAW, Rockwood Frailty Score or bespoke composite measures etc) at the point of being accepted and at the end of engaging with the social prescriber. In some programmes this was at 12 weeks, although follow-up rates were often low, potentially biasing the findings. We could not identify programmes that followed up users beyond this. The length, language, relevance and format/design of the outcome measures used could also influence their acceptability and use by social prescribers, to the point that they were not used for fear of hindering the quality of engagement with users (Torbay).
- ❖ Nevertheless, where data are available they show positive impact on peoples' wellbeing and levels of activation, on average showing statically significant improvements ranging between 20% with WEMWBS with and 23% with PAM.

Service activity outcomes

- ❖ We could only find data on health and social care service activity use in relation to those receiving the 'holistic' service in Torbay and South Devon. Here, two members of the Evaluation Team have been working as RiRs with both SP programmes since 2017 to ensure that the mechanism, processes and consent measures were in place to do this, principally through working closely with service commissioners and providers. In South Devon, despite improvements in all user outcomes, average service activity use increased. By way of contrast, Torbay saw a 17% reduction. Explaining these very different outcomes is challenging but it might be related to the type of cohorts referred (generally younger, less ill or frail in Torbay) or data availability (just from GPs who provide the NHS number in Torbay) and subtle differences in the neighbourhood context i.e. Torbay has a network of community builders.
- ❖ Looking forward, there may be scope to link pseudonymised GP referral data with secondary and community services data using NHS numbers through the Devon Population Health Management Group, as part of the One Devon Dataset project with NHS England, and this should be explored further firstly with the Data Usage Management Group. However, our experience from South Devon suggests that to interpret any findings will need a granular and qualitative understanding of cases and local programmes.

Other important outcomes

- ❖ Programmes reported that routine outcome measures often do not capture the broad range of benefits of SP at either an individual or community level (often related to the social determinants of health), as would be expected of a programme that is in essence person-centred. Individual outcomes might relate to overcoming anxiety, addressing suicidal ideation or domestic violence, gaining employment or resolving housing issues, whereas community level outcomes might relate to users becoming a volunteer or running a support group, increasing community resources or capital. As these outcomes are not being systematically captured, the full benefit of SP programmes is not being recognised and is at risk of being undervalued. That said,

most programmes are capturing their impact to some degree by using case studies to illustrate the range and complexity of cases and the outcomes achieved.

- ❖ Although programmes are taking different approaches to developing their case studies (content and presentation etc), even where it is being well done, there is still a selective bias in the cases presented (i.e. generally all positive) that impedes learning from what is not working well in which cohorts and why. However, there is interest from SP programmes in developing a case study methodology to do this in a more systematic, consistent and robust way.
- ❖ In relation to the content of case studies, we have noticed a common theme or thread that often runs through them, relating to Maslow's hierarchy of needs; that is physiological and basic needs that form the base of the hierarchy (food, shelter, warmth, safety) are often a cause or a barrier to people addressing or resolving the higher level psychological and self-fulfilment needs, responsible for their presentation. Without addressing these needs it is often difficult to work with individuals at a deeper level to achieve a change in outcome. In general, this requires far more intense and prolonged engagement by link workers.

Lack of user voice and experience

- ❖ An area where there is a dearth of data relates to user voice. This has two dimensions: first, concerning the experience of people using the service, and; second, the impact of SP on them (what has changed for them). Qualitative data on user experience is being collected, but is patchy across localities and programmes and evaluation methods vary. We could not identify any systematic collection of the user voice on the impact of SP. Both types of user voice data are potentially a rich source for improving the quality of service, enhancing effectiveness and valuing service impact (or estimating a return on investment). The absence of user voice appears, in part to be due to it not being considered during project design or specified when commissioning programmes.
- ❖ There is also scope for user voice to be considered in service and research design and interpretation. This is similar to 'patient involvement' sometimes seen in surgeries as Patient Participation Groups (or PPGs). In this case involvement does not relate to data collection, but to including lived experience in areas of development of services.
- ❖ Given the heterogeneity of SP programmes across Devon, our findings suggest that one approach to SP is probably not suitable for every programme. However, a framework for evaluation could be developed by the STP to ensure some consistency and comparability in approach. In doing this, it would be important to recognise the practical issues with data collection and how measurement tools can impede engagement with users and the quality of the conversation (PAM is felt to be medicalised and irrelevant to many people) and to include outcomes in relation to social capital and/or community asset building and connecting ([Polley et al. 2020](#)).

Discussion and recommendations

Social prescribing has evolved organically across the Devon system over the past 4-5 years, and often in areas with the most developed, vibrant and well-structured VSCE. This has led to much innovation and a large variety in practice, delivery models and approaches to evaluation. This picture is further complicated by the expansion of PCN funded SP link workers (an objective of *The NHS Long Term Plan* with an ambition to put one link worker in each PCN by 2023, funded through PCN Directly Enhanced Service contracts), which in some areas have taken advantage of this infrastructure where present, and in others areas have not. While recognising that local context and place are important to ensuring services are working for local circumstance or populations, this makes it challenging to support and develop SP services sustainably and equitably across the Devon system.

That said, we believe that the investment by Devon STP and Devon CCG in Social Prescribing, including investment in projects, Voluntary Sector Strategic Lead, and Voluntary Sector Reference Group (and PCNs infrastructure) provides a real opportunity to develop a more cohesive, connected, equitable and impactful social prescribing system across greater Devon. Indeed, Post COVID our initial findings suggest these SP networks have become have strengthened and become more integrated in localities as well as across Devon. It would be apposite to build on these developments:

Therefore, we recommend these forums work on the following areas:

1. **Developing a common SP framework, based on systems thinking and social capital model.** We would recommend developing a common framework for a 'holistic' model of social prescribing, based on the community development model, that through the STP SP Executive Group, Voluntary Sector Reference Group, and other strategic forums e.g. Primary Care, Collaborative Boards and Local Care Partnership arrangements at place could be used to promote and communicate a cohesive vision of what social prescribing is in each locality. This could help link:
 - a. Strategic and national guidelines and infrastructure to
 - b. Middle range organisations/programmes and their implementation and delivery issues, to
 - c. Individual SP practitioner issues and user and understand system impact

This approach could also help ensure the experience and expectations of providers and service users across Devon is similar. The framework could also be used to help guide and shape future commissioning and investment in SP, and its infrastructure, but would not be prescriptive.

The framework we propose is set out in Figure 3. Targeting individuals and conditions is based on a medical model that may not be suitable for the wider aims of SP to enable people, informal caregivers and communities to manage their health and wellbeing within their local area. Social capital theories ([Tierney, 2020](#)) and community frameworks ([South, 2015](#); [Polley, 2020](#)) may be more suitable and are evidenced in the models in One Northern Devon, Wellbeing Exeter and Torbay where a system-wide partnership approach situates SP within its local community, rather than a health setting. VCSE organisations, in partnership with the statutory agencies are uniquely placed to support this model. A key element to this framework is that SP is seen as a pathway that involves social prescribing and community development

functions, and that it recognises the effectiveness of SP is very dependent on the strength and depth of the voluntary sector and local community assets, and the connectivity between and to them. Having a partnership structure that brings SP programmes and other key stakeholders together can also help grow SP more strategically by providing a forum for linking strategic priorities and local needs (using a common understanding of SP) and greater system integration. One Northern Devon, Torbay and South Devon and Exeter have started to develop mechanisms for doing this.

Such a framework could also help local areas **develop a common approach to supporting and training social prescribers** as well as **shaping approaches to addressing capacity issues**. As discussed above, these are primarily related to who is referred to SP and **how they are triaged**, the type of engagement provided and the **expected case load of link workers**. Where local capacity is stretched, a local area could decide to invest in or develop the sign-posting function beyond the link worker, allowing them more time for engaging with users holistically. Frome in Somerset, for example, has developed a community-based approach to sign-posting. Torbay on the other hand uses Community Builders who also seek to support local people to build their community assets in response to their own needs. A review by [Bertotti et al. 2019](#) identified nine types of 'people who provide support to patients and help them to access further services where necessary' or navigators (besides social prescribers) which could also be developed within the system.

The Care Pyramid model promoted by NHS England Personalised Care Programme suggests three possible cohorts: high, complex health need, targeted at long-term conditions, universal (whole population). However, we are not sure how helpful this model is. For example, we would see the universal offer as the foundation for all SP regardless of cohort. There is an inherent, unproven assumption in the model that the capacity to benefit from SP (whether individually or from a service activity perspective) is greater in the high need cohort than the universal cohort, possibly based on their high use of statutory services. But this might not be the case for an essentially social intervention, if an individual's need is impacting significantly on their ability to connect socially or to access local resources. Another way of thinking of these cohorts might relate to how they touch the system, and, if they identify as having a need for SP, they can access and use the service at a level which is appropriate to them according to the continuum co-developed in Devon (see diagram)

2. *Funding, investment and sustainability*

We have also identified that **short termism in funding is impeding strategic thinking and planning such that a system-wide approach** and, in particular, community development model of SP is difficult to implement. This is potentially undermining sustainability of SP, although we recognise it is hard for health and social care organisations to plan longer term and prioritise SP without understanding impact and potential for SP, and working within financially challenged environment where front-line services are competing for funding.

Short term funding has a number of detriment effects on SP and makes it more challenging to increase community assets which may, in turn, reduce the potential

impact of SP in the long term (i.e. if there are limited options to refer people to). It also makes it difficult to demonstrate impact at an individual level due to time required to set up data evaluation systems and to see a maintained change in behaviour or use of services, and therefore the value or return on investment funding brings.

Funding also needs to recognise that **robust management, peer support and training systems** are not only needed but need to be appropriately funded in order to retain a healthy workforce. We would therefore recommend a more strategic approach to funding that is not solely focused on projects and annual funding streams, but **more focused on building SP infrastructure**, based on the gaps identified using the proposed SP framework and in discussion with localities. We identified a number of areas to work on:

- **building personal capacity** through supervision (professional/clinical),
- setting out **management standards** (role/hours/case load/working conditions and terms of reference),
- **peer networking and support** (both informal peer contact and more formal team building with colleagues in primary care or VCSE)

Although the Index of Multiple Deprivation has been used as a proxy-criteria for targeting the funding of projects, this has not been applied to other funding streams relevant to SP. **Thus, there is scope to use health inequalities measures to not only guide investment but also programme design.** For example, Westbank have challenged the strategic push to maximise case numbers by terminating engagement with referrals at 12-weeks (if not before), as this time frame was not considered enough to make progress with individuals when addressing significant, complex needs.

Given the limited resources to invest in SP, **we recommend a co-commissioning approach** between health and social care and the VCSE to make best use of existing resources (inputs) and assets, especially where the voluntary sector infrastructure is more mature. Given the heterogeneity in and disparity across the voluntary sector in Devon, it makes sense to use the VCSE partnership infrastructure to foster a more cooperative, integrated approach and to reduce competition. **We recommend funding is targeted at communities with high needs and low social capital** (using IMD and other measures to do this), and that an investment is considered in the context of the SP whole pathway and targeted at where there are gaps in the SP framework. **We would recommend that projects linking into or building on existing VCSE infrastructure**, as a means of ensuring the system remains well-connected and supported.

3. *Equity and accessibility*

Currently, we do not have sufficient information on equity or accessibility of services, apart from recognising the under development of programmes in some localities. It is possible that certain groups or populations are not able to access or get referred to social prescribing when there is a need. Neither is it clear what proportion of referrals go on to use local assets or are excluded due to accessibility issues. As far as we are aware, this data is not collected systematically by programmes. However, Living Options is currently undertaking a survey of vulnerable groups, the house-

bound or people with protected characteristics across Devon (which the Evaluation Team have contributed to) that will begin to address some of these questions. **We recommend these findings should inform existing programmes and the commissioning of future services.**

4. *Sharing best practice and supporting learning across the system*

We found that many SP projects are not aware of the other SP initiatives and roles across Devon. This means there is a missed opportunity to learn from each other or share best practice. This is particularly important in localities that still have evolving or under-developed programmes. Supporting events or other mechanisms to do this would help catalyse and strength programmes. Some type of accessible digital resource that links projects has been suggested as helpful. Cornwall has some examples from which Devon could learn. **We would recommend the STP Delivery Group/CCG support a digital resource platform to share learning and best practice across Devon. Ideally, such a system would be intra-operable with existing clinical and community IT systems.**

5. *Evaluation of social prescribing programmes*

Evaluating SP prescribing is significant challenge for the many reasons identify above. A key question for commissioners to address is how to meet the requirement for evaluation that both addresses quality improvement for programmes as well as providing evidence of effectiveness and value to funders (including Devon CCG). This should drive the focus of any data collection and the methods used. To support this, we recommend that a Devon-wide evaluation framework is developed to sit alongside the overarching SP framework, and is developed in negotiation with programmes to provide some uniformity and comparability. This could set out some generic or basic process or outcomes measures (that also facilitate engagement) for use in all programmes. Additional outcomes could be added depending on the target cohort and purpose for the SP project being funded. Beyond this, and given the diversity of inputs and potential outcomes, we suggest that no one measure will adequately capture all the impact and value of SP (given the variety of impacts across a broad range of domains commonly seen in programmes), and that **the STP should move away from its narrow focus on reducing demand in the statutory sector, and see SP more broadly as an approach to reducing health inequalities.** One way to address this could be to use qualitative service user experience and impact questionnaires given to service users at the end of their engagement with a social prescriber. This would start to fill the absence or void of serve user voice in current data collection.

Such data collected could be used for service improvement as well as for assessing the impact on service users and for establishing the value of programmes beyond that on the health and social care system. If it were a methodologically uniform approach across Devon, responses could be amalgamated to inform a Social Return on Investment (SROI) evaluation – other social prescribing programmes around the UK have used this approach at programme level (e.g. Walsall, Bristol Wellspring). Responses could also provide a source of cases studies. There is already interest amongst some programmes to develop a case study methodology, and this could be explored and extended further. Therefore, **we recommend the formation of a user**

forum and engagement group to collaborate with stakeholders in designing co-produced evaluation method as outlined above.

Recognising that resources might be a limiting factor, it is likely that such an approach would also need to be proportionate to the resource available. It would also be important that the methodology used ensures that respondents are representative of service users and not just those with positive experience of SP. This will also help support learning, improvement and a true valuation of worth.

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1.0 INTRODUCTION

In September 2019, Devon STP commissioned the University of Plymouth to support an 18-month evaluation of Social Prescribing (SP) across its footprint.

The commission proposed to use Researchers in Residence (collocated in Devon CCG) to better understand what social prescribing projects were being delivered, where, to whom and how much impact was this having on service users and the health and social care system. 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.

In doing this, the Devon STP SP Evaluation and Research (DESSPER) team or hereafter Evaluation Team sought to address the two research questions below (see 1.1). In the first 6 months, four aims were identified to enable them to do this (see Section 1.2), providing a baseline by which to guide further work for the rest of the evaluation.

This report presents the interim findings of the project until March 2020. It presents the findings from the mapping and engagement work, identifies issues with implementation and evaluation, whilst seeking to provide initial answers to the research questions posed.

1.1 RESEARCH QUESTIONS

- What are the factors that make social prescribing successful at place, locality and system level across Devon?
- How can we develop a consistently high quality and equitable approach to social prescribing within the STP whilst supporting local delivery models and innovation?

1.2 AIMS

Year 1: September 2019 – March 2020 outputs / outcomes

1. Understand what is already in place;
2. Work within Devon system (STP footprint) to evaluate what is already have in place to:
 - Identify what is working well, and the factors that are contributing to their success
 - Identify what could be deployed at greater scale
 - Develop evaluation measures that evidence the benefits of social prescribing, relating them to system priorities where relevant;
3. Provide direct support to existing and emerging schemes in relation to evaluating their efforts; and
4. Describe the mechanisms by which system can be upskilled in relation to its capability to evaluate the benefits social prescribing in the longer-term. (Insert)

1.2.1 IMPACT OF COVID-19 CRISIS ON PROJECTS AND THE DESSPER EVALUATION

Lockdown for Covid-19 occurred in March 2020, just as many pilot projects' funding (i.e. iBCF and STP funding) was coming to a close and due to report on their outcomes to the STP. This impacted on the deadlines for reporting and therefore the availability of project summaries and outcomes data to the DESSPER team. Some interim reports were available for the funding period but this was not consistent across the STP footprint. Where these reports came in during write up (post March) we have included available data.

Although the original intention was to build on the project aims in 1.2, as set out in the tender, the COVID pandemic has resulted in a re-direction of research in order to capture how SP programmes have adapted and innovated their services in a response to lockdown, the lessons learned and to identify what innovation in response to COVID-19 needs to be supported going forward, learning from this experience to inform 2.3. The revised protocol to guide this work is shown in Appendix A, and will be reported on in the final report in May 2021.

1.3 GLOSSARY OF TERMS

Table 1: Glossary of terms and definitions SP in Devon

Access	The process by which an individual is referred into a Social prescribing scheme - involves referral by self or other person (including health and social care practitioners)
Activation	In a realist sense 'activation' is a response mechanism that is triggered by individuals, contexts, and referrers and in turn causes outcomes such as engagement (with a programme or approach) and attendance (to/with an activity or initiative). In health services it is used as an indicator of 'readiness' to participate in some interventions – i.e. having skills, knowledge and confidence to manage a long-term condition.
Active Signposting	Light touch approach to Social Prescribing where existing staff in local agencies signpost to services using local knowledge and directories
Activity (experience)	The resource/s to which a person is connected in the SP pathway
Assets	People and personal qualities: things like skills, knowledge, capacity, resources, experience or enthusiasm as well as activities or experiences that can be harnessed for health and wellbeing within a community setting. Examples include libraries, groups, social networks and also less tangible things like proximity to services, ability of community to offer certain resources.
Asset Based Community Development (ABCD)	Methodology for the sustainable development of communities based on their strengths and potentials. ABCD is a localised and bottom-up way of strengthening communities through recognising, identifying and harnessing existing 'assets' that individuals and communities have which can help to strengthen and improve things locally.
Common Outcomes Framework	Framework for consistent data gathering and reporting of outcomes. A common outcomes framework has been developed by NHSE using outcome measurement tools PAM (Patient activation measure), ONS wellbeing scale and Short Warwick Edinburgh Mental wellbeing scale (SWEMWBS)

Community Developer (CD)	Generic title for a community worker who researches, maps and builds assets and connections within a local area. Includes all the titles used currently in projects in Devon such as Community Builder/developer/connector
Connect	The interaction that happens between an individual and the SP /the conversation by which the individual defines their wishes/goals and the activities or experiences in the local area that will meet them. Includes the mechanisms by which a relationship is made, how a WMTY conversation or personal narrative happens and how a shared plan is developed.
Health Coaching	Personalised approach based on behaviour change. There are many health coaching roles within primary and acute settings. (outside of the NHS, health coaching roles connect people with their local communities and services)
Need	Health or social need: illness, mental health (MH) symptoms, loneliness, social isolation, debt, housing; SP seeks to address needs identified by referrers and self-identified by individuals
Pathway	An individual's experience of services as they 'progress' from a place of need, to primary care or other, to link worker, to activity;
Personalised Care	Giving 'patients' choice and control over the way their care is planned and delivered (this agenda is implemented through the Comprehensive Model for Personalised Care)
Project	An intervention or activity designed to deliver SP with an observable outcome aligned with the broad aims of SP (as defined here). Projects deliver the intervention via front line staff and are often time-limited in nature.
Programme	A programme is a group of related projects managed in a coordinated way to obtain benefits not available from managing the projects individually. A group of projects administered or managed by one organisation where SP is one of their interventions (e.g. Wellbeing Exeter)
Social Prescriber (SPs)	Generic title for a practitioner designated to have some type of interaction with an individual in order to connect them to solutions or activities to meet their expressed needs or goals. Includes all the titles used currently in projects in Devon (Link worker, Connector, Wellbeing Advisor etc)
Social Prescribing (SP)	A referral pathway that identifies a person in need of help and links them with help, which is provided by a social solution. Often this will be of a non-clinical nature, based in or provided by the community, augmenting the individual's personal and familial resources. However, linkages are also made into statutory services where this is deemed necessary.

What matters to me (you) (WMTY)	Initiative to encourage and support more meaningful conversations (in which the person defines the concerns of interest to them) between people providing health and social care and the people, families and carers who receive the health and social care. The person's health is seen within a wider social and relational context.
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2.0 METHODS

Embedded Researchers-in-Residence:

This evaluation extends and builds on [the work on integrated care of the lead applicant conducted in Torbay and South Devon](#). Embedded research is an innovative, nationally emerging way to improve services (<https://www.embeddedresearch.org/>), by:

- Researchers being co-located with frontline staff, managers and public representatives, to:
- Evaluate and feedback on service changes, making sure that local and wider knowledge informs these changes, and that they are centred around the people they serve.

At the core of this approach lies the principle of co-production, for example the main researcher (DW) was appointed in a joint recruitment process with VCSE service users and representatives. This also entails being responsive to be adaptable to changes in the system, for example aligning with changing governance and reporting structures (STP prevention and Integrated Care Model workstreams), or conducting a rapid, focused piece of work on COVID-19 responses (described below).

System engagement:

Over the period of involvement with the STP programme informally since March 2019, embedded researchers (JE, FG, DW) have attended and observed:

- 12 Social Prescribing Delivery Group Meetings,
- 3 Voluntary Sector Reference Group Meetings, and
- 26 dedicated evaluation project group meetings with partners.
- Embedded researchers also helped with co-facilitating a range of engagement events and training workshop, like the Social Prescribing Link Worker Conference on 29.01.20 at Exeter Racecourse,
- 2 regional link worker support groups and workshops co-facilitated with the NHS-E Social Prescribing Regional Learning Coordinators (Southwest),
- 8 VCSE peer-network meetings at Devon district levels, and
- 5 meetings of the Academic Health Sciences Network [Social Prescribing Institute](#).

Data collection

This report draws on broad variety of data collected primarily through our engagement with SP services across Devon as outlined above. It includes field notes captured at naturally occurring, or dedicated events and workshops above, documentary materials produced by the STP programme (like strategy documents, formal meeting notes etc), and such materials produced by partners delivering social prescribing programmes (e.g. annual reports, websites, business cases, contract performance reports etc).

2.1 FORMATIVE ANALYSIS

The formative evaluation (i.e. on process and implementation issues) of the above data was facilitated by qualitative data analysis software (NVIVO), formally and informally coded in

iterations between the key researchers focusing on key themes related to the research questions (DW, JE, FG). The mapping data analysis is described below.

2.2 MAPPING ANALYSIS

To help us understand what is already in place (aim 1) and map provision across the Devon system we collated and analyses data from a number of sources. Extensive field notes were made from all of these data sources:

1. Documentary analysis of reports, funding tenders, emails and other papers sent to the Devon STP (Devon CC, Devon CCG)
2. Attendance at regional and local meetings (strategic and delivery), front line team meetings, peer support meetings, conferences and other events
3. RiR conversations and emails with project managers and front-line staff
4. Regional/local/project meetings organised or hosted by RiRs
5. Learning and implementation events co-organised with projects and RiRs (e.g. those organised with One Northern Devon to examine implementation challenges for the projects in their area)
6. A rapid evaluation survey of front-line workers carried out during April 2020 (post lockdown), as some of the findings were relevant to mapping the pre-Covid situation.

Data were collated into a spread sheet and also onto a physical map (see figure x). Themes for data extraction were iteratively refined by the Social Prescribing Evaluation Project Group. This report is organised around these themes.

3.0 FINDINGS - DEFINING SOCIAL PRESCRIBING IN DEVON (AIM 1)

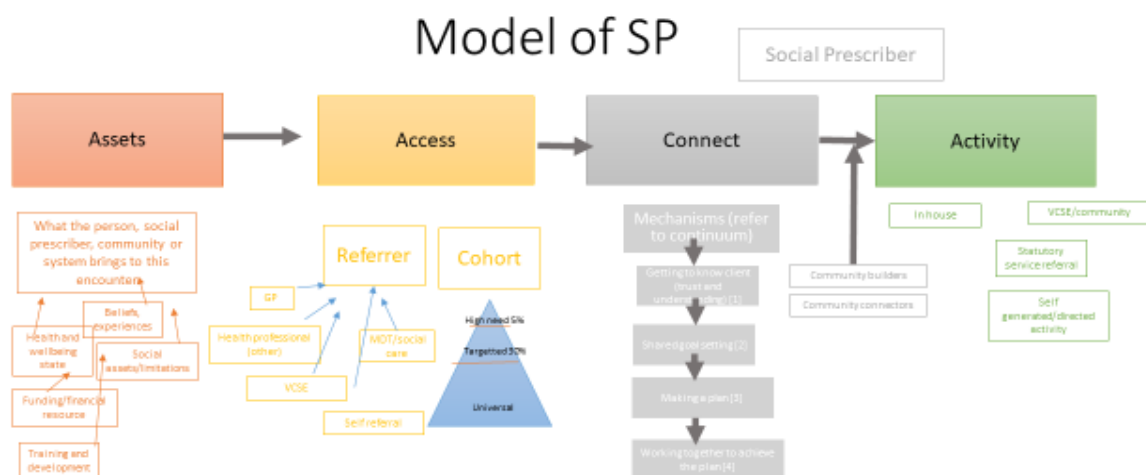
It is widely reported in the literature that there is no one definition of Social Prescribing. Broadly, it is understood as a conversation enabling individuals to identify needs and preferences and a pathway that may connect individuals to community-based support to promote health, well-being and independence. Many programmes seek to improve an individual's self-management of their long-term health condition, although this aim is not always explicitly stated. The pathway may include referral or signposting to community groups or voluntary sector activities, including support to access the service, and advice on employment, housing and debt¹. The connection is often facilitated by a link worker; the level of support provided by the link worker and the actual activities offered can differ between locations.

We understand SP to have three key elements ([Husk et al 2019](#); [Elston et al 2019](#))

1. **Access** and enrolment through GP practices, NHS services, voluntary sector or self-referral; different cohorts are offered access depending on a variety of factors relating to funding, contractual arrangements and skill sets of social prescribers
2. **Engage and Connect** through a link worker. Our evidence from across Devon shows that there is a continuum of activity that is called 'social prescribing' from 'light-touch' sign-posting to a more 'holistic', person-centred approach with well-being goals and support over several months. This is further explored through our continuum model explored below
3. **Activity**: Attending community-based or voluntary sector activities or experiences and/or accessing advice or practical support. Referral to statutory services is also a possible activity.

However, it is important to acknowledge that there is a key context that enables the mechanisms of social prescribing to work with an individual or a community of people: these are the **needs** and **assets** that the person, practitioner and community or system brings to the interaction.

Thus, using our engagement work and analysis of social prescribing programmes we have started to conceptualise a model of social prescribing in Figure 1 which allows us to describe the diversity of programmes across the Devon system.



Nationally policy has located SP within place-based strategies that draw on assets and resources of the local area and which conceptualise health and wellbeing as a community-centred activity, not merely an individual one. This resonates with the community development model of health, which also involves the strengthening of communities, volunteering and peer roles, collaborations and partnerships and access to community resources and looks to address health inequalities (South 2015). Here, social prescribing interactions are one of a number of activities located within this model and provide the bridge to community resources, but also to volunteering and partnership building.

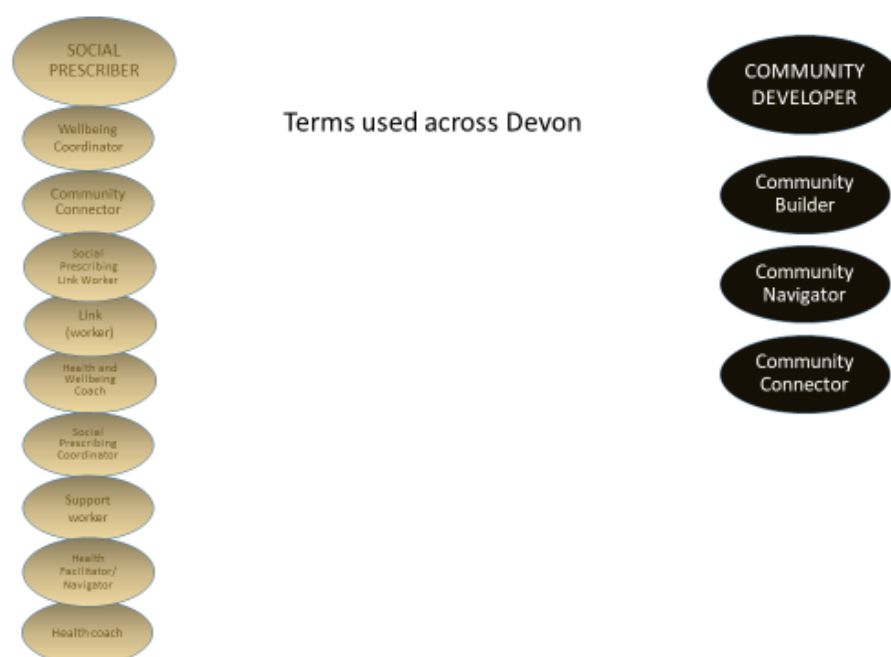
However, national funding streams to support the development of social prescribing across primary care in England have tended to focus on the connecting role in our model, through the employment of social prescribing link workers by primary care networks (PCNs).

Nevertheless, in Devon, commissioning of social prescribing is being developed to reflect this wider community development model, through its work with place-based initiatives (such as Wellbeing Exeter (WE) and One Northern Devon (OND)) and its investment in voluntary sector organisations that work within their communities.

3.1 WHAT IS A SOCIAL PRESCRIBER IN DEVON?

Across Devon there are at least 10 different role titles given to people who are working in social prescribing projects. (see Figure 2). Role titles are largely unhelpful as a way of defining role activities, as what it means to be a Community Connector (CC) in one project, does not necessarily describe what it means to be a CC in another project.

Figure 2. Different names ascribed to social prescribers and community developers across Devon



3.1.1 SOCIAL PRESCRIBERS

Social Prescribing Link Worker (SPLW) or 'link worker' as it is often shortened to is a frequently used term to describe someone working in an NHS primary care setting. However, this accounts for only one of the settings in which people working in social prescribing work, and one type of contractual arrangement for the post. Hence, this report will use the term 'social prescriber' (SP) to describe the general role and SPLW to describe only those working in the primary care setting (when needing to be more specific).

3.1.2 COMMUNITY DEVELOPERS

Those whose role includes stimulating the voluntary sector and developing community initiatives so that more opportunities can be offered to SP clients, are often referred to as 'Community Builders' (CBs) or Community Connectors (CCs). However, this role is also not mutually exclusive from other types of SP activity, since some CBs also link individuals to activities and some SPs also stimulate community activities by starting groups up or working alongside CBs to tailor experiences to meet individual needs. Hence, those whose role is primarily to develop and support community initiatives we have called community developers (CDs) in this report. The interrelationship between SPs and CDs and the overlap between their activities is part of the community centred approach to SP and is described by the continuum and dimensions model of SP and CD shown below.

What is clear across the roles is that SPs in Devon are:

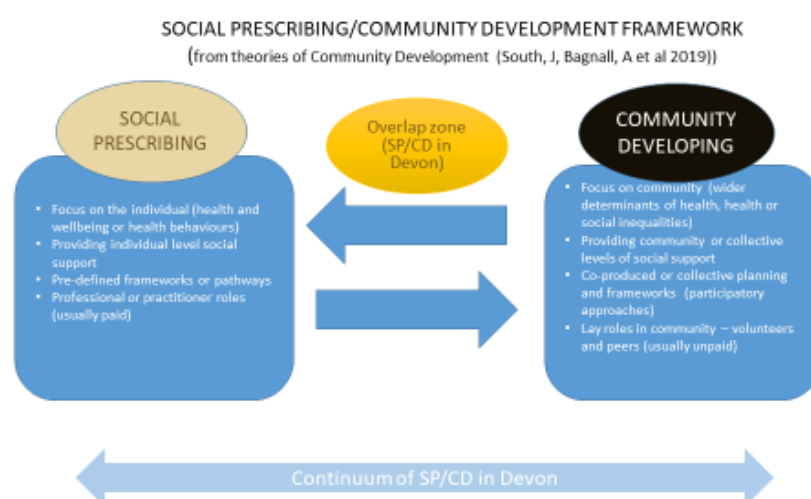
- ❖ Individuals with a widely varying background and skill set
- ❖ Developing creative ways to meet individual needs

- ❖ In some areas they are working alongside community builders and connectors and these roles are inherently linked as part of a community development model of SP

3.1.3 THE SOCIAL PRESCRIBING – COMMUNITY DEVELOPMENT CONTINUUM

The continuum and dimensions models of SP and CD (shown in Figure 3 below) emerged as a result of our analysis following a series of workshops and meetings with front line practitioners, managers and strategic level stakeholders led by the Evaluation Team during February and early March 2020. The literature on community development enabled us to situate this analysis within a CD framework, seeing SP as a set of activities that sit within this. Key to these models is the conceptualisation of a continuum in which practitioner activities move up and down a continuum, rather than being bounded by a discrete role title. It is not therefore surprising that many of the named SP or CD roles in Devon show overlap in a number of their functions and activities, as illustrated in more detail in Figure 4.

Figure 3. Social prescribing and its relationship to community development



Initially we tried to codify our analysis of social prescribing programmes using the framework developed by Kimberley (2015). This used five categories to describe programmes, from those offering 'light touch' engagement (referring people to community assets, typically voluntary transport, befriending, advocacy services) to those that offer a more 'holistic' service i.e. it offers a more instrumental, person-centred approach that engages the individual to identify their needs, set well-being goals, and provide practice and emotional support to address these over a period of time, typically three months (Kimberlee, 2015).

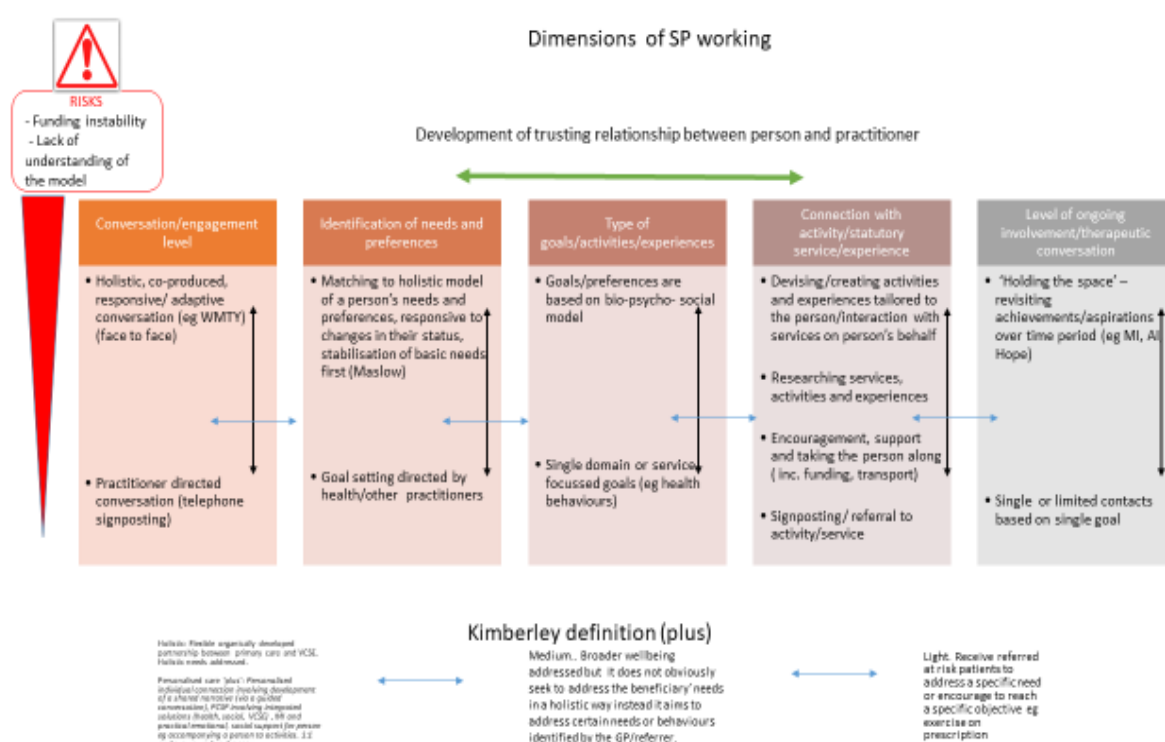
Our analysis of social prescribers and their approach to engaging and connecting people to local community assets and resources was not easy to categorise within this schema, as we found significant variation in the social prescriber role across Devon system within a number of dimensions.

Figure 5 shows the diversity of practice across five key dimensions of practice. It shows how these dimensions vary (vertically for each dimension) in relation to the individual level work engaged in by social prescribers in Devon. Where a social prescriber is located in this

model will vary according to their skills, service delivery model and the needs and preferences of referred individuals to which they are responding.

Projects emphasised that funding instability and incomplete understanding of the essence of SP present a risk to the holistic model of SP, shown at the top of the dimensions, by pushing activities down to the bottom of the rectangle, often in order to meet increased demand or reduced supply of, for example, SP hours. Thus, we found examples where high demand (due to broad or ill-defined referral criteria or lack of referral triage resulted in programmes shifting away from a more holistic model towards a service that provides dimensions at the bottom of each rectangle i.e. a service that increasingly uses telephone signposting to manage the workload.

Figure 5. Five dimensions of SP working across the Devon system



4.0 SOCIAL PRESCRIBING PROJECTS AND FUNDING IN DEVON

In order to start to address RQ2 on how to develop an equitable approach to SP it is important to understand not only what SP services or service are in place across the Devon system (Aim 1 of the project specification), but also how this relates to funding of programmes and the need for SP at an individual, community and locality level. Need can be considered as the capacity to benefit from a SP programmes, and proxy indicators of this need might relate to the target populations (typically people who are lonely, anxious or depressed or struggling to manage one or more long-term conditions) or the community (levels of deprivations, social capital or community connectedness).

Table 1 gives a broad indication of funding distribution and type across Devon by projects according to localities and workstreams. The workstreams relate to descriptions of target populations or cohorts of individuals who considered to receive different levels of

intervention within the comprehensive model of personalised care (see appendix). This segmentation is sometimes referred to as the 'care pyramid'. This pyramid is inserted into our model above as an element of 'access' to SP.

Table 2: How is social prescribing in Devon funded by locality and workstream

Description of type of funding	Number of schemes/projects funded	Localities or geographies represented	Target populations (see care pyramid)
iBCF funded SP projects (iBCF Fund A)	21	ALL	High, targeted,
Community Development underpinning SP Schemes (iBCF Fund B)	6	ALL	Universal/all
Strategic development projects (includes supporting schemes or some SP capacity (STP Fund C))	8	ALL	?
PCNs funding SPLWs	31	ALL	High/targetted
ICO funded	7	Southern	High
Co-commissioned across Devon CC, PCNs, STP, Exeter CC, RDE, Sport England	1	Eastern	
Royal Devon & Exeter NHS Foundation Trust, Devon County Council, Action East Devon and Leisure East Devon	1	Eastern (3 PCNS)	Targetted

iBCF monies (Funds A and B) were available in the Devon CC footprint for 12 months to March 2020. STP monies (Fund C) were available across the Devon STP footprint (so included the unitary authorities of Plymouth and Torbay as well as Devon CC).

The Northern and Eastern localities each received Fund A monies to support 6 projects at a total funding amount of over £200K. The Southern and Western localities received Fund A monies to support 3 and 2 projects respectively.

There were 4 pan-Devon projects funded at £172K in total. These were the Veterans Hub, based in Exeter, the Live Well at Home pilot run by Westbank in East Devon, Citizens Advice Devon and DEVA Social Prescribing Lite.

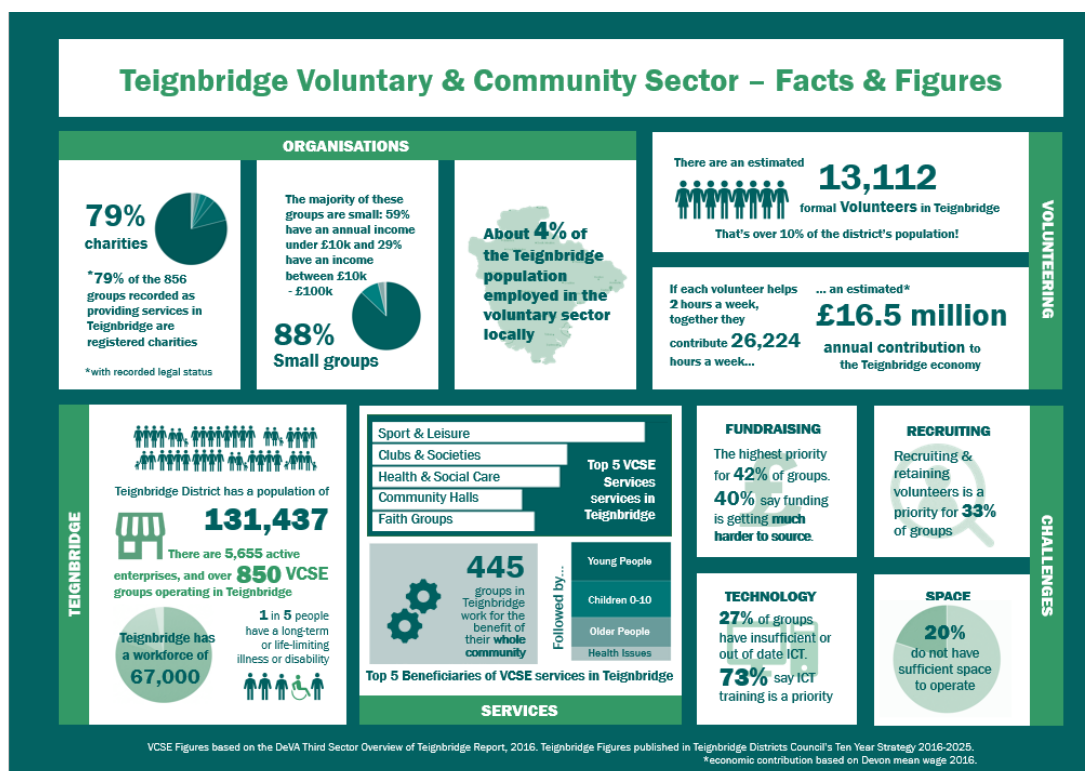
Fund B represents community development underpinning funding that creates the environment and resources that can be offered to the individual. The Northern and Eastern localities again attracted higher levels of funding in this stream with Northern locality monies going to the One North Devon programme and Eastern locality monies going to three programmes spread across the locality. In Fund C Southern and Western localities benefitted from the higher levels of funding, with Plymouth receiving the majority of Western locality funding (administered by the Clinical Director of the PCN?) and Torbay and South Devon ICO receiving the total Southern locality funding. These funding levels were linked to the IMD levels in Devon.

Table 2: iBCF/STP funding (£K) by CCG Locality- Devon

Locality	Northern	Southern	Western	Eastern	Pan Devon	Total (£,K)
Fund A	270	86.5	65.5	214	172	808
Fund B	80	64	29	86		259
Fund C (STP)	35	70	82.5	62.5		250

It is important to note that full on-costs for individual projects' work on social prescribing, with the exception of PCN contracted link workers, come from mixed sources depending on historical, geographical and other local factors. Funding was distributed reportedly on a fair shares basis using a formula based on population, deprivation etc. VCS projects are only partially funded by these streams. Statutory funding does not tend to cover the full budget for activities linked to SP, such as community development, management, supervision and training. Projects/programmes often rely on funds from other sources and in some cases subsidise the considerable infrastructure costs of social prescribing through substantial fund raising by their organisations. Besides the STP funds for example, there are other funds being used county-wide to support SP such as members discretionary funds, historic grant agreements with CCG etc.

Data has not been collected for this mapping exercise on the breakdown of the wider costs of SP to VCS organisations, although an example of this would be Teignbridge CVS. Annual reporting across this region (<https://www.teigncv.org.uk/about/numbers/>) shows that the CVS is aware of over 850 mainly small VCSE groups (59% with an annual income under £10k), estimating they mobilise over 13,000 volunteers, contributing an estimated average of £16.5 million annual contribution to the regional economy.



Many VSCE organisations provide the infrastructure and activities to support social prescriptions without receiving any direct funding from designated social prescribing budgets or being labelled as such. For example, Devon Communities Together (DCT) employs a co-designed, place based community development model working in rural communities to promote community resilience, capabilities and skills. As part of its commitment to health and wellbeing in rural communities, Village agents and Community Connectors encourage networking and support individuals, many of whom experience social isolation. Living Options is another Devon-wide user-led organisation which works with protected groups (Deaf people and those with disabilities) applying a personalised model of listening, advocacy and signposting as well as providing activities and support. While neither of these organisations have been designated formally as 'social prescribing', there are clear connections with the model.

4.1 GEOGRAPHIES OF SOCIAL PRESCRIBING

The rationale for geographies of programmes and projects are varied and overlapping according to historical factors and funding patterns. Geographies are partly a response to historic funding strategies and funders' geographies (particularly in the case of primary care network funding). This report is organised according the geographies of projects and programmes, aiming to organise around the four CCG localities where this makes sense to the project boundaries, however the LA districts are frequently referred to by programmes and managers and appear to have most significance in terms of VCSE since Local Authorities are often the main funders of programmes. CVS organisational boundaries also correspond to these boundaries at district levels.

The learning here relates to the challenge of engaging with a vibrant and diversely organised VCSE sector strategically across Devon, with multiple and overlaying layers of statutory and non-statutory boundaries, and meaningful use of and accessing of data sources for strategic commissioning (return on investments, health inequalities and gaps in assets, health and environmental indicators etc).

From recent observations of the STP Voluntary Sector Reference Group (14.07.20), and the South Devon Wellbeing Partnership (09.07.20) regional collaboration appears to have accelerated since COVID-19, with emerging local COVID recovery committees, and five local care partnerships (Plymouth, South, North, West, East) being used to engage with the VCSE.

PCN FUNDING AND GEOGRAPHIES

There were 11 PCNs in Eastern locality and *at the time of writing*, the 3 PCNs in East Devon LA had subcontracted to the RDE Health and Wellbeing programme (Health and Wellbeing Coaches employed by the Ways2Wellbeing project) and the 4 in Exeter to WE

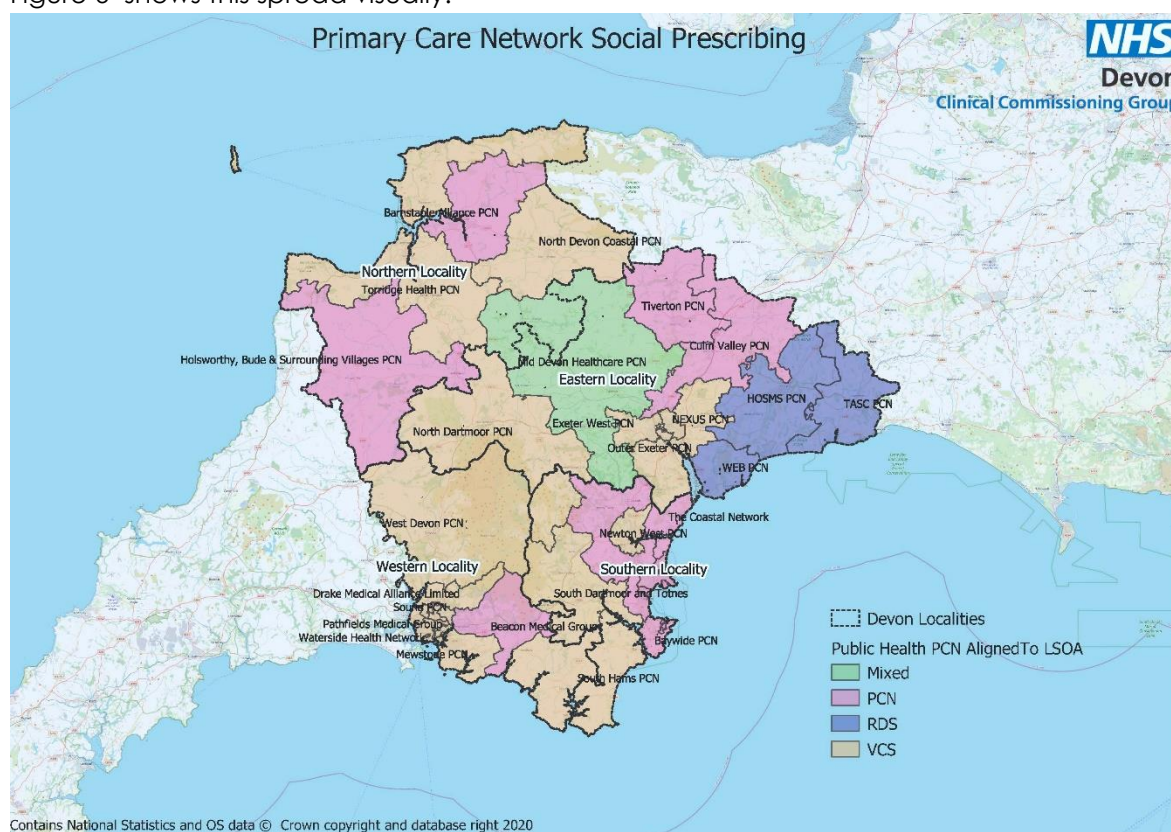
In Mid Devon LA 2 PCNs have directly employed Link workers and 1 PCN has both directly contracted LWs and subcontracted 2 VCS Wellbeing Advisors. North Dartmoor PCN, which straddles both West and East Devon subcontracts, from the VCSE. Culm Valley PCN was directly contracting its Link worker.

Table 3 PCN Social Prescribing Contractual Arrangements March 2020

Localities	PCNs employing SPs	PCNs sub-contracting from VCSE	PCNs sub-contracting from RDS	PCNs directly contracting
Eastern	11	6*	3	3*
Northern	4	2		2
Southern	7	2		5
Western	9	8		1
Total	31	18	3	11

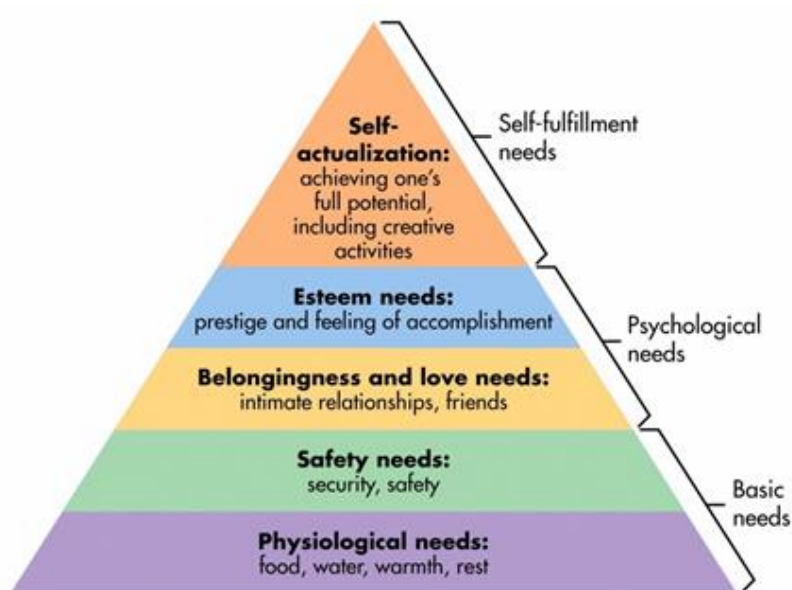
*1PCN has mixed contracting arrangements

Figure 6 shows this spread visually:



4.1.1 COHORTS SERVED BY PROJECTS

Defining which cohorts are given access to SP is not a simple or binary task; therefore, the offer of the programme in relation to the care pyramid is not always straightforward. The essence of SP is in its attention to the complexity of the individual and their holistic needs, rather than their categorisation into bio-medical or administrative cohorts. The experience of SP practitioners is that while a referral may indicate a certain need, through the conversation with a potential client, which may develop over time, it becomes clear that they have different priorities or additional needs to those perceived by the referrer, and that assets/needs in people and their environments may vary over time. This is particularly true in the example of mental health where a referral for low level mental health concerns (anxiety, depression, feelings of isolation) (targeted group), or indeed for another unrelated social concern, becomes an onward referral to specialist mental health services (high need group). Another example would be where a financial hardship issue may be identified as having impact on all areas of health and wellbeing. SPs in some projects make reference to Maslow's theory, hypothesising that unless primary physiological and social needs are attended to first, higher psychological and self-actualisation goals are less likely to be achieved



"Thinking about Maslow's hierarchy of need. We are doing essential work supporting clients with their needs but lower down the triangle than before. I have found this has changed my daily role massively BUT is still preventing those we/I support from needing the support of other primary care services such as their GP surgery for non-medical issues / matters. Clients are being supported to manage their needs without adding further demand to NHS/GP's" (Community Connector, Survey response, April 2020)

For the more strategic purposes of this report, we describe the target cohorts identified by projects themselves from their funding proposal or other reports, rather than from the qualitative data at the front line, which indicates a much less clear separation in these categories. However, this categorisation is not always clear and ultimately may not be helpful in ensuring equity of approach.

Each of the four localities are mapped in turn in the following sections

- Description of projects and funding (**Assets**)
- Cohorts served (according to the comprehensive model of personalised care) (**Access**)

- Types of SP and CD – organisation and description of roles and activities (Engage, **Connect** and **Activity**)
- Evaluation data collected (Activity data, outcomes, qualitative and case studies)

4.2 EASTERN LOCALITY

4.2.1 DESCRIPTION OF PROJECTS AND FUNDING

There are 14 mapped programmes or projects in Eastern Locality (which includes the city of Exeter, and the local authorities of East, Mid and part of West Devon). The SP programmes in the locality are predominantly managed by VCSE organisations ([Wellbeing Exeter](#), [Westbank](#), [West Devon CVS](#), [Involve Mid Devon](#), [Wellmoor](#)) with the exception of [Ways2Wellbeing](#) (East Devon) which is managed by the Royal Devon & Exeter NHS Foundation Trust (RDE), a Trust which manages both secondary and community healthcare. Six projects have received some iBCF Fund A monies.

Wellbeing Exeter is a programme funded by a partnership between six statutory bodies and organised around the geography of the 4PCNS in Exeter. The Ways2Wellbeing programme is jointly commissioned by a partnership of statutory and VCSE organisations and organised around health and social care clusters (which receive funding from PCNs but are not coterminous with them). Culm Valley Integrated Health Centre's social prescribing project was jointly funded from iBCF funding and PCN funding.

4.2.2 COHORTS SERVED BY PROJECTS

In the Eastern locality 13/14 individual projects were working with targeted populations. The Crediton project reported it worked with adults with long term conditions, the isolated, carers, those who were frequent users of primary care. The one exception was the North Dartmoor Domiciliary Care project which provided support to high need individuals in their own home. However, programmes such as Wellbeing Exeter, and one of its partner organisations (Westbank) provide a universal offer through their localised community development work.

The [Veterans Change](#) programme, while based in Exeter and mainly serving a local population, is an offer to veterans throughout Devon. The Citizens Advice Devon project (which is unique in project terms as it provides financial hardship advice training and support to SPs rather than front line social prescribing) is also based in Exeter.

4.2.3 WHAT TYPE OF SOCIAL PRESCRIBING OR COMMUNITY DEVELOPMENT WORK DO THE PROJECTS OFFER?

Eastern locality has a wide range of activities and projects that are funded or conceptualised as SP. This diversity could be explained by the varied geography of the locality from remote rural populations to the urban conurbation of Exeter, but is also associated with the development of its voluntary sector organisations and their relationship to statutory bodies.

While there are well established VCS organisations that have been operating in East Devon for some time (for example: Light Up Axminster/ Honiton Health Matters), the East Devon LA is characterised by a less coordinated landscape of VCS; there is no infrastructure body such as a Council for Voluntary Services (CVS). The STP are working

with the area to develop this type of structure. It could be that the decision to sub contract PCN SPS from the RDE Trust may have been influenced by this absence of a developed VCS sector. Ways2Wellbeing provide Health Coaching to targeted populations referred by GPS and other health care professionals (including IAPT services). (

This contrasts with the Exeter conurbation where a consortium of 4 VCS providers are coordinated by Wellbeing Exeter, who provide infrastructure and support to front line staff (Community connectors) working in the 4 PCNs of the city. Inherent to the WE approach is an integrated community development model provided through Community Builders. (See box for a more detailed exploration of WE's work). Cohorts worked with vary across the member organisations (and include work with both the under 18s and over 55s) but are both targeted and universal due to the community development activities of the wider programme.

Mid Devon/West Devon LA was home to a group of projects predominantly supported by the West Devon CVS and Involve, and employing Wellbeing Coordinators, some of whom were subcontracted by the PCNs. Mid Devon includes the pioneering work of the Culm Valley Integrated Health Centre (housing College Surgery) which, along with a partner surgery, has employed a Health Facilitator for over 10 years. These surgeries employed iBCF funding to, among other development activities, facilitate a community building role in recognition of the need to increase the offer for SP connecting experiences within their surgery populations.

The projects in Eastern locality received referrals from health and social care practitioners (HCPs) and stated that they employed a model of SP that begins with an in-depth guided conversation ('what matters to you' or WMTY). This conversation seeks to uncover the individual's expressed needs and preferences (which may include, but are not limited to, bio-medical concerns) in order to connect people to activities, experiences or services within their community according to these needs. The implication of this is that the individual's self-identified needs are prioritised over the referral reason (e.g. a benefits issue may be prioritised over a social isolation concern). Wellbeing Coordinators or Community Connectors managed by VCS organisations provided a range of support from practical hands-on support and activities, to signposting and also empathic, listening work dependent on personalised needs. An example of this would be the Crediton social isolation project. In Westbank, Exeter's case, triage of referral to a Connector based on their particular skills and expertise (e.g. in mental health or knowledge of local community groups) provided a highly individualised approach.

The Health Coaching model employed by Ways2Wellbeing, differed in its focus on factors of concern to referring health care practitioners (HCPs), such as social isolation, mental health or weight loss/fitness. While it also connects individuals to community activities, experiences or services it employs a targeted approach, based on the coaching model, and is careful to boundary its offer to individuals such that self-motivation to engage in activities is promoted. The model incorporates the setting of personalised, individual goals to tackle these referral issues, while striving to avoid dependence on the service by setting limits on the session length and time-span of involvement with service users. This is in contrast to some other projects in the locality which do not set limits on length of involvement and may maintain contact with individuals over many months, working through their needs in a process they describe with reference to Maslow's hierarchy. The Connector scheme at Westbank, for example, negotiates reduction of involvement on a

needs-basis balancing the potential for service dependence with the need to establish new patterns in peoples' lives (see WE box).

4.2.4 DATA COLLECTED BY PROJECTS – PROCESS DATA, IMPLEMENTATION DATA, CASE STUDIES AND OUTCOMES DATA

There were a mixture of available process and outcomes evaluation data across this locality. Process data (e.g. numbers referred, accepting and declining the offer, number of sessions attended, closure of cases) is more available than outcomes data, particularly from organisations such as WE which subscribe to Charity Log (CLOG) , an online case management system that allows for data extraction and reporting of process measures (<https://www.charitylog.co.uk/>) . This is the only online data management system used across programmes in Devon that we are aware of. Elemental (<https://elementalsoftware.co/platform/>) a digital platform with a broader function than Charity Log, is another system employed by SP projects nationally, including in Cornwall, to extract data, but has not been adopted by projects in Devon due to the cost of subscription.

The Evaluation team does not have access to all data collected (so there may be data we are unaware of). A range of measures were collected with a varying degree of response rates, follow up, time lapses and consistency in data collection and analysis techniques. Process data, while seemingly straightforward and easier to access, should be treated with some caution since there is inter and intra-project variability in describing a 'case' and a 'case termination'. COVID lockdown has delayed final reporting to the STP, so data may still come in for projects funded to March 2020. For these reasons it is not currently meaningful to aggregate data across projects, due to quality and accessibility and because of the range of different measures collected. It could be that there are advantages in introducing some consistency in collection of basic activity data across the STP to facilitate knowledge of basic metrics such as how many people have been referred to a SP project and how many individuals took up the offer and have received some form of SP.

For example: The shortened Warwick Edinburgh Mental Health and Wellbeing Score (SWEMWBS) was collected by Ways2Wellbeing and the Crediton SP project, and is incorporated into a self-designed questionnaire by WE. PAM is collected by Ways2Wellbeing, but seemingly not by other projects in this locality. The ONS4 was collected by Culm Valley. The Outcomes Star is collected by the Veterans project. The Five Ways to Wellbeing Tool, a goal setting tool which encourages individuals to identify their own goals and progress (and as such is a reflective tool rather than a standardised outcomes measure) is used by WE organisations and by Ways2Wellbeing, but not by other projects that we are aware of.

Some projects have sub contracted evaluation to independent evaluators which has produced some examples of robust analysis. Nevertheless, external evaluators are constrained by the quality and validity of the data collected by projects as well as by compliance factors and the reliability of measures chosen. An example of this would be the externally commissioned evaluation undertaken for Crediton Social Prescribing (in process of submission June 2020) which found improved outcomes in mental health and wellbeing (positive effect size in SWEMWBS scores) for 72 respondents, which were sustained for 3 months after intervention completion. However, a non-standardised outcome measure of loneliness and isolation was used by referrers leading to inconclusive

findings. Qualitative findings from interviews with a small sub sample of respondents (n = 8) showed increased perception of wellbeing and reduction of feelings of isolation.

Qualitative data are generally collected by projects in the form of case studies from client notes. Case study formats are decided on by projects and therefore vary in content. They tend not to include client experience data or direct quotes from participants. However, Ways2Wellbeing collect qualitative data in the form of anonymous client feedback forms (n=77). These data are currently being analysed by the programme lead who has expertise in qualitative research, supported by the Evaluation team. The team are working with the project to strengthen the qualitative feedback by developing online collection tools that will enable more useful analysis and are hopeful that this will be a useful dataset going forwards.

'Wellbeing Exeter is different from other social prescribing projects because of the placed-based whole system approach with a parallel focus on support for individuals (Social Prescribing through Community Connectors) alongside support for communities (ABCD through Community Building)' (Website)

Funding: Jointly funded by 6 organisations: Devon CC, PCNs, STP, Exeter CC, RDE, Sport England

Consortium of 4 voluntary sector provider organisations: Westbank, Age UK Exeter. Estuary League of Friends, Exeter YMCA

Model: Strategic connections between commissioners and the VCS.

How does SP work in this project?

- **Asset based community development approach organised around PCNs and CB clusters across Exeter city (n=4)**
- **Integrated, holistic approach with practical support**

It's not just signposting, people don't go to things, we need to get to bottom of trauma and why they don't go – change behaviours – spend time engaging with clients who have chaotic lives – can take 3-4 months and only then get to edge of light. We walk the journey with them until we know they are really engaged – until its sustainable change (Field notes. Interview with provider organisation managers. 23.01.20)

- **Qualities of staff and management approach**

It's all about the staff we recruit and the way they are managed. We look for certain qualities in staff. We want to enable them to work and keep giving that level of service – feel part of a supportive team with a supportive manager and organisation. It's an unspoken emotionally intelligent way of working. (Field notes. Interview with providers organisation managers. 23.01.20)

Case studies are collected by a number of the projects in this locality. These vary in their format and construction. Both Ways2Wellbeing and WE are currently developing their case study design and method, in discussion with the Evaluation team, and again we are hopeful that this will produce good data for the future. The most complete dataset available in this locality is from Wellbeing Exeter, which is a programme overseen by Devon Community Foundation (DCF). WE's dedicated evaluation team have established a comprehensive evaluation framework which was due to be launched across their projects before the COVID lockdown (see Appendix). This includes monitoring, process,

outcomes measurement, for both social prescription and community building, as well as more system level evaluation of their programme. Individual outcomes are collected through a self-developed questionnaire (incorporating elements of some standardised measures) that is administered at baseline and end of engagement as well as qualitative interviews and case studies. Data are reported through a monthly dashboard and quarterly report. WE is engaged in a project to build a One Devon Dataset with Devon CCG and Public health team to develop a dataset showing service use data collected at point of delivery in primary and secondary health and social care.

Activity and outcomes data:

Wellbeing Exeter Community Connectors report (Quarterly report Oct-Dec 2019)

- 233 referrals (Total of 2530 people referred since 2016)
- 80% engagement rate
- 161 successful connections made to 108 different groups/services
- Approx. 75% of needs were anxiety/emotional; 70% isolation, 37% physical activity; 35% managing health conditions
- Improvement on all 5 areas of 5 Ways to Wellbeing



Wellbeing Exeter
Breakdown Map 21.

4.3 NORTHERN LOCALITY

4.3.1 DESCRIPTION OF PROJECTS AND FUNDING

There were 6 iBCF funded SP projects under the management of the One Northern Devon integrated partnership in the period up to March 2020.

One Northern Devon is a partnership of public and voluntary sector partners working together to improve wellbeing in North Devon & Torridge. It aims to reduce health inequalities through co-ordination of the activity of all partners involved in the wider determinants of health and an approach that is person-centred and place-focussed. ([website](#) 2020)

These projects had a place-based, asset building approach in four towns (Ilfracombe, Barnstaple, Torrington, Braunton) a fifth town (South Molton) was developing its SP offer at the time of writing. The projects included both work with individuals (Community Connectors/Social Prescribers) and in community building (Community Developers) to increase the offer to individuals of activities and experiences. In some towns the CD worked closely with the Connector (e.g. Ilfracombe) such that their roles were complimentary and overlapping. The towns varied in their level of development of community assets and development of the SP model. The 4 projects funded were intended to be complimentary, but due to their different starting positions, the projects were not designed along the same lines, which made a direct comparison of impact difficult.

A pilot learning disability project and two Flow projects (High Flow and Flow) were also funded in Ilfracombe and Barnstaple. The Flow projects were an innovative model of SP not seen in other areas of Devon.

"One Barnstaple Flow is an alternative approach to traditional social prescribing whereby instead of individuals being referred to a social prescriber for non-medical support, practitioners have 'what matters' conversations with the individuals they are working with and are supported to offer non-medical options themselves by means of a Wellbeing Co-ordinator. The Wellbeing Co-ordinator interacts with practitioners rather than individuals in order to build system links with wider support so that the 'system flows around the individual' rather than the individual bouncing around the system." (Flow final report)

PCN funding and geographies

There are 4 PCNs in Northern locality. The Barnstaple Alliance and Holsworthy PCNS had directly contracted SPs, while the North Devon Coastal PCN (covering a widespread area from Ilfracombe and Braunton to South Molton) had subcontracted Community Connectors from One towns (Ilfracombe and South Molton) and a Link worker/Community Developer from Livewell Braunton. One PCN (Torrington) remained without a SP service after the link worker resigned in Jan 2020.

4.3.2 COHORTS SERVED BY PROJECTS

The OND partnership aims to support local communities and operates with a universal model in mind, with specific focus on areas of deprivation, through its Community Developers. The SP Community Connectors accept referrals from health care professionals, but also self-referrals. It is not known which group from the care pyramid the Community Connector service is focussed on across OND; it varied in its focus across the towns. For example, Livewell Braunton focussed on the targeted group (people living along aged over 80, over 65s discharged from hospital, people with identified long term conditions).

The Flow and High Flow pilots were specific in their focus and worked on a different application of the model of SP (see below). Flow was described as a 'universal access social prescribing approach' (iBCF funding bid), although in practice it appeared to work with targeted populations (who may have long term conditions, such as diabetes or chronic pain or mental health concerns and are known to practitioners in health, social care and other statutory and voluntary services). High Flow extended this approach to work with the high-need group by targeting the 'top 30 high intensity users of our collective public services'.

As in other areas, PCN SPs received health care professional referrals to work with targeted populations. PCN contracted Link workers reported a high number of referrals from GPs for complex mental health needs.

4.3.3 WHAT TYPE OF SOCIAL PRESCRIBING OR COMMUNITY DEVELOPMENT WORK DO THE PROJECTS OFFER?

Titles used: Community Connectors, Community Developers, Social Prescribers, Link workers

The model across Northern Devon varies according to factors of place and level of development of the 'one town' integrated model in each of the towns within OND. One Ilfracombe has the most mature model of social prescribing embedded within a community asset-building approach. The co-location of the Community Connector and Community Developer facilitated the development of a close working relationship over time and underpinned the model, which has been replicated to SP projects in the other towns, where both Connectors (also known as Social Prescribers where they are funded by PCNS but sub-contracted from the VCS) and Developers are co-hosted by a CVS organisation under the umbrella of OND.

A coordinator had recently been employed to provide training (for example in Motivational Interviewing, guided conversations) and support across OND to front line workers.

Where there are PCN contracted LWs, there have been attempts to draw them into local meetings and trainings.

A workshop involving social prescribers from across OND, co-facilitated by the Evaluation team in February 2020 found an important synergy in the work of Connectors and Developers. The overlap area is key to their work and marks a notable disparity in the SP model offered by PCN LWs and the Connectors sub-contracted from the VCS.

4.3.4 DATA COLLECTED BY PROJECTS – PROCESS DATA, IMPLEMENTATION DATA, CASE STUDIES AND OUTCOMES DATA

It was reported by the OND Communities group that each pilot had agreed different impact evaluation methods. These were being collated monthly through the OND Communities Group and sent to the funders, however only a small sample of these reports had been seen by the STP Evaluation team. The reports seen tended to be uncollated or analysed lists of organisations to which Connector links had been made or groups which had been

Models of Social Prescribing and Community Development – a synergistic process

'Both are about engagement whether individual or community, attending events and training and communication of each other's roles. Some of the skills are similar: listening, networking, gaining trust

Variability in activities of the person who does Social prescribing (from a phone call with signposting to a conversation over tea and cake and taking someone to an activity). That this variation can also exist within one SP's practice depending on need of the person or the evolution of a programme – eg where the workload/referrals have increased the Connector may be having to do more signposting and less holistic work (victim of own success). (Evaluation field notes Feb 2020)

Flow project outcomes – One Barnstaple

'At the evaluation workshop, practitioners piloting the Flow approach described the benefits of increased connection between agencies and increased ability to provide a holistic service due to newfound knowledge of community support. Having quick and easy access to funding helped them remove barriers, trigger further funding and gain the trust of the individual. Without Flow, a gap between practitioners and them accessing the wider system would be re-created. Whilst it is impossible to predict the future and assess what Flow has prevented within the wider 'system', it is obvious from the case studies that the approach has significantly reduced future demand on it.' Final report, Paul Jones, March 2020.

stimulated by the Developer or examples of case studies.

There was historical reporting (2016) of a system evaluation (Return on Investment study or ROI) of the community connector scheme in One Ilfracombe, externally evaluated. The AHSN has carried out a recent evaluation of the Ilfracombe Test

bed (forthcoming). As far as the Evaluation team is aware, metrics such as outcomes and experience measures were not collected by the iBCF funded projects.

Some process and implementation data has been collated by pilots but the Evaluation team has not seen many examples. The Evaluation team were involved in a series of co-facilitated implementation workshops that sought to aid in qualitative reporting for the Flow project and to explore overlaps and potential improvement areas for the various types of work described as SP in OND. See boxes for extracts of reports and fieldnotes.

Case studies have been written by a number of the pilots. The Flow project had developed a method of collecting client views via a series of three questions with Likert scales (see Appendix) that were included in case studies.

4.4 WESTERN LOCALITY

4.4.1 DESCRIPTION OF PROJECTS AND FUNDING

Western locality includes the LAs of West Devon (half in Western, half in Eastern) and South Hams (partly in Western, partly in Southern). It also includes the unitary authority of the city of Plymouth.

There are 4 projects/programmes mapped in Western locality, two of which are hosted by West Devon CVS and received iBCF funding (Fund A) as pilots: the Okehampton North Dartmoor PCB project, which straddles both Western and Eastern locality, and the Tavistock Abbeyrise project. The [Wolseley Trust](#) programme comprises a Community Economic Development Trust with a business arm (Community Managed Company Limited by Guarantee) which provides space and networking opportunities for a number of community organisations. Kingsbridge, [SHAW](#) (South Hams Area Wellbeing) is a Community Interest Company (CIC) that aims to enable and educate local individuals to be resilient in their own wellbeing. Both of these organisations have a community development focus that hosts SP programmes based in PCNs and work in partnership with local VCS organisations.

PCN GEOGRAPHIES

Plymouth city's PCN SP service (6 PCNs) is subcontracted to the Wolseley Trust who host a Healthy Futures Social Prescribing service. Infrastructure and community development costs for the service have been funded by Wolseley Trust's own business model, the DHSC funds, and partly PCN funding. The DHSC fund was co-funded on a sliding scale with Plymouth CC PH team (20% sliding to 80% over 3 years).

Of the other PCNs, in the Western locality, Two have subcontracted from the local CVS (West Devon and South Hams) and 1 has directly contracted its Link worker service (Beacon Group, Plympton and Ivybridge).

4.4.2 COHORTS SERVED BY PROJECTS

The VCS pilots work with the targeted group. The Tavistock project receives referrals from GPS and social care for any adult who is socially isolated, is a carer or has 2 or more long-term conditions and is a frequent attender. SPs based in GP surgeries are working with cohorts referred by primary care staff – principally GPs. WBCs were employed by 3 VCS organisations.

Wolseley Trust SPs receive almost all primary care professional referrals. Some self-referral was initiated but demand was so high this had to be limited. Cohorts were diverse, and reflected those thought most likely to benefit by referrers; mild to moderate MH difficulties as well as other social isolation or linked issues.

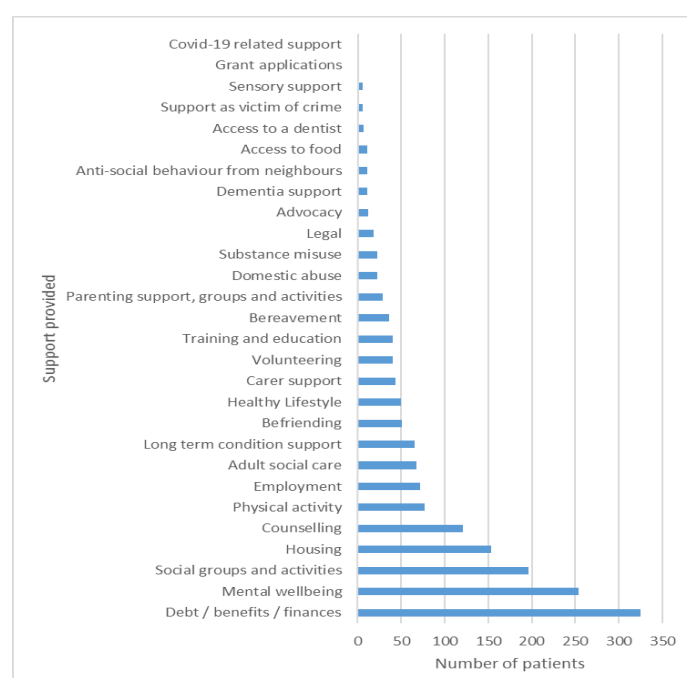
The SPs in the South Hams PCN are newly appointed and yet to receive many referrals.

4.4.3 WHAT TYPE OF SOCIAL PRESCRIBING OR COMMUNITY DEVELOPMENT WORK DO THE PROJECTS OFFER?

Titles used by Western locality projects: Link Workers, Wellbeing Coordinators, Community Builders

For West Devon CVS all roles have been mapped onto a PCN link worker job description, but also include elements of community building through the iBCF funded community development activity and participation/enabling fund. It is reported that they use a WMTY holistic approach, which combined with community development work creates an offer tailored to the needs and preferences of the individual.

In Plymouth, Wolseley Trust LWs engage clients with a variety of community services and activities, many of them provided by partner organisations in WT sites or as part of other WT funded roles (see figure below from annual report, 2020). While mental wellbeing is the second most frequent type of support provided, and it appears that referrers most commonly define MH as a need, it is interesting to note that the most frequent support *provided* is around debt and other financial hardship issues (around a third of all support provided). The third most frequent is housing. This illustrates the important relationship between health and wellbeing and social factors and the function that SP has in areas of deprivation.



4.4.4 DATA COLLECTED BY PROJECTS – PROCESS/ACTIVITY DATA, IMPLEMENTATION DATA, CASE STUDIES AND OUTCOMES DATA

The Wolsley Trust has collected activity data as well as outcome measures and case studies. During 2019-2020 1,203 people were referred to the service of whom 893 (81%) engaged (Healthy Futures report, 2019-20). Outcomes data showed an improvement in the SWEMBS for 69% of the 96 individuals completing the measure. The programme ceased using this measure during the year and switched to the ONS4 Wellbeing scale in line with NHS England guidelines. Of the 214 individuals reporting outcomes, there was an increase in the mean score for all questions (range between 3% reduction in anxiety and 17% increase in happiness). There was no comprehensive analysis of the results. In 2019 a volunteer counselling service received referrals for 221 people, mainly via link workers. 107 people had accessed counselling. Outcomes are not known.

West Devon CVS reports that it collects outcomes data using SWEMBS and the ONS loneliness and isolation measure. The Evaluation Team currently do not have evidence of activity and outcomes data collected or analysed, but an independent evaluation has been commissioned, which may provide this information (conversation with Sarah Taragon of Clarity CIC, June 2020)

The PCNs in this region have an ongoing pending review of performance of West Devon CVS sub-contracted WBCs due in March 2020. We do not have access to this data.

4.5 SOUTHERN LOCALITY

4.5.1 DESCRIPTIONS OF PROJECT AND FUNDING

Southern Locality comprises the unitary authority area of Torbay Council (Torquay, Paignton, Brixham) and parts of the South Devon area. Torbay and South Devon is a coastal and moorland area, comprising approximately 286,000 people, mainly resident in six market and coastal towns, served by 34 General Practitioner (primary care) practices. It has a high proportion of older people compared to England, comparably less community assets in contrast with market towns, and pockets of deprivation, particularly in urban areas of Torbay. Torbay and South Devon therefore vary in the types of programmes, as described in more detail below.

Torbay: The [Ageing Well Torbay](#) Programme is a six-year programme running between April 2015 and March 2021 (Wellbeing Coordination starting in July 2016). The Wellbeing Coordination programme is core-funded by a £6Mio grant from the Big Lottery, brokered through [Torbay Community Development Trust](#), and delivered through [Age UK Torbay](#) and [Brixham Does Care](#). Beyond the Wellbeing Coordinators, the programme also entails a "social prescribing system to tackle social isolation, that includes asset based community development, timebanking, peer support, digital and financial inclusion for people 50+" ([Bit.ly/TCDTsocPreReport](#)). The wider programme is unique in having WBCs working closely with 19 'community builders', nourishing a volunteer workforce of over 1400 'community connectors', and stimulating more than 250 new community activities and groups since 2014 (Torbay CDT, Annual report 2018/19).

South Devon: Southern Devon Wellbeing Partnership - [Wellbeing Coordinators Service](#) was commissioned by Torbay and South Devon NHS Foundation Trust (ICO) through an umbrella contract with [Teignbridge CVS](#), who from 2016-21 commissioned 5 VCSE partner

organisation across market towns in South Devon ([Volunteering in Health](#)-Teignmouth and Dawlish – 35% of income; [Kingscare](#) Newton Abbot – 37% of income; [Moorland Community Care Group](#) – three partner organisations covering Bovey Tracey – 85% of income, Ashburton and Buckfastleigh; [Dartmouth Caring](#) – 14% of income; [Totnes Caring](#) – 13% of income). Funding is based on a partnership bringing together Care Model investment from the ICO, Ageing Well, and iBCF moneys. Spin-off projects since 2019 include specialist Wellbeing Coordinators (Wellbeing Programme for those facing Dementia/Memory Loss/End of Life), Role out of the peer-group intervention Help Overcoming Problems Effectively- HOPE (now pan-Devon), and the 'Home from Hospital' pilot.

PCN contracting and geographies

Across Torbay and South Devon only one of five NHS Trust sub-localities overlaps directly with the PCN footprint (The Coastal Network). It appears that integration in Coastal locality results in more stratified pathways, where GPs want frequent attenders being streamlined through the PCN link workers (Regional away day together with WBCs, 21.01.20).

The Southern locality has the highest number of PCN directly-contracted SPs. Of the 7 PCNs, 5 were directly contracting SPLWs located in Torbay, Newton Abbott and Teignmouth. We are aware that negotiations between the voluntary sector and PCNs across Torbay were hampered by the lack of management funding from NHS-E (training, supervision, overheads etc). This issue has been fed up through the STP programme and since addressed with an additional £3k per link worker for infrastructure costs. Nonetheless, relationships appear to be the focus of dedicated effort across the patch, with assets and responses coordinated (see Torbay helpline example in box below). Furthermore, PCN link-workers are being invited to attend quarterly Away-Days, facilitated by Ageing Well and Teignbridge CVS, and a peer network is also forming across the region, for example where PCN boundaries overlap into South Hams or the Livewell footprint.

4.5.2 COHORTS SERVED BY PROJECTS

Both in Torbay and South Devon the target cohort is people with complex needs (≥ 2 long-term conditions), and an age cut-off for inclusion of over 50 years of age. Research conducted by embedded researchers-in-residence on the first two years of service, shows that Torbay is a younger cohort by 5 years on average with more 50-70 year olds.

In South Devon and most recently, the source of referrals comprise: Internal Charity/Self/Family (30%); H&WB Teams/MDTs-24% (social care, nursing, Co-ordinators), Torbay Hospital / Local Hospitals (22%), GPs (18%), Housing or Social Sectors (4%), Other (3%)

PCN employed SPs have a wider intake regarding age (18+ years of age), reported the referral of a high number of complex individuals (and do not advertise self-referral), many of whom experienced varied levels of mental health concerns. Torbay PCN link workers, who have been seeing clients since December 2019, reported significant social and mental health issues to be a challenge ("much more complex than expected", "I panicked the first time", Away Day, 21.01.20).

4.5.3 WHAT TYPE OF SOCIAL PRESCRIBING OR COMMUNITY DEVELOPMENT WORK DO THE PROJECTS OFFER?

Torbay and South Devon: Through its established, and matched-funded nature offering a range of services clients can benefit from light-touch to holistic input. All referrals receive an initial 30–40 min strengths-based, guided conversation, mostly in their homes (80%), to determine need and decide whether signposting, a short conversation or a more in-depth 'holistic' conversation is required.

The latter uses a range of tools over several meetings to enable the person referred to understand what matters to them and set goals for living well. This includes resilience-focused coaching and practical support and advocacy to navigate and access local health, social and economic services. Wellbeing Coordinators use goal-setting tools to produce a strengths-based, person-centred plan, supported by 12 weeks of coaching, if considered appropriate, to provide practical and emotional support and connect patients to their family, friends or communities, and improve their independence and well-being. Local GPs were actively encouraged to refer deteriorating older patient, and the programme is distinguishable by its close integration (in some case co-location) with community-based NHS services (GP practices or health & wellbeing hubs).

Figure: Key elements of Wellbeing Coordination:



This networked approach allows WBC clients to tap into a range of services, for example in South Devon: Transport 24%; Shorter Conversation 16%; Befriending / Social Support 15%; Bridging and Advocacy 15%; Carer Support 9%; Paid Services 7%; Memory Café / Dementia Support 7%; Other 8%.

It appears that the PCN-based link working is not yet fully formed in terms of the cohort or intensity of input offered, and also varies in terms of how much link workers can tap into existing community assets (also depending on whether PCN link workers are employed by the voluntary sector as opposed to the PCN). Practitioners report issues around fulfilling recruitment targets ("offer 6 visits, supposed to see 250 people a year – not possible" Away

day quote, 21.01.20), and the range of support options defaulting to sign-posting wherever possible ("signposting, motivational interviewing, onward referrals, goal solving, some health coaching, in exceptional circumstances go along with people, little bit of mental health", Away day, 21.01.20).

4.5.4 DATA COLLECTED BY PROJECTS – PROCESS DATA, IMPLEMENTATION DATA, CASE STUDIES AND OUTCOMES DATA

The Ageing Well Torbay programme is currently formally evaluated nationally through [ECORYS](#), and locally through [SERIO](#) at the University of Plymouth, with final reporting pending.

Highlight figures from (SERIO's Ageing Well Torbay, Interim Findings Year Four, Key Learning, Report, January 2019):

In four years of operation, WBCs have worked with 4,061 people

- 1,609 of those were isolated
- Self-reported visits to GP's have fallen by 38%
- 60% of people report improvements to mental well being
- Loneliness rates have dropped by 61%
- People's ability to use their expertise to benefit their community has risen from 32% to 61%

In parallel, the [Torbay Medical Research Fund](#) and the ICO, with support from the National Institute for Health Research (NIHR) Applied Research Collaboration (ARC) South West Peninsula (PenARC), have commissioned two embedded [Researchers-in-Residence](#) since April 2016 to evaluate both the Torbay and South Devon WBC programmes.

The ICO contract with South Devon required partners to collect a range of patient-reported outcome measures (Well-being Star™, Patient Activation Measure (PAM); Warwick-Edinburgh Mental Health and Well-being Scale (WEMWBS); Rockwood Clinical Frailty Scale (RCFS), and goal achievement), and statistically significant impact on these measures is reported in an [academic paper](#) published in 2019.

More recently, data analysis by embedded researchers-in-residence of service activity/cost 12mths before and after receiving WBS support showed contrasting findings between the Torbay (n=81 clients) and South Devon (n=154 clients) programmes. This data excludes primary care and mental health services activity data, but comprises: accident & emergency (A&E) and minor injury units (MIU), in-patient, outpatient, community, service (ie, occupational therapy, physiotherapists and nursing), and social service contacts and length of stay (in-patients only). Findings show a decrease in activity rates in Torbay for all service except outpatients (OP), but an across the board increase in South Devon.

Variations in the programme structure, like younger cohorts on average in Torbay and more integration with acutely ill clients in South Devon may partly explain this variation. For example, a [clinical audit](#) of sub-groups of clients in Coastal locality illustrate the degree of complex and costly frailty, and end-of-life support delivered by the multidisciplinary team (including WBCs). Implementation learning from Coastal locality was also summarised in an [academic paper](#) published in 2020, emphasising the importance of bottom-up, place-based, and tailored solutions that empower practitioner leadership, with readiness for change being expressed through processes and cultures that are risk-enabling, strengths-based, person-/outcome-focused.

Detailed analysis of the first cohorts of 81 patients receiving Wellbeing Coordination Support in Torbay, shows an average of -17% in service activity reduction from 12months before the intervention compared to the 12months after. This translates into a total cost reduction for these 81 people of -£37,109 (from £224,645 down to £187,536), meaning an average cost reduction per person of -£458 (from an average per person of £2,773 in the 12months before, down to £2,315 in the 12months after):

Covid response:

WBC, Torbay, Covid Survey April 2020:

"What I do think is nice is, how the people of Brixham, Paignton and Torquay have come together as a community to help people in their time of need and how important, more now, than ever, the voluntary sector really is !!"

Illustrating how more mature, networked and voluntary sector-led systems can be more nimble and responsive to demand is the example of a [COVID-19 helpline](#) developed across the Bay Area. The STP embedded researcher-in-residence team conducted a pan-Devon online survey in April 2020, that showed that both PCN and other link-workers had to change to remote working, but that voluntary sector-based practitioners were more able to continue providing more hands-on, and tailored support, and mobilising volunteers for essential face-to-face deliveries to self-isolating clients (e.g. food, medication), facilitate transport for essential

travel, and being creative around client needs ("We have also raided the Brixham Does Care charity shop as people have been asking for jigsaw puzzles, puzzle books, adult colouring books and reading books to help with their boredom and delivering them", WBC, COVID response survey April 2020). Based on existing wider links this allowed the Ageing Well Programme to provide crucial support, taking on higher risk clients:

Ageing Well Torbay Manager: "we became the more complex support for the line which plays to the teams strength in mental health, domestic abuse and suicide and bereavement support. And our established link in with social care and housing we have been able to help people in much more complex situations other than practical support."

5.0 CUMULATIVE FINDINGS ACROSS DEVON

5.1 What is working well and what are the factors contributing to success (aim 2)?

- Experimental, formative approaches are rapidly leading to refinement of the models of SP/CD and increasing our learning of how SP can work. Overall, the VCSE offer across Devon constitutes a rich, vibrant and crucial addition to statutory services.
- Passionate, resourceful individuals with wide-ranging experience are being recruited to roles across the region and are supporting each other to develop SP activities and skills.
- Dynamic VCS organisations are providing infrastructure to support local/regional strategies as well as working alongside front line SPS to develop community assets for individual clients and the community as a whole.

- Strong and supportive managers VCS managers are inspiring and holding the space for front line workers to explore the complexity and challenges of this newly developing role and enabling appropriate boundaries to be drawn.
- Champions in primary care – there are key examples of GPs who have spearheaded the approach in their area. However, these pockets of enthusiasm do not necessarily lead to a progressive approach across other practices within a PCN or across GPs in a practice. SP LWs report the wide variation in support for and understanding of SP even within a single practice, where types of referral may indicate a lack of awareness of what can be achieved by a single front-line worker.
- Place based programmes are developing that harness local knowledge/assets; relationships between VCSE orgs. These appear to be stronger where historic relationships are trusting and strong (and more important than competition for funding), knowledge of local communities is high, and programmes are broad in offer (and activities therefore more coordinated and responsive to changing needs and mobilising assets) (South Devon Wellbeing Partnership, 09.07.20).
- The Evaluation team have not engaged in observation of SP interactions with clients and there has been no user group with lived experience involved in project design or evaluation, so we cannot make definitive statements about experience or how closely work is aligned with the comprehensive model of personalised care and personalised approaches in general. However, some projects are collecting patient feedback which has been largely very positive. Many projects are working to the model of personalised care in responding to individual, self-identified needs and tailoring their approach and offer to service users.
- Where patient-reported outcome measures are collected (Examples of PROMS: Wolsley, Torbay, South Devon, East Devon?), these show meaningful or statistically significant improvements in terms of mental health, social isolation, quality of life, and activation (see section below on outcome measures).
- Some areas are starting to assess impacts on service activity, which tends to show more benefit when people are younger, and needs are more psycho-social than bio-medical. From numbers of volunteers mobilised through VCSE networks, there is considerable and hard-to-quantify social return on investments, while also highlighting gaps in health inequalities and unmet need.
- Mechanisms of impact: Time seems to be one of the most important resources and distinguishing factors of programmes, both with regards to implementation history (i.e. having time to build relationships, assets, and coordinate), as well as holistic assessment of client need, continuous interaction and tailored input.

5.2 PCN FUNDED SOCIAL PRESCRIBING – HOW IS IT WORKING?

5.2.1 DIFFERENCES BETWEEN THE EXPERIENCE OF PCN EMPLOYED AND VCSE SUB-CONTRACTED SPS LOCATED IN GP SURGERIES

Across Devon, the majority of PCNs have sub-contracted SP from VCS organisations or a community health trust in their local area (21:11); this includes the PCNs in our largest cities of Plymouth and Exeter. At the time of writing, these arrangements were still at a developmental stage. PCN SPs were still establishing relationships, roles and role boundaries with primary care colleagues. However, support structures, management and training were provided by established, mature mechanisms within VCS infrastructure. This experience was similar for SPs working for an NHS community trust in East Devon. VCS contracted PCN LWs benefitted from relationships within the communities in which they were seeking to make connections for their clients and were able to be agile in their responses to client needs. They were also enabled to develop community assets (where their role also included this function) because of existing networks. It is important to clarify that this infrastructure of support to front line workers was not necessarily funded by the contract with the PCN, but assumed as part of their role.

Given lesser maturity of implementation, the experience of directly-contracted SPLWS across Devon was one of isolation and the need to be pro-active in defining their role. This involved clarifying their function to colleagues in primary care, boundary setting around referrals and workload and creating their own networks into the community. It is fair to say that often neither their managers and primary care colleagues, nor the SPs themselves were sure of what their responsibilities were at this stage. SPLWS also reported the need to self-manage and define and develop their own training and supervision needs and peer-support mechanisms (while support from NHS-E regional learning coordinators was thinly spread across the Southwest [2 posts, currently based in Bristol area], and intermittent with those posts being short-term funded, and a lack of continuity with turnover from 2 enthusiastic learning coordinators resigning). The largest number of PCN-employed SPs were in Southern Locality for reasons discussed above. A highly active, informal peer support group has formed in this locality and, supported by the Evaluation Team has been instrumental in making connections between PCN contracted LWs across Devon. This group has also successfully collaborated to make necessary linkages with VCS organisations to map out activities and experiences for its client base. The peer support group includes a smaller number of Southern locality VCS contracted SPLWs and Community developers, again facilitating networking across organisational boundaries.

Some PCNs encouraged professionalization of the SP role by constructing it within a primary care model of interaction which limits contact time, location (in the surgery) frequency and duration of appointments. LWs in one PCN in Northern locality wore a uniform. SPs working in this environment reported it was difficult to work within a holistic model of SP, as set out in the comprehensive model of personalised care.

PCN employed SPLs sometimes struggled to be included in the primary care team as their value and potential contribution was not always recognised or understood. Physical issues were also in the process of development: a number of LWs did not have dedicated desk space, access to patient

record systems and software or even basic facilities of a work phone and laptop (there were SPLWS who continue to use personal mobile phones and laptops at the time of writing). A rapid evaluation survey carried out by the Evaluation team in the early days of the COVID lockdown revealed key deficiencies in basic provision of tools and support for their post.

- ❖ 20% of all front-line workers have no mobile phone or laptop provided
- ❖ 40% (at least) have no licensed video conferencing platforms provided (e.g. Zoom, Teams)
- ❖ 20% have no regular meetings with their teams/supervisor
- ❖ 90% have no access to NHS System 1/EMIS from home
- ❖ 80% of VCS managed SP workers have regular support/supervision meetings compared to 20% of PCN managed

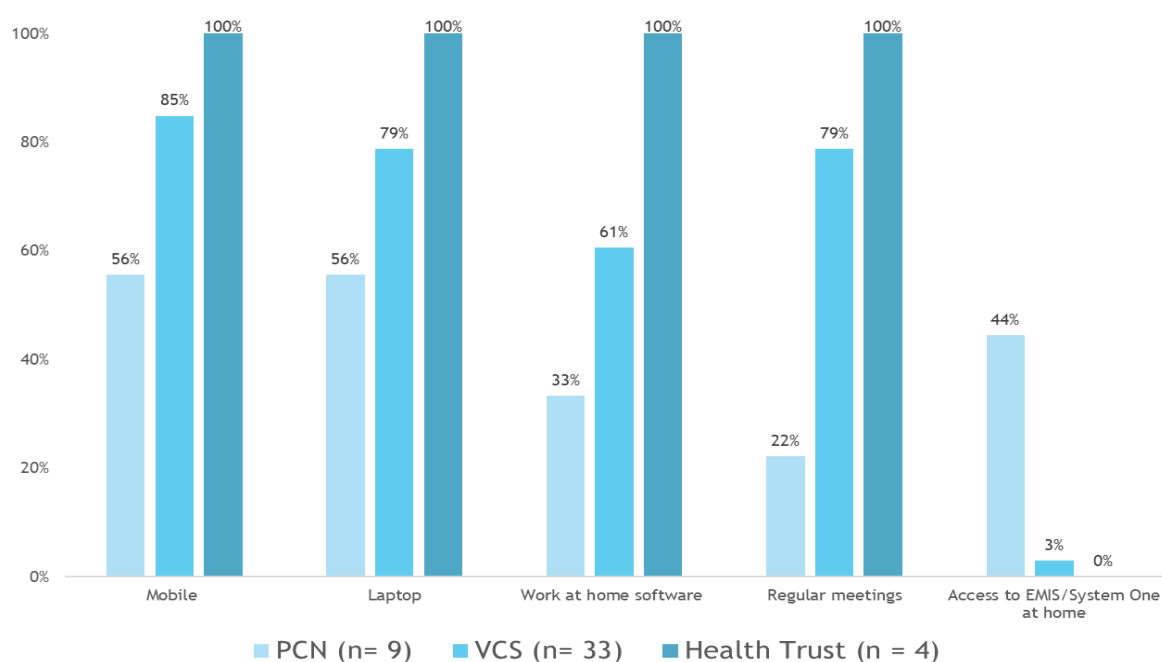


Figure 1: Percentage of SPLWs provided with work and home equipment and regular support meetings according to contracting organisation (Source: survey, April,2020)

Data showed a marked difference between contracting organisations in the equipment and support provided to SPLWs. The largest disparity in the data showed more than three times as many VCS employed SPLWs reported they had regular meetings with supervisors or managers as directly contracted SPLWs. 56% of PCN contracted workers had mobile phones and laptops provided by their organisation, while 85%/79% of VCS contracted front-line staff were issued with this essential equipment. While these tools were urgently needed due to the necessary conversion of activities to enable distance working, the

COVID crisis only served to highlight existing issues that had been reported by LWs prior to lockdown in March 2020. (link to report). These experiences contrasted sharply with the experience of VCS contracted PCN link workers in significant ways. For example, our COVID survey showed how existing programmes in Torbay were very nimble in responding with a comprehensive helpline, mobilising hands-on support to people self-isolating (<http://bit.ly/torbayhelpline>)

5.3 EVALUATION AND IMPLEMENTATION CHALLENGES

5.3.1 IMPLEMENTATION ISSUES

ROLE DEFINITION: WHAT IS SOCIAL PRESCRIBING IN DEVON?

As explored in the introduction, the diversity of roles, functions and titles in SP has led to

Public's expectations have to be managed, there is a lack of understanding of our role – “but how can the public or professionals understand our roles when we don't understand or make them clear ourselves?” (Field notes, workshop, OND, Feb 2020)

confusion about what can be expected of social prescribing.

The model of SP/CD moves along a continuum from a simple short signposting conversation in which the individual self directs to the experience or activity to a

long-term engagement in which the SP may engage in a WMTY conversation with them, set goals with them and write a plan and take the person to an activity. Length of engagement with the SP/CD also varies. Regional differences in the current assets of the VCS mean that CDs may be engaged in simple signposting of an individual to a helpline or established community development trust, to conducting community consultations and participatory evaluations in order to making funding applications and set up community groups and activities.

There are great contextual variations according to localities, JDs and employers. Making single definitions and job descriptions would be difficult with VCS managed organisations as by and large it is this responsive approach to client needs that is seen by many projects to be the essential nature of their work.

SPs contracted by primary care were more likely to work to role definitions and have role boundaries drawn, however PCN contracted SPs were still subject to varied expectations about their role and what was required of them by their contracting organisation and the referring primary care practitioners. There was significant variation, even within a practice, of GPs' and other health care staff's understanding about what SP could and could not address.

FRONT LINE STAFF SKILLS, TRAINING, SUPERVISION AND MANAGEMENT

Front line SPs were disparate in skill sets, experience, professional background and training across both the VCS and health sector. They were, however, united in their passion for the new way of working and opportunities for change presented by the role. Some SPS had worked for many years in the VCS and were familiar with a wellbeing approach, linking people to resources within their organisations or local partners. Some had received formal training in, for example, WMTY conversations, MI and goal planning, others relied on experience of similar interventions and tended to see SP as a practice they had been

'doing for years'. New recruits to PCNs whose background was in nursing, social care or mental health conceptualised their role in a more specialized way, suggesting codes of practice and professionalization of their role.

Umbrella VCS organisations (such as CVS) had training, management and supervision structures in place for new recruits to SP and CB or were able to buy it in from partner organisations. For example, our researchers observed regular, quarterly away-days between wellbeing coordinators across South Devon and Torbay, which also invited newly appointed PCN link-workers.

The need for training in a range of aspects of the new approach was identified by PCN employed front line staff at conferences and in peer support meetings and individual interviews (Exeter racecourse, Jan 2020; S. Devon peer support meetings March 2020). Training needs were being consulted on by the regional NHS England SP network at the time of writing.

The expertise and capacity to provide for the specific training and supervision needs of SPs was a challenge in primary care (Evaluation Team Survey results, April 2020, peer support meeting field notes March 2020). The isolation of PCN contracted SP LWs in contrast to those sub-contracted from VCS organisations was notable across Devon. A South Devon peer support group (initiated and coordinated by a VCS subcontracted LW) was an invaluable sounding board and support mechanism for a disparate group of front-line staff with varying levels of experience and knowledge of SP practice. The group incorporated VCS and PCN contracted SPs. The group was particularly valued by newly appointed SPs to give them orientation and a sense of professional community. Other localities were hosting similar, if less structured, meetings.

Line management and supervision were highlighted by PCN contracted LWs. Working with referred individuals who had complex needs, often in mental health, in a role that was not clearly defined was challenging. Whereas their VCS counterparts could rely on informal peer support and team meetings with other SPs and more regular, individual supervision sessions with their manager, PCN LWs' experience was that while they may have general, friendly support from primary care colleagues and mentoring meetings with a GP colleague, more formal structures were lacking. Patient case reviews, while helpful, were also not sufficient for their own development, learning and support needs in this newly developing role (Interviews with LWS and field notes from LW peer support meetings, Feb, March 2020).

REFERRAL PROCESS, RISK AND SAFEGUARDING

The Ways2Wellbeing programme draws clear boundaries about the coaching approach they take with their clients. The team lead and community services manager reports they have been successful in educating primary and social care colleagues about appropriate referrals to their service. However, this took time to achieve and is arguably more successful in defining SP referral criteria because of the nature of the role, which does not seek to address the wider needs of individuals, such as financial hardship or mental health concerns. It is also a time bounded intervention.

This was not generally the case in other projects and there was a wide variation in types of referral and what was expected of the front-line SP. This was particularly true of PCN contracted LWs.

'In most projects there were many issues relating to referrals: the remit too wide, SPs are expected to take on any age and anywhere. Clients with medical issues are being referred or with complex, multiple issues -often it is the same people over and over again. Some GPs are using the service as a parking place for people that they don't know what to do with' (Reflective Field notes, workshop Feb 2020)

Some VCS projects had been successful in establishing referral criteria and had developed a referral and triage system that highlighted any risk and safeguarding concerns and enabled referrals to be filtered before they reached front line staff. SPLWS based in surgeries highlighted the risk posed by working with individuals for whom they did not have a complete history or notification of safeguarding concerns. Examples were given of LWs not having access to complete patient records and histories, patients being sent to them without an appointment and the expectation that they would see patients who had severe mental health concerns such as drug and alcohol dependence, suicidal ideation or who making home visits to people who were in situations of domestic violence.

WORKLOAD

The increase in complexity and number of referrals was leading to a dilution of the holistic model of SP for some front-line workers. Rather than having a WMTY conversation with individuals, that enabled them to identify their wider health and wellbeing needs and preferences, they believed they were increasingly moving back along the continuum to a signposting role in order to manage volume of referrals without imposing long wait times. The role of strong VCS management and leadership in pushing back and preserving what they believed to be the project's core SP rationale and principles was seen to be invaluable (Field notes, team meetings and interviews with managers Jan – March 2020).

Those present noted that nearly everyone in the room was working over-time sometimes 50% more of their time. Thus, the current model is not sustainable. More time is also required to do admin. This can take as much time as the conversation. Also, it is important to have reflective time to be able to do research for clients. Many clients are on the edge of mental health issues (Field notes, workshop OND Feb, 2020)

PERSONALISED APPROACH TO WORKING WITH INDIVIDUALS

The Evaluation team have not engaged in observation of SP interactions so we cannot make definitive statements about how closely work is aligned with the comprehensive model of personalised care and personalised approaches in general. As we have explored above, projects vary in their model of engagement with individuals. Where their model is to adopt a personalised approach with clients, projects report that resource limitations, as well as restrictions placed on their roles by some primary care models of SP, are limiting their capacity to follow a personalised model. If personalisation is the model that the STP wishes to promote, this limitation needs careful consideration.

Because of lack of data, we are unable to establish whether the goals and preferences of individuals are recorded into a shared, documented plan. Projects using outcome planning tools with their users have reported difficulties in encouraging individuals to complete these. Careful consideration is needed of the context needed for a trusted relationship to develop in order that person centred approaches are authentic and meaningful.

COMMUNITY DEVELOPMENT IMPLEMENTATION ISSUES

CD is about much more than building assets for referral. Synergies between SPs and CBs are important since their roles are necessarily overlapping in the central space of the continuum. Both roles concern engagement whether with individuals or community, attending events and training and communication of each other's roles. Some of the skills are similar: listening, networking, gaining trust. Relationship and trust building, by meetings or regular contact between SPs and CBs is important, especially where they are not employed by the same organisation; co-location is helpful. CBs can significantly reduce the burden of the SP role by doing the ground work of researching organisations and activities and establishing risk and safeguarding for clients wanting to engage in them.

In some areas gaining acceptance of CD programmes in small rural communities was a challenge and significant trust building was required with communities and organisations (Field notes, OND, Feb 2020).

5.3.2 EVALUATION AND QUALITY IMPROVEMENT WORK

USE OF OUTCOME MEASURES

APPLES AND PEARS...

A clearer understanding of the essential components of the SP/CB role is needed for each project in order to evaluate outcomes and impact. Currently it would be difficult to establish a universal evaluation framework to cover all projects in Devon as the variation in the components of the role (activities, responsibilities, organisational culture, skill sets of the workers) as well as the type of varied needs brought by the service user and activities or experiences they are referred to is so great.

Process evaluation or [realist evaluation](#) of implementation may be more feasible and could uncover the variation and contextual factors about why some programmes have certain outcomes with certain people.

COMMUNITY DEVELOPMENT EVALUATION

WE includes a number of process and outcomes data collection tools in its evaluation framework to assess what community builders do, how they engage with the communities in their 'patch' and what the experience of community members is. These included case studies, neighbourhood profiles and mapping reports. It is not known whether this data is now being collected and analysed. Most projects were not systematically measuring community development or were reporting on unanalysed activity data such as lists of, for example, the type of organisations clients were referred to or the groups developed within a given area. It would be useful to further investigate how projects could collect and analyse data that reflects the richness of community development work (Polley, 2020; South, 2019).

NATIONAL EVALUATION GUIDELINES

The use of PAM and ONS4, as specified by national guidance, was problematic for many front-line workers in SP in Devon and is reflected in the literature (Polley,2020). Baseline data collection was often felt to be disruptive of the developing relationship between an individual and the front-line SP who was not previously known to them. The questions asked in outcome measures were felt to be intrusive or upsetting to clients who were vulnerable. Confidence in using the tools and lack of understanding of their value were issues for front line staff.

Programmes focussed on a holistic model of SP, that embraced a wide range of potential needs and outcomes directed by the person's circumstances and their relationships within their community, founded measures such as PAM were more reflective of medical theories about how SP works and not appropriate to their work.

There were some exceptions to this. For example, Torbay and South Devon, which benefitted from substantive evaluation budgets (through AgeUK/Lottery funded local/national evaluations, and University of Plymouth – SERIO, and embedded researchers), contractual setups that required specific data collection.

PCN-employed SPs found recording of SP patient data on primary care systems problematic. Many had not received training on coding and found the codes (other than the basic referral codes) did not fit their intervention. The lack of capacity for analysis of READ or SNOMED codes about SP was intrinsically unrewarding as LWs could not draw any conclusions – for example, about their referrals or the difference they were making.

As of July 2020, some SPLWs were experimenting with the use of case management apps (e.g. the [Joy app](#)) that allow for recording and reporting of process and outcomes data, which also integrates with EMIS is and SystmOne.

RELATIONSHIP OF EVALUATION TO PRACTICE: IMPROVEMENT AND CYCLES OF LEARNING

Perhaps because of the apparent lack of inherent value applied to practice, as well as a sense of top-down imposition of outcome measures such as PAM, the interest and engagement of front-line staff in evaluation is variable and connected to their previous experience, training and personal motivation to collect outcome measures.

In many cases the rationale for measures or data collected were not clear to workers or assumed to be for monitoring and reporting to funders alone. Where the use of measures had an inherent and immediate value to practitioner and client in identifying goals or demonstrating progress or development, such as a goal planning tool, they were more likely to be collected (e.g. MYCAW, Well-being Star or Five Ways to Wellbeing). However, this varied according to project, client and worker.

“Whilst a degree of measuring and monitoring of outcomes was seen as necessary, link workers noted that using an outcome measure in the consultation could at times be inappropriate and that referral reasons were not always the issue prioritised as in need of immediate support by the service users. All of these points raise the need to be pragmatic and flexible about approaches to data collection, measurement and monitoring.”
(Polley, 2020)

It was not clear to the Evaluation Team whether analysis of data collected was shared with front line staff or used by projects to inform cycles of learning or quality improvement.

Where programme analysis was shared via a dashboard of aggregated results (eg WE) individual VCS projects would have preferred a breakdown that enabled their learning and development at team meetings, but also facilitated funding applications for their organisation.

An example of the cycle of learning approach would be related to ongoing embedded research support since April 2016 in South Devon. For example, ongoing performance reports were fed-back, shared and discussed with contracted providers. The below flyer was shared at a team meeting with Kingscare, 11 February 2020:

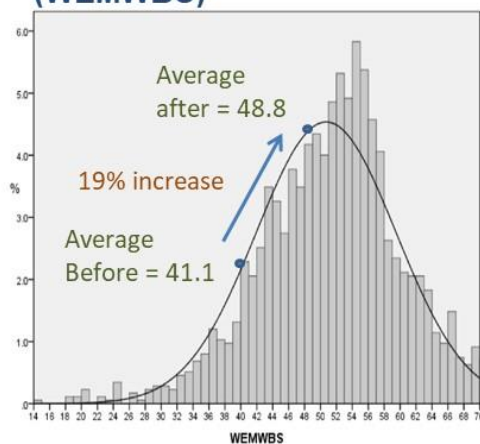


<https://www.torbayandsouthdevon.nhs.uk/services/wellbeing-co-ordinators/>

From July 2019-December 2019:

- Overall, 365 people received a guided conversation and social prescribing options
- 173 of these were supported through evaluated 1-2-1 Coaching
- 46 of these were supported through funding by Torbay and South Devon NHS Foundation Trust Wellbeing Programme
- 25 were supported through evaluated group Coaching e.g. HOPE

Warwick Edinburgh Mental Health and Well-being scale (WEMWBS)



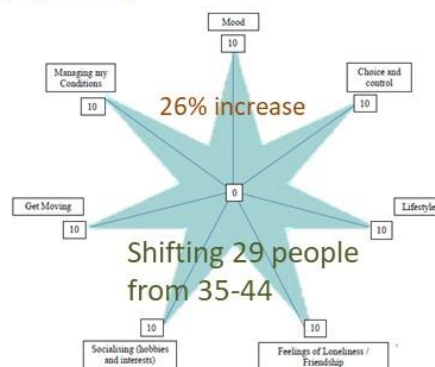
33 people improved 7 points from 41-48 on average (19%); Mental wellbeing meaningfully improved (threshold of 3-8 pts); bringing people closer to the National average of 51.6.

Achievement of living well goals – 98% (23 people)

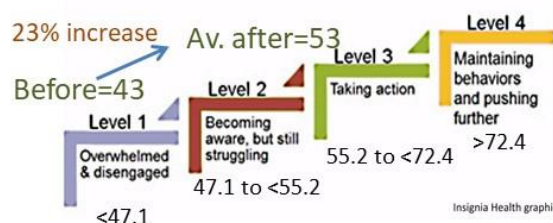
Evaluation of the Wellbeing Coordinator Impact

These were statistically significant improvements (n=41 people receiving WBC)

The Star Motivational Chart Tool (Age UK)



Patient Activation Measure (PAM)



Shifting knowledge, skills and confidence to manage own health one PAM level on average (6 people)

In Collaboration with:

Torbay and South Devon NHS Foundation Trust | Torbay Medical Research Fund | UNIVERSITY OF PLYMOUTH | NIHR | Collaboration for Leadership in Applied Health Research and Care South West Peninsula

6.0 DISCUSSION AND CONCLUSIONS

Targeting individuals and conditions is based on a medical model that may not be suitable for the wider aims of SP to enable people, informal caregivers and communities to manage their health and wellbeing within their local area. Social capital theories (Tierney, 2020) and community frameworks (South, 2015; Polley, 2020) may be more suitable and are evidenced in the models in OND, WE and Torbay where a system-wide partnership approach situates SP within its local community, rather than a health setting. VCS organisations, in partnership with the statutory agencies are uniquely placed to support this model.

Community assets are the core of the social prescribing offer and their existence, sustainability, funding structures and accessibility are important enabling and constraining factors to programmes' operation. We would argue that the sector should not be considered a *resource* to be used by the health service, but a key *collaborator* in building healthier communities. Given their importance, it is somewhat concerning that the push from NHSE to use the VCSE has come without corresponding work assessing demand, capacity and impact within the sector. New health-service models must not seek to re-invent or duplicate good practice by failing to understand local communities or ignore and smother VCSEs through

rapid increases in the numbers and types of referrals without linked funding and support. A project funded by the MRC is examining the routes individuals can use to access social prescribing resource in the absence of health service 'scaffolding', and plotting these complex systems at local levels.

A recent review of evaluation outcomes data highlights the wide variety of potential

outcomes of the holistic and community development model of SP and cautions against defining outcomes of SP narrowly using a bio-medical or individual health model (Polley, 2020 p 15.) It has also been argued that impact of contextual factors must be considered in any evaluation model (Husk, Elston et al, 2019). Seeing SP as a system approach rather than a single intervention would indicate the importance of considering the full value of VCSE organisations in the SP model.

Our findings show there are different models of SP and CD operating across the region with varied motivations for labelling projects and programmes as 'Social Prescribing'. The Evaluation Team (RiRs) have facilitated open discussions from these different viewpoints. Stakeholders included those at STP level within the Evaluation Project Group and Delivery group, managers and leads of projects and front-line workers. They bridge the VCS and statutory organisations. The need for inclusion of the views of stakeholders, including

"The broad range of outcomes identified by stakeholders would map more appropriately onto a community capitals framework. This would enable the interconnected elements required to create sustainable communities to be incorporated and valued in research studies, particularly where the economic value of social prescribing is being determined at scale. Without sustainable communities and a VCSE sector that is appropriately and fairly valued for the contribution it makes, social prescribing at scale is at risk of failing." (Polley, 2020)

service users, in formulating research and evaluation questions and what constitutes outcomes, is also emphasised ([Polley et al. 2020](#)).

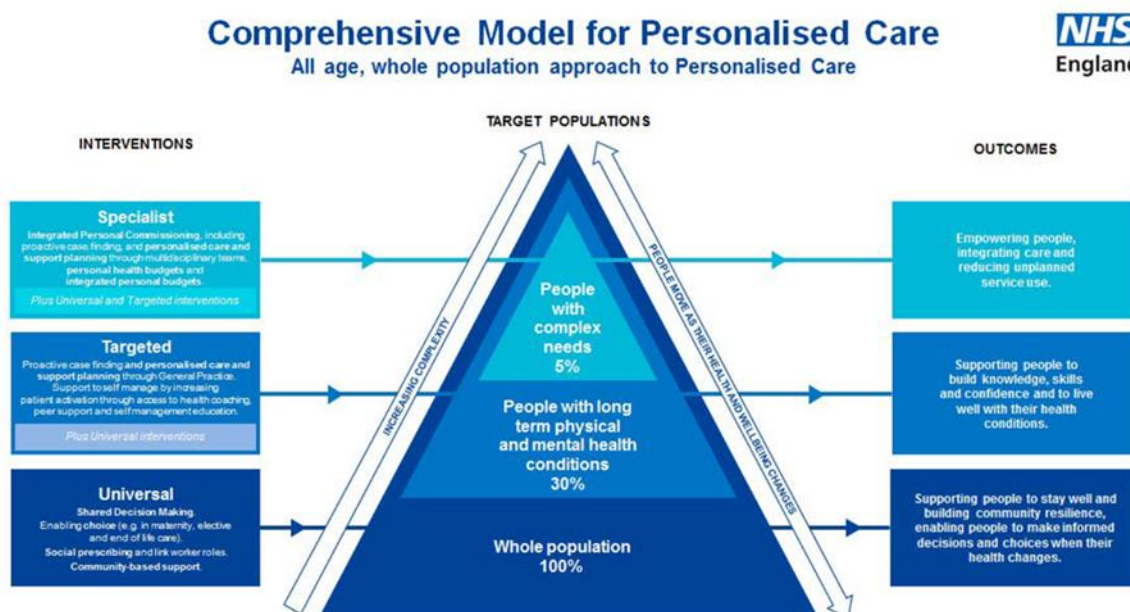
Furthermore, from a population and public health perspective, the real benefit in providing holistic, continuous and primary prevention more universally earlier and further down the population pyramid might yield more longer term, and hard-to-quantify benefits than low touch, high frequency and reactive programmes targeting high-intensity users of statutory services.

From a commissioning perspective, it is important that valid strategic concerns around for example equity, safety and dependency are not undermining the necessary place-based, risk-enabling, and strengths-based approaches so unique to the VCSE sector. The STP social prescribing programme has demonstrated an outstanding effort to better partnership working and co-commissioning in this respect.

Authentic person-centred approaches are resource intensive, but there is emerging evidence that as well as resulting in increasing individual outcomes in wellbeing and self-management of health, they can result in system cost savings over time ([Lloyd et al. 2017](#), [Kimberlee, 2016](#)). It is important that the model of interaction with users is not diluted, so that the desired outcomes for individual and the system are compromised.

APPENDIX 1 – SOCIAL PRESCRIBING LOCATED WITHIN THE INTEGRATED CARE MODEL

The STP Social Prescribing (Programme) 2020/2021 refers to the three work streams of the Comprehensive personalised care model as defined below:

**Work group 1: High Impact / Need**

Scope: This work group will be looking at the way integrated SP can support both those who more complex and high need individuals and the higher impacts they have on the system in terms of cost and flow.

- Enabling & facilitative approach
- Working through ICM Information, Resource and Ways of Working themes that impact at individual, place and system delivery levels.

Example: someone who is fragile or frail, maybe without 'capacity'; end of life; high cost 'frequent attender' of single or multiple services (ie GP, A&E, Police, Ambulance); Learning Disability, significant mental health condition; complex multiple needs and chaotic lives; high vulnerability including those at risk of harm or exploitation; very deprived individuals who don't have their needs met. Also where the system identifies significant pressures that SP might be able to impact on in terms of need, flow or sufficiency.

Workgroup 2: Targeted SP (middle of Care pyramid)

Scope: This work group will look at ways of supporting - through the provision of information and networking together – best practices, key issues, key information – with stakeholders (ie PCNs/Linkworkers/Services) that are providing or could benefit from the use of SP approaches in support for this population target group.

- Enabling & facilitative approach
- Working through ICM Information, Resource and Ways of Working themes that impact at individual, place and system delivery levels.

Example: Those with Long Term Conditions (CPOD, Diabetes), those looking after people with Long Term Conditions (ie Carers), socially isolated, low level anxiety & depression; frail but independent in community but requiring increased support as frailty increases; 'mainstream' social prescribing as delivered by PCN Linkworkers.

Workgroup 3: Universal

Scope: This work group will look at how SP-approaches can be built into communities and workforces. This will focus on supported key elements of the ICM Framework (that matches SP methodologies) to build in SP into wider workforce beyond just using link workers or community developers. In addition, this workgroup will look at ways that SP-approaches can be built into communities beyond just using professional link workers or professional community developers. The scope includes how this capacity can both support the system (both link workers and services) and the community (both the link workers and the community developers) in relation to improving an individual's wellbeing outcomes.

- Enabling & facilitative approach
- Working through ICM Information, Resource and Ways of Working themes that impact at individual, place and system delivery levels.

Example: Frome Model; community activists and volunteers connecting with and either directly helping or signposting individuals with low level / moderate needs (befriending, home help, meal preparation, weigh loss groups, activity groups, community transport, help with shopping, signposting to CAB etc) in the community to assets in the community that can help support them or to escalate to link worker. Also where professionals (OTs, Community Nurses, Physios, Dementia Advisors, Mental Health professionals, Carer Support Workers etc) who deal with clients/patients are both trained in guided, asset-based conversations but also where to signpost/refer them to if required.

CASE STUDY EXAMPLES

Flow case study ref F1

One Barnstaple Flow

One Barnstaple Flow is an alternative approach to traditional social prescribing whereby instead of individuals being referred to a social prescriber for non-medical support, practitioners have ‘what matters’ conversations with the individuals they are working with and are supported to offer non-medical options themselves by means of a Wellbeing Co-ordinator. The Wellbeing Co-ordinator interacts with practitioners rather than individuals in order to build system links with wider support so that the ‘system flows around the individual’ rather than the individual bouncing around the system.

About Lindsay

Lindsay¹ has long-term back and leg pain with related functional impairment together with PTSD from historic physical assault.

Recent benefit issues have culminated in the threat of losing her motability car.

Lindsay supports her partner who has chronic illness as well as 4 other family members.

Lindsay has benefited from using an outdoor solar pool for hydrotherapy exercises and general exercise, a key component of her pain self-management and wellbeing.

Winter weather meant that this could not continue as she couldn’t afford a pool heater.

The couple’s accommodation has open access to the back of the property, a cause of anxiety due to previous experience of being assaulted in the home.

What did the Flow practitioner do?

The Clinical Psychologist in the Pain Team at NDDH: had a conversation to understand the circumstances contributing to Lindsay’s ongoing pain and as a result:

- Psychological therapy (Eye Movement Desensitization Re-processing)
- Provided Lindsay with food bank vouchers
- The practitioner connected Lindsay to support from DWP to resolve the immediate benefits issues.
- The practitioner connected Lindsay to Encompass / Wiser Money to support her with an appeal to DWP regarding the decision to cut her PIP benefits. They are also supporting the extended family in liaison with DWP regarding another benefit cessation.
- Used Flow funds to purchase a pool heater to enable year-round use of the hydrotherapy pool
- Used Flow funds to fit a rear gate to increase Lindsay’s sense of safety and security.

¹ Not real name.

Lindsay has used clinical letters to support a litigation process in relation to the physical assault.

How Flow has helped

- Lindsay is now able to feel safe and secure in her garden.
- Lindsay is now able to continue exercising in her hydrotherapy pool in the winter months.
- Food bank vouchers took pressure off during financial hardship by providing food basics.
- Lindsay's mobility benefits have been reinstated to an enhanced level

How Lindsay feels about the Flow support

"It's good to know that there are charities (sic) that take things seriously and try to help, especially in the current climate we are living in. I would like to say thank you for the help you have given us. Now I can feel a lot safer in our back garden and get back to the much-needed pool therapy without freezing to death."

In answer to the three Flow evaluation questions, with the options of 'not a lot, a little, more than a little, quite a lot, a lot'

To what extent did you feel supported to meet your needs? Lindsay answered 'A lot'

To what extent were you able to meet your needs? Lindsay answered 'Quite a lot'

What were the limitations of Flow?

The latter score is a reflection on the fact that although the individual has been reinstated on the enhanced level for mobility allowance, they have not been reinstated on the enhanced level of care allowance which means that they cannot afford to re-purchase a motability car. Due to the rural location where the family live, this will impact on quality of life and being able to get out and about as much as they would like. The issue of lack of community transport is a common thread identified throughout the Flow pilot.

How the practitioner feels about the Flow support

"The Flow approach complements and enhances the approach that I already take within my work as a clinical psychologist in a pain team. My approach is informed by a biopsychosocial model and the input from Flow has enabled taking a more active stance in relation to the social/environmental dimension, via provision of funds to purchase items improving the security of the individuals home environment (addressing a basic human need for security) and purchase of a pool heater – enabling them to continue with their home based hydrotherapy exercises. This means that they are better placed to experience sustained and on-going benefit from the time-limited therapeutic work they have engaged with in the pain team. I hope that the pilot project will continue to receive funding going forwards."

What would have happened without Flow

This viewpoint is subjective but provides an input to a not unusual series of developments.

If the clinician had not recognised the need for a holistic solution to the issues affecting their patient, any clinical interventions that they would have provided would have been difficult for the patient to sustain due to the other factors affecting their life. Had the

clinician not had a full understanding conversation with the individual, the full set of circumstances would not have been understood.

The patient would have ceased to use the outdoor solar hydrotherapy pool during the winter months due to their feelings of insecurity and cold. This would have meant that their physical and mental health could have been severely negatively impacted. Given that they are the main carer and supporter for their partner, 2 daughters, grandchildren and elderly aunty, there would have been increased and wider reliance on public services by the whole family.

This reliance would have been exacerbated by lack of financial funds due to DWP benefits decisions.

The individual feels that without the support offered that they would have been an increased 'burden' on the system which in turn would have increased the family's 'burden' on the community.

System impact

The clinician is now better assured that their patient is able to continue self-management of their pain thereby reducing the longer-term reliance on health and social care services. The clinician is also now more aware of what other support there is available in the system that they can connect their patients to.