INSPIRING ASHFIELD INITIATIVE: WORKSHOP BRIEFING REPORT

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The content of this briefing report does not reflect the opinions of any of the funders of the Inspiring Ashfield Initiative. This is a report on the content of the workshops conducted by Nottingham Trent University (NTU) and Ashfield Voluntary Action (AVA) to deliver knowledge to other local stakeholder organisations.

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1. EXECUTIVE SUMMARY

1.1. Background

In this series of six workshops, local stakeholders across the Mid-Nottinghamshire region came together to learn about the insights gained from the Inspiring Ashfield initiative, as well as discuss these insights with representatives from other local organisations, such as Community & Voluntary Services (CVSs). This report details (1) the presented content of each of the workshops, and (2) the discussions that were sparked by these presentations grouped into five key themes. This executive summary will briefly outline the key points from each workshop presentation, and then briefly summarise the themes that came up throughout the discussions. The organisations that the stakeholder attendees represented are shown in Table 1, below.

Table 1. *Organisations and stakeholders that attended the workshops*

Mansfield CVS	Newark & Sherwood CVS
Primary Integrated Community Services (PICS)	Newark & Sherwood District Council
Mid-Notts Integrated Care Board (ICB)	Mid-Notts Integrated Care Service (ICS)
Ashfield Voluntary Action (AVA)	Mid-Notts Place Based Partnership
Citizen's Advice	Sherwood Forest Trust
The Dukeries Community Workshop	Nottingham Trent University (NTU)

1.2. Workshop Summaries

The first workshop was largely focused on providing the stakeholders present an understanding of what Inspiring Ashfield was, how it was run, explain what worked, what didn't work, and providing some surface-level findings, so that the stakeholders were aware of how this kind of initiative could be relevant and implemented to their local area. In the first session of the first workshop, the Inspiring Ashfield initiative was introduced, and some of the results from both the community survey, and the qualitative interviews were presented, with a specific focus on the role of how increased sense of neighbourhood identity lead to greater levels of resident wellbeing.

In the second workshop, both the successes of, and the challenges that arise during, Inspiring Ashfield were presented. The challenges of running Inspiring Ashfield were clarified via a planned mid-point evaluation. This evaluation found that the main challenges were issues with attrition, and anxiety. This lead to an adaptation of the Inspiring Ashfield initiative to improve communication between link workers and activity organisers, enhance scaffolding of 1-2-1 support, and a diversification of activity offer. Highlighting these challenges allowed the stakeholders present to get an understanding of how initiatives such as Inspiring Ashfield need to be dynamic and adaptable in order to meet the specific needs of their local community if they are to undertake similar projects. As a result of the adaptations, data from both qualitative interviews and quantitative surveys show that Inspiring Ashfield met its three primary goals of enhancing place identity, encouraging a thriving third sector, and improving health outcomes.

The third and fourth workshops was focused on providing more comprehensive insight into the outcomes of Inspiring Ashfield. In the third, a greater focus on the evidence gathered

from both the survey and the interviews conducted during Inspiring Ashfield was placed. A more in-depth presentation of the findings that were relevant to the stakeholders in attendance was given. This included highlighting the importance of a diversity of types of activities for residents' wellbeing (and social prescribing), as well as the major barriers for residents to engage of cost, lack of time, and anxiety. The importance of anxiety was highlighted in excerpts from the qualitative interviews, which were also presented to the stakeholders.

In the fourth workshop, an Ashfield Voluntary Action staff member discussed the development, and creation of a novel approach to scoping and engaging members of the community who may fall through the cracks of the current system. This approach, named Assertive Outreach, is a scoping and re-engagement strategy that uses local knowledge and seeks to develop local specialists to help increase the level of trust in the community outreach programmes. The rationale and development of the method was explained, and then examples of how this approach was used in practice were provided to stakeholders, so that they might be able to use it themselves.

In the fifth workshop, we dissected the advantages and disadvantages of using the different evaluation methods that can be used when assessing initiatives like Inspiring Ashfield. The overall message provided by this session was that, when it comes to complex interventions like Social Prescribing, a single method of evaluation is not enough to capture both the breadth and the depth of information required, nor can any single method capture the nuances and complexities involved. Consequently, information on the importance of incorporating both community surveys and qualitative interviews to assess the initiatives was made clear. Moreover, discussion of the language of evaluation and how communication between CVSs/link workers and their funders (such as county councils) can be improved to ensure that both sides are able to get what they need out of the evaluation process, such as describing outcomes in a way that meets the KPIs of funders.

In the final session, an AVA staff member provided a talk on methods to make activity provision more sustainable from the point of view of charitable organisations. In this more conversational session, discussions around (a) the types of funders to approach, (b) the ways in which CVSs and other volunteer groups can work together to approach funders, (c) planning for activity sustainability, and (d) how to navigate activity costs during the Cost-of-Living crisis occurred. The main take-away from this session was that the general population may not distinguish between arbitrary boarders the same way that CVSs and/or other organisations do, and so working at multiple levels – locally and collaboratively at a Mid-Notts level – could help ensure that activities are able to become more sustainable, and to reduce duplication or increase chances of gaining funding.

1.3. Discussion themes

The discussions held after each of the workshop presentations were recorded, transcribed, and then time was spend to group the points made into themes. The five major themes that came up are listed below. Specific comments made will be provided in Section 9.

1. Locality-based approaches: Community Needs
2. Strengths and Limits of Social Prescribing
3. Barriers to community uptake
4. Challenges of integrating health, community, and local gov. services
5. Funding and Sustainability and the cost of living crisis.

2. SCOPE OF PROJECT

2.1. Funding remit

The Inspiring Ashfield Initiative is a project that was funded by the Thriving Communities Fund by the National Academy for Social Prescribing (NASP), as well as funding from the Arts and Humanities Research Council (AHRC). The project sought to help fulfil the goals provided by NASP of: (a) fostering place-based partnerships to increase the range and reach of social prescribing, and (b) helping communities deal with the impact of COVID-19. The Inspiring Ashfield Initiative did this by (1) creating a locality-based partnership between Ashfield Voluntary Action (AVA), Ashfield District Council, other local 3rd sector organisations, and the local social prescribing team, and (2) working alongside local providers to increase the range of activities that were on offer. In doing this, Inspiring Ashfield sought to enhance place-based connectedness and engagement.

As part of the funding, the aims of this project needed to be assessed in various ways. This is where Nottingham Trent University (NTU) are involved. NTU helped provide methods of evaluation, alongside helping to co-ordinate and facilitate the creation of some of the place-based partnerships. As part of the funding remit, NTU were charged with not only evaluating the Inspiring Ashfield Initiative, but also to help bring the findings, and understandings gained from the project to other local organisations within Mid-Nottinghamshire (Mid-Notts).

2.2. Meeting the need

In order to disseminate the findings of the evaluation to other organisations within Mid-Notts, meetings were organised where invites to various stakeholder organisations were sent out. Many of the stakeholder organisations were excited at the prospect of hearing about the insights and findings from the Inspiring Ashfield Initiative. However, simply providing some information to these organisations was deemed to be inadequate, as the needs of the various stakeholders, and how the findings might apply to their specific areas would not be within the scope of pure information dissemination. So, instead of presentations, these meetings were designed as workshops where a multi-way line of communication could be fostered. Each of the hour-long workshops were designed around having only a 20 minutes of the workshop focused on the presentation of information, with the remaining 40 minutes dedicated to the discussion among the stakeholders present about how these findings may be applicable to their goals and needs, as well as meeting the needs of their local area.

In this way, these workshops not only met the need to disseminate the findings of the Inspiring Ashfield initiative to relevant stakeholders, but they also served as a method of further strengthening place-based partnerships between local organisations, thus meeting a major target of the Thriving Communities Fund.

3. WORKSHOP 1 – THE IMPORTANCE OF PLACE

In this workshop, delivered by NTU staff, the Inspiring Ashfield initiative was introduced and explained. After this, the importance of place-based approaches was outlined, including references to NHS's goals, residents' outlooks, and social prescribing in particular. Before presenting some of the findings from Inspiring Ashfield, background research on the importance of place-based approaches were provided.

Following from this, results from the community survey that was conducted as part of the Inspiring Ashfield initiative were presented to the stakeholders. Specifically, the results of how local identity and community support were related to personal wellbeing among Ashfield residents were discussed. The added context of financial situation for Ashfield residents was provided, and the relationship of how well residents manged financially with local identity and wellbeing was explained.

This session ended with a talk about some of the qualitative interview data that was gathered as part of Inspiring Ashfield. Accounts from service providers highlighted the importance of their role in fostering a feeling of connection to the local community. Accounts from service users that ended up disengaging from the services showed that they disengaged if this feeling of local community and community support was not present. Finally, accounts from engaged service users showed that the past loss of community identity (of being a mining town) has had to be replaced by new community identities, and community meanings that are fostered by programmes such as Inspiring Ashfield.

4. WORKSHOP 2 – SUCCESSES AND CHALLENGES OF DELIVERING INSPIRING ASHFIELD

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5. WORKSHOP 3 – SCOPING: COMMUNITY SURVEYS AND INTERVIEWS

In this workshop, delivered by NTU staff, the methods that can be used to scope community need were outlined. Two approaches were explored. The first approach discussed was conducting a quantitative community survey, and the second approach discussed was about conducting qualitative, in-depth interviews within the community. To demonstrate the effectiveness of a community survey, NTU staff presented some of the data that was gathered from 388 individuals from within the Ashfield community.

The first thing that was demonstrated from the data in the community survey was that there was evidence for a benefit for being a member of different types of group. The data from the community survey showed that members of the community who are part of more types of groups are likely to have greater levels of wellbeing, with this effect going via their feelings of creativity and loneliness. This suggests that ensuring that there is a diverse offer available for social prescribers to send individuals to is important. The second thing demonstrated from the data was that respondents stated that they did want to see a diverse offer in their local community, and that what they would like to see matches with the breadth of activities that the Inspiring Ashfield initiative was able to provide.

Beyond this, the community survey was also able to show what barriers a specific local community might have to taking up the activities that are on offer. The main barriers that the Ashfield community reported were around cost, time, and anxiety. Importantly, the data showed that, at least within Ashfield, transport, cultural fit, and having past negative experiences with groups were not key barriers. It was explained that conducting community surveys like this enables local charities, and authorities to be able to better tailor their offer, and their resources to help encourage uptake, to their local area's need.

The second approach discussed in this workshop was conducting qualitative interviews. Here the focus was on digging deeper on how one might be able to understand specific barriers to attending these groups for their local resident. The focus for this workshop was anxiety. Some qualitative data was presented to show that, while service users are aware of the benefits of attending the group activities, it can often be a constant battle against their – often very strong – symptoms of anxiety, and how small gestures, such as having a single person meeting them outside the venue, can help ease them into things to alleviate the anxiety of joining a group. This helped demonstrate how the use of qualitative interviews can help local charities and CVS organisations learn what works, and what they might be able to do to improve their delivery.

6. WORKSHOP 4 – SCOPING: ASSERITVE OUTREACH

In this workshop, presented by Ashfield Voluntary Action (AVA) staff, they discussed an innovative approach to scoping and community engagement that was developed during the Inspiring Ashfield initiative: Assertive Outreach. The first part of the workshop was based on explaining what Assertive Outreach is, what its aims are, and how it is implemented in Ashfield by AVA.

In short, Assertive Outreach is a scoping and re-engagement approach that seeks to target people who may have fallen through the cracks of traditional/mainstream services and methods of scoping. The aim is to re-engage these individuals with systems, such that they can benefit from the help and offering that is available in the local area, that they may be unaware of. Assertive Outreach operates on the principle that the current assumption underlying the social prescribing pathway – that the most vulnerable people will present to the GP, who can then be referred to social prescribers – is flawed. Assertive Outreach, instead, suggests that the most vulnerable members of the population won't present to GPs at all: they have completely disengaged from the system (e.g., people who don't think a GP can even help with their problem). Within Ashfield, this may stem from a deep mistrust of government systems due to multiple years of failures to address their needs, going back to the closure of the mines. As such, it was stated that Assertive Outreach is a bottom-up approach, as opposed to previously attempted top-down approaches to re-engage vulnerable, disengaged populations.

Throughout the workshop, examples of the methods that were used by AVA to conduct Assertive Outreach were provided. For example, the acknowledgement that certain sub-populations, such as older men, may not actively seek out help that they actually need. Instead, AVA staff went into the local pubs where they initially just started speaking to 'regulars'. This first step of engagement, and meeting people where they are, allowed for these men to be, over time, directed to the kind of help they needed, such as bereavement groups, that they would have otherwise never considered. This led to self-reported improvements in wellbeing for these newly-engaged vulnerable individuals.

The presentation phase of the workshop closed with two key points: (1) the explanation of how this innovative approach seeks to be preventative in nature: by re-engaging vulnerable communities before they reach a crisis point. This is based on the idea that preventative action is far more cost-effective, and person-centred than reactive responses to crises (e.g., falls, suicide attempts, or other major concerns); and (2), that Assertive Outreach relies on key people within a community, and a 'contagion' model, where local word of mouth helps propagate awareness of the help that is being provided. This relies on ensuring that organisations incorporating this approach are embedded within communities (such as using local charities, CVSs, or volunteer groups) as opposed to from outside the community. That way, a build up of trust, and an historical awareness of the local area's needs are built into the approach, and leads naturally to the creation of 'community specialists' that are able to help vulnerable people in the local area.

7. WORKSHOP 5 – EVALUTION TECHNIQUES AND TOOLS

In this presentation, the evaluation techniques and tools that were used throughout the Inspiring Ashfield programme were themselves brought into focus for discussion. The benefits and the drawbacks of each method – (1) quantitative surveys, (2) qualitative

interviews, and (3) appreciative inquiry – were touched upon and discussed both in the specific context of Inspiring Ashfield, as well as in the wider context in which service providers, social prescribers and CVSs might use them.

After this, a move to discuss how the language of evaluation is used at different levels: from the delivery of the social prescribing offer, to the assessors themselves, to the funders and wider audience that the evidence gathering process is geared toward. Within this, came discussion of key performance indicators (KPIs), and how the different evaluation methods may each be used by 3rd sector organisations to help demonstrate how they meet the KPIs of funders and county councils.

8. WORKSHOP 6 – UP-SCALING AND SUSTAINABILITY

In this presentation, Teresa Jackson, from Ashfield Voluntary Action (AVA) provided an outline of why it is important that we can ensure the long-term sustainability of the programmes that are run for social prescribers to send people to, and discussed how to approach sustainability. Firstly, discussions around the differences between working alone and collaborating with other CVSs/charities to apply for funding may work.

Secondly, specific funding sources were identified and explained, to help paint a picture for how the CVSs may come together to create a local team, where a "Mid-Notts" application may be made, or even applications by pairs of CVSs may be made. Finally, a frank talk around the costs of delivering the services that social prescribers refer clients to was provided, and how the need to charge per session – be it a fixed amount, a "pay what you can" approach, or a deposit model – may be required to ensure the attendance of social prescribing clients, and the sustainability of the offer.

9. DISCUSSIONS

After each of the workshops, discussions were held by attendees to talk about the various stakeholders' perception of the key things to take away from the workshop, as well as some of the issues that may need to be addressed. There were some things that came up across multiple discussions, and so instead of simply providing the content after each workshop, we have grouped the salient points from the discussions into five major themes.

The content provided below, segmented out into themes, is mostly comprised of comments made by stakeholders, verbatim. This is so that readers are able to see how exactly the stakeholders expressed their views on certain topics. On some occasions, paraphrasing has been used due to the stop-start nature of conversations, or in the case of people being interrupted. For this, square brackets – [] – have been used to help with readability. However, in these instances, the meaning of what was said has been left completely unchanged. Particularly salient and/or emotional speech has been put in to speech marks – "" – so as to ensure it is clear that this was a specific quote and not a section that has been paraphrased.

9.1. Locality-based approaches: community needs

Localised needs

- Ashfield has a culture of not considering their own health
    - [There is] a culture of disenfranchisement since closing of the Mines under Thatcher
    - [a feeling of] "screw the system, it doesn't help us"
- Different communities experience different issues
- By comparison, Lincolnshire is a predominantly farming community, not ex-mining. So, their population has very different needs and desires compared to Ashfield.
    - This means that Ashfield is also different to Newark, which is very different to Nottingham City Centre, etc.
- People higher up in the system seem to need to know what the end-users need in their local area, as opposed to a county-wide need.
- [We] must understand the needs of the specific area

Communities as Unique Places

- Every community is different-cannot create 'one size fits all' plans
    - Funders/councils want county-wide versions/one-size-fits-all things, which causes them to over-complicate some things, and over-simplify others. One size will not fit all.
- Even affluent areas can have hidden poverty, so [we] cannot make assumptions.

Local Environment is Part of the Community

- As well as a disconnect from community, there is also a disconnect from nature/landscape that needs to be addressed.
- Ensuring a welcoming environment to newcomers makes repeat attendance more likely.
- More deprived communities have fewer community centres in their local environment, meaning there are fewer places for community groups to be created and maintained.

Assertive Outreach as a Local Approach to Understand Local Need.

- Surveys and questionnaires are often not sufficient to understand local need
    - They may be too siloed, and lead to only a certain type of person responding
- Assertive Outreach solves this, as it reaches out to local people who have historically not engaged
- "I'm a local, and so people recognise me – Assertive Outreach rings true."
    - [The local community] know that I know things
    - They know I am interested in helping them out because I'm from the same place
    - I use the same colloquialisms. I know the same landmarks, etc.
- Lived experience of the area is so, so important, and Assertive Outreach ensures that.

9.2. Strength and Limits of Social Prescribing

Strengths

> Benefits of increasing Social Prescribing

- The greater range of activities/offering is incredibly helpful.

> Social prescribing can work, but there is a need for "scaffolding"

- "Scaffolding" and one-to-one handholding support is needed.
- Gradually making people feel safe in the new community
- Volunteers who can do [scaffolding] are vitally needed.
- [Social prescribing] gives the participants a person to actually rely on/be accountable to.
- The use of a scaffolding volunteer can help encourage fewer no-shows.

Issues with Social Prescribing

> Issues of Awareness

- Some residents are unaware of Social Prescribing/do not know what it is, especially if they have not visited their GP for a long time.
- Easy to overlook informal Social Prescribing within communities, which involved community workers signposting residents to relevant sources of support/community groups. [Official channels] need to connect with these community champions.
- This is a major issue – the pathway is opaque: some people don't know [how to access it].
- NHS Social Prescribing leaflet ignores complex problems like debt, housing, and family difficulties.

> Issues of scope of role - Social Prescribers/Charities as Social Workers

- Pressing "Pause" is something that we [social prescribers] sometimes need to do, but can be hard
    - Too busy "firefighting" crises
    - If we can get to a stage where we can stop firefighting, we could possibly address *want* as well as *need*.
    - CVS is infrastructure to help other charities/CVSs, but people often view "infrastructure" as unimportant
- There is also depression [in clients]
    - Many of the groups/activities are acting as "holding rooms" (lack of a better term) until the person can get the care they need.
    - The activities can provide social support, but only enough to help them survive until they can get the help they really need.
- Social prescribers are now not just for activities
    - Their role is becoming more overlapped with a local area co-ordinator, or even social workers.
    - Social prescribers are providing poverty assistance
    - Social prescribers are helping clients navigating housing, dental, finance, etc. issues for their clients.
        - Benefits forms, PIP assistance, transport advice

    - Social prescribers have become pre-occupied with fighting fires – i.e., crises – instead of doing what they were first meant to do.
- The issue is that social prescribers have been drafted as local area co-ordinators and social workers
    - Duplication of work, we need to reduce duplication

> *Issues in the Social Prescribing pathway*

- Difficulty of actually getting GP appointments means that many residents cannot get on the Social Prescribing waiting list-many are not even registered with a GP
- Those who need it often do get it.
    - BUT, many are simply on a waiting list so are stalled on the pathway
- Other – informal – ways of gaining access to the [social prescribing] pathway can be just as important.
- A big issue is that the community don't know how to identity many mental health issues:
    - If we conceive of services as a "Health & Wellbeing train".
        - Social Prescribing is just one carriage on this train
    - People don't know when they need to board the train, meaning the pathway doesn't work as intended.
        - They don't know they should got to the GP to get a social prescribing referral
- That SP requires a GP referral is, itself, an issue.
    - Some GPs don't know what an SP can and cannot offer
    - Some people don't attend the GP until issues are very bad – long after SP would have been able to help them
- The issue is that people in the healthcare chain talk about "many doors" to entry to the system, but this doesn't really happen, as most are obscured.
    - We need 1 ***obvious*** door that people can be easily signposted to, that is well-funded, so it isn't a bottleneck
    - And, if that single door is a coffee shop or community space it would work better than if it was a medicalised door.
    - This [single door] could definitely work… but it needs money and volunteers to make that community space approach/single door approach work
- Also, a problem with the SP pathway, specifically, is that it becomes medicalised.
    - This medicalised approach/view can cause disengagement
- Recognising mental health issues in the community is difficult
    - The average person can't do so to start them on the pathway
- Issues exists for Social Prescribers
    - Why do they [clients] need to come to us via the GP? By the time they reach the GP, they are already at crisis point, and it is no longer preventative

> *Issues with consistency/focus*

- Changes of staff can also be a big issue.
    - Turnover in LW/SP can cause a loss of knowledge about local offer or processes, or who to tell the information to.
    - It takes time and SPs may not have the time due to be over-worked.
    - Deliverers need to know the general issues a person is having, even if not specifics. This way they can appropriately prepare to ensure the best experience for both the new client AND the rest of the group.
- Charities ***should*** get the information from the social prescriber
    - Social prescriber's job is to communicate.
    - The whole USP [Unique Selling Point] of social prescribing is that they were able to have the time to communicate, follow-up, bring the client to the offer, etc.
        - Social prescribers should not only be a signposting service
    - HOWEVER, Social prescribers are now often overworked, and there is an issue with KPI incentives
        - Instead of a focus on follow-ups/closing the loop, it is on referring X number of people
    - The Drive for data to meet these KPIs leads to worse outcomes due to behavioural shifts away from intended purpose.
        - [Goodhart's Law/Campbell's Law]
- Something that is often forgotten is that the client is person – a human.
    - We, of course, need to fulfil their needs!
    - We need to say to people along the chain if anything has fallen through the cracks to make sure it doesn't happen again.

Interest in other methods

- There is the "triage" method used in Spain that is worth learning more about and implemented – more on prevention
- Leeds do a community space approach, I think. That would be good
- There is a need for "warm banks", but they could be used as more than plasters
    - Could place CVSs/charities in there to help signpost to more activities/SP offer
- Issues with conducting surveys/interviews on people who *do* come is that it is often the same people who come.
    - You end up surveying the same people over and over again.
- You also have the issue of a response bias in who it is that actually responds to surveys
    - Only ~1.3% of people sent the survey actually responded

9.3. Barriers to Community Uptake

Lack of awareness of offer / need

- People are not aware of the local offer
    - This is common, but may be due to various reasons outside of not having seen adverts
        - Not because they don't need offer, but because they don't ***know*** they need the offer
        - It becomes white noise until they actively look for something specific.
- Lack of acknowledgement of need until it is too late (and it is crisis)
    - "just a bad day" -> bad week -> bad month…
- Ways in which services/offer are found/located is important:
    - Word-of-mouth is the most common way for most people to find out…
        - But if you are lonely, you already don't have access to this way of finding the offer.
- There are outreach issues with social prescribing (creating a lack of awareness).
- Having the social prescriber aware of what the offering actually looks like is important:
    - Helping understand potential barriers and ***how to get around those barriers***.

Specific Barriers: Money, Anxiety, Time, and Transport (MATT)

- Transport (or, lack thereof) as a major barrier to attendance
- The cost of services may be an issue, especially as the cost of living crisis worsens.
- Some people don't have the time to attend these activities (or the activities are run at the wrong time)
- Social anxiety is a very clear problem in many social prescribing clients
    - They don't turn up due to anxiety
- Not explaining the value well enough to potential participants: "This is worth X, but you can go for free" may be more successful than simply offering something for free.

Digital Literacy, and General Literacy Issues

- Telephone/Digital interfaces to sign up can lead to a barrier for digitally illiterate individuals.
- The 'Digital Agenda' is negatively affecting residents with low levels of literacy and/or digital literacy, or lack of access to computer/internet
    - Especially the elderly
- There is a strong post-pandemic expectation that people will use online forms to apply for things such as benefits etc., but many people need support to complete these long and complex forms
- Digital poverty means that elderly people cannot talk to their grandchildren online, exacerbating loneliness

- Better English and Maths foundational qualifications are needed in schools, as well as more digital tuition
- The NHS also tends to use technical terms and jargon that residents sometimes struggle to understand
    - Residents can't follow this up so there is a barrier.

Migration – Language barriers

- Recent census data shows a large increase in Eastern European individuals in Mansfield. Second only to Nottingham (City), but without the resources and infrastructure of Nottingham.
- Limited English knowledge can be an important barrier to migrants accessing services and receiving appropriate support
- Also, a language barrier limits their ability to volunteer: volunteering is especially valuable for migrants, as it helps them to become citizens who are integrated into the community, and to experience the benefits of community membership and belonging
- There is a small fund to help support Ukrainian volunteers as a way to boost their mental health, language skills, citizenship, etc.
- Many Ukrainian refugees have been housed in affluent rural areas, which encourages feelings of isolation due to lack of transport links and social events
    - Assumption of having own transport
- Arrival of migrants changes the community dynamic, and impacts on services and opportunities, and their demand.

COVID Legacy

- Many people remain quite isolated/socially anxious after COVID, which can affect engagement-especially young people
- COVID was a very specific moment in time, when communities came together to volunteer via WhatsApp groups and social media; people had time off work and had time to support their neighbours. But this has now been lost, mainly due to people going back to work, but need for support has remained
    - Volunteering numbers are not the same

9.4. Challenges of Integrating Health, Community, and Local Govt. Services

Talking past each other

- Using the wrong language with, say, County Councils, can lead to duplication of services, or effort, when working together with what already exists could be done instead.
- Services can adapt themselves given the right point of view/framing
    - Not "instead of", but "as well as".
    - Services that already exist can upscale better than starting something from scratch

- Issue with lack of information: 3 users [of our activity] were referred via a link worker
    - Not enough information comes with them (we didn't know their needs, or why they turned up, just that they were referred)
    - There was no follow-up from the link worker/social prescriber
    - The only information we gained was through asking questions of the person.
        - This can lead to issues if there is something we would need to know to ensure the person's safety/integration ahead of time.
    - There is a need to "close the loop", as it were
        - Social prescriber should come back to check in to see how the client is doing, to see if it worked out
        - This has not been occurring, in our experience

Co-ordination with other parts in the chain

- How do we bring them [GPs/link workers] in?
    - Has there been a discussion around how we help social prescribers/link workers/GPs to enable them to do their job better/more easily (not just asking how we can benefit from them)
        - Is there an offer shortage we can solve?
        - Is there a lack of communication on our side, too?
    - How do we enable the workforce on the other side to be able to help us?
- From a system POV:
    - Is this system something that is robust?
    - Does the system's design enable someone to do their job well?
        - i.e., does doing it this way actually help people at each level?
- The POV of charities
    - Were the charities/deliverers of the offer involved in the evaluation process, or the referral process?
- Social Prescribing gives GPs yet another thing to think about during appointments: residents with chronic challenges already need a lot of hand-holding
- A big issue is that CVSs are not consulted enough by the 'Social Prescribing system'.
    - Charities want to help, but they don't know what is needed by the social prescribers

Change in language needed

- Volunteers collected evidence base to enable the funding to be given to help ensure information transfer.
    - It is important to change the conversation with those up the chain to make it in their interest to help you [those lower in the chain].
- How to use relationships/language to help make KPIs make sense.
    - Can a single strong case study mean more than a survey showing X number of people attended?

The need for co-ordination between CVSs and Council

- Council/NHS should include CVSs in discussions on where funding should be allocated/which projects to run to find out if there are already similar/the same offerings in the area.
    - Often something new is favoured over something that is already working.
- The need to reduce duplication (or triplication) of work done
    - Lots of "community surveys" by council/government are conducted asking the same/similar questions, but then follow-up doesn't happen. Instead, a new set of similar questions are asked.
    - Such community surveys can lead to "community fatigue", and disengagement from all activities by the local community.
- CVSs and community groups are already integrated into the local area. Councils can utilise these already-established connections and activities instead of trying to start things up from scratch every time.
- Council/NHS tend to want to fund things that stem from their own ideas/area instead of including CVSs.
    - In-group/Out-group dynamics.

Mismatch of KPI and Realities

- This makes me think of doctors/nurses in palliative care. Often the discussion is around what they ***think*** patients want, but often doesn't comport with what patients <u>actually</u> want.
- We need to demonstrate that we actually meet the needs of the community, not simply **<u>assume</u>** that it meets the needs.
    - This is where the language of evaluation is important
    - Just having a service there may not help if people can't get to it/use it properly
- We want to deliver for communities, but often we are given excuses by funders that don't make sense.
    - This isn't fair.
- Re: KPIs
    - Setting service level targets
    - Funding for CVSs
        - Tell us what you need
        - Help us make the case
    - KPIs need to be discussed across different levels.
- People not knowing/realising that this [KPIs] can lead to manipulating data in some ways: excluding what didn't work to focus on what did work etc.
- KPIs in CVS contacts are often not what the community actually needs.
    - However CVSs still have to meet these KPIs.
    - Diverts time and resources away from doing actually useful stuff

Gap between local need and council assessment of need

- Sometimes the system itself can be a problem in getting people to engage with the help.
- There is a major issue with having priorities set by people much higher up who don't know what the local needs are
- There are now "County Health and Wellbeing Officers"…
    - What do they do (that isn't already being done)?
- Lots of duplication of work.
- Ability gap
    - Services are often delivered by a certain type of person: a very homogonous group of people
        - These can be more, or less, inclusive depending on location

> *Local Need compared to wider targets*

- Assertive Outreach was not set up to meet a specific need. This is good, as it can identify things. However, we are often forced to identify a specific need before we can do things.
- There is a major issue: GPs are targeting to meet specific KPIs
    - GPs, thus, want to see a return from social prescribing on those specific KPIs
    - They want quantitative outputs from social prescribers, but how can we give that every time?
    - Many social prescribers would find qualitative evaluation more informative.
- Council wants to create a "community hub" but without knowing (1) what should go into one or (2) without involving local charities who already know which needs need to be met
    - There is a disconnect between the local needs and the offer desired from the clinical/council side

Communication gap/Overuse of Jargon

- I didn't even know about new community/county officers being implemented, and it is my job to – there is a lack of communication at every level/between levels.
- Lack of communication to the charities is worse for charities:
    - Charities aren't told about changes to chain, or new community support roles etc., so do not know how to engage with those further up in the chain.
    - There are also FAR too many acronyms that they assume charities and the community will know about.
    - "Oh, you just need to talk to the ICB, who will tell you about the [3 letter acronym], and that can get you access to the [3 letter acronym]" What does that mean!?
- Even high-up professionals don't seem to understand it
    - Too much use of jargon

- What does "self-referral" even mean? Most people even in the system don't know, let alone the average person in the community

Disconnect between preventative and reactive action

- Social prescribers' aim is signposting, and to suggest pathways to longer-term help, etc.
    - However: GPs work on the acute/clinical model
        - It is very short-sighted
    - GPs don't acknowledge the role of preventive services due to their KPIs
        - Preventative services offer much more value for money
- Mansfield CVS is more of an 'infrastructure' approach to help build preventative measure, not react.
    - This means people don't want to fund it
    - The council etc. need to acknowledge the preventative value of the CVS
        - If you don't, it eventually goes away and all of the facilitating work they do can't happen
        - Suddenly community anchor orgs can't do what they need to.
- [local politician] said that they would like to emphasise prevention over reaction
    - Time may be right to argue for preventative care: strike while the iron is hot

Holes in the current pathway

- Do we need to bypass the current pathway to do Assertive Outreach?
    - In reality, bypassing the pathway is already happening
        - Just in an informal way in local communities
- This informal bypassing causes a post-code lottery.
- That we have so many issues with holes in the pathway at the moment already shows that the current approach isn't working
    - Something has to change
- Social prescribing is not meeting the CVSs where they are
- The important thing is finding people who have the skillsets to deliver what is needed
- Finding those with the skillset is CVS's role
    - If not funded, then those with the skills cannot be identified
    - Services need to be within the community… but if things fall apart there won't ***be*** a community
- Social prescribers are often asked whether what they do works/what has or hasn't worked. But they (GPs/Council) are currently failing in their job.
    - We need to ask them: "What have ***you*** been doing that hasn't worked?"
- We need to find a way of presenting this in a non-confrontational way to help them identify their own shortcomings without being accusatory

- Should there be GP training in preventative care?

Desire for more communication with/from funders/Councils .

- County Council have, thankfully, recognised they need to correct things. But how long will that take? Will they actually make those changes?
- County Council need to be in the room for discussions, and willing to listen.
- If they are not careful, the County Councils will 'kill-off' the CVSs [if they don't listen to CVS needs]

9.5. Funding and Sustainability – The impact of the Cost of Living Crisis

Cost of Living Crisis

- Cost of Living is fundamental to the discussion: residents cannot attend activities due to lack of money/inability to afford transport
- Some residents cannot afford to get to their GP in the first place
- Appreciation of financial issues is often missing from Social Prescribing, especially since financial struggling affects mental health, is intertwined with loneliness and family discord, and is stigmatised
- The high levels of debt and mental ill-health are beyond what service providers can support: many residents are unable to accept practical advice due to these more fundamental and complex problems
- Debt training is vital, as residents frequently describe suicidal ideation due to debt, and volunteers struggle to support this type of issue
- Residents often have quite chaotic lives, and may not turn up for debt training
- A Cost of Living crisis group was created to discuss the issues raised by the Cost of Living crisis and how to respond (foodbanks, social supermarkets, etc.)

Volunteer Shortage

- Many older volunteers have been lost due to issues such as later retirement and having to look after grandchildren due to family financial issues
- Far fewer people volunteering post-COVID too
- System partners think there is a large stable of volunteers ready and waiting to help in projects-this is not the case
- System partners are generally quite dismissive of volunteers and what they are required to do (e.g., not allowing them to claim for expenses)
    - Causes loss of volunteers
- Volunteers/voluntary groups often have to pay for resources out of their own pocket due to lack of funding
- Volunteers can no longer afford to be volunteers in a CoL Crisis.
    - They now spend their 'free' volunteering time helping family or friends, instead of charities.
- Volunteers are beginning to need to access help themselves, due to CoL crisis.

Changing Perception of cost

- £5/session seems to work historically
    - Cost-of-Living crisis may alter how much people are willing to spend on activities
- The disengagement caused by Cost-of-Living crisis may be hard to come back from
- Sometimes 'free' doesn't have a perceived value, so they don't turn up.
- Vouchers: attendance is still 'free' at point of service, but it could add perceived value to encourage attendance.
- What about payment that can be recouped (e.g., deposits)?
    - They pay £X, and they get back a portion each time they attend.

Issue of Short-Termism

- I can employ 'X' for some short period of time
    - I would prefer to focus on 3-year agreements, not 1-year agreements
- This (Inspiring Ashfield) was a new project, and was a single set of funding for multiple new 6-week offers.
    - This is different and may show different results to one (e.g.., P3's offer) that has run weekly for many years.
- We try to meld these things
    - Prefer to work with existing offers
    - Need a longer-term thing
    - 6-week short-funded programmes are difficult to work with, as they can be easily missed.
- It (short-term offers) makes the KPI data even more of a focus, with short-termism leading to a worse outcome, even if the data/numbers look good on the face of it.
- Longer-term programmes are definitely better.
- A lot of services lack funding, or are just short-term pilots. Need to do cost-benefit analysis to show how these initiatives actually save money in the long-term

Sustainability through organisational/systematic approaches

- It is also important to try and cultivate a service-user-to-volunteer pipeline to help with sustainability, and to reduce long-term training costs.
- The sustainability can also be encouraged at an organisational level.
    - E.g., a "safety net" system for offers: The service deliverer can use a set of funds to run a service for free for a few weeks, and then start to charge after there are people there, and pay back into the system for future services to take from.
- Sharing good practice is important
    - If we get funding at the CVS level, can we push it out to the smaller groups (e.g., even the ones without bank accounts)

Sustainability through indirect co-ordination with small deliverers

- It is not the deliverer's skill-set to seek out funding. We could co-ordinate with them to do it for them, to help get them to be sustainable
- However, it is important we aren't the "volunteering sector police"
- Need to protect the very small groups, as a funder refusing funds could knock the wind out of the sails of people who are not accustomed to rejection.
- It is important to be creative to help the smaller groups
- Direct vs. indirect delivery. Can CVSs set up things as a facilitator
    - Arbitrary boarders don't mean much to the general population, but do to us.
        - Can working together to help deliver things work?

Lack of sustainability caused by systemic issues

- Regarding Evaluations, Community Champions was well-received, it was evaluated, a report was made… and it now sits on a shelf. Even with this evidence, funders have said, effectively "computer says 'no'".
- The funders, sadly, are missing from this discussion. We need to hear from them what exactly they want.
- Until some funders change criteria, it will be difficult to work together to deliver things, or to have longer-term/repeat funding.
- Instead of re-funding a programme that was shown to work, Notts County Council took the "Community Champions" idea, but changed it slightly – over-complicating it – and causing issues with implementation, when we could have done it ourselves, given our prior experience.
- We need to jump through so many hoops, just to get £750 from the County Council, but they can spend loads of money on internal projects. It is a systems issue

Funding gap

- As a Social Prescriber, it is important to ask the individual "what do ***you*** want/need?"
    - But sometimes we can only offer the next-best thing, due to funding issues for offering
- ~77,000 visit/registered to GPs in Newark.
    - There are only 5 Social Prescribers for the whole region
    - Too many people for too few SPs
    - AND not all people are registered with a GP – some fall through the cracks
- The issue is that we need greater access/funding for Social Prescribing in order to get through the backlog
- Also, now we are seeing social problems (not health problems) going to the GP
    - Adult social care is drastically under-funded
    - People who are waiting for packages of care are sent home, but can't really live at home without the package

        - They end up bed-blocking in A&E due to the delay in package of care delivery
    - This causes more issues
- I would love to be able to have a person-centred approach
    - Issue is, without funding, you can often only do the next-best-thing
    - Same is true at the GP level and at A&E level
- As time goes on, activity offer has reduced due to CoL crisis hitting charities, too.
    - Transport is also now becoming more of an issue (cost of bus/fuel more a concern)
    - Minorities may not be catered to anymore
    - Lack of cultural diversity in some areas can be a detriment
- If a block of money followed the person that could help:
    - We could then set up things for that person more easily.
    - [NOTE: nods of agreement by others in attendance]
- Social Prescribers need to know the lay of the land
    - Sadly, money for scoping is going away, so we know less of the offer
- Issue with funding distribution:
    - Few bits of large funding CAN be gained, but lots of bits of small funding CANNOT be gained.
        - So, 1-2-1 help, or small group help that requires only small amounts of funding can't be offered.
- There is also now a volunteer shortage due to the CoL Crisis
- This is the issue with a person-centred approach without a person-centred funding. We can't help the person get what it is they need because the funding doesn't follow them
    - Next-best thing doesn't fit for everyone, and so they disengage.
- This brings us back to firefighting and the CoL crisis.
    - It will likely cause more issues as there will be more reliance on "next-bests".
- Charities have issues, too: who will offer it (volunteer shortage), who can ensure it is safe (first aiders etc. needed)
    - Costs money. ***Money doesn't follow the person***, so charities can't necessarily help the person with what they want/need.

Good Samaritan App

- Volunteers register with the app and can be assigned to local projects.
- In theory this should reduce the amount of work that CVSs do, but CVSs still need to provide volunteers with help in registering via the app
- CVS gets no feedback from the app, so no idea if volunteering opportunities have actually been filled
- App is 'anti-community': whereas the CVSs are embedded within the community, the app is more centralised and less place-based: loss of community knowledge and relevance

Evaluation

- Evaluation is not completed if all funding is provided to volunteers/activities immediately.
    - If funding is provided only after evaluation documents completed, may lead to more successful outcomes (in terms of evaluation)
- Council/NHS wants specific outcome information:
    - They want to know about an "X% rise"
    - This is, often, not useful.
    - There is a need to change the narrative on the evaluation perspective
- Effects of CVS projects are often longer-term
    - Project is often gone/has funding cut long before the positive effects are seen.

Demonstrating We meet Funders' KPIs is necessary, but difficult

- As CEO of a CVS, I work this way already. I have a business mind
- I am always thinking "how do we demonstrate things"
    - Including admitting what doesn't work.
- Navigating the two [did it work/didn't it work]
    - No one can be objective, but we do try to present things as though they are objective. Evaluation helps provide evidence for subjective arguments
    - Relationships are important
        - The things we are evaluating are services to help people. They aren't "just pieces of paper"
- Quantitative evidence gathering needs to happen for the decision makers to see evidence
    - The other side of things (interviews and Appreciative Inquiry) also need to happen for support of this evidence

Legitimising Assertive Outreach

- When approaching funders/local council etc. it is important to explain to them that this is what ***local people*** are saying [that they have disengaged for various reasons] and not just my opinion as someone who works for a charity
- This can lead to brokering a union with the local/district council
    - Trying to re-engage people so that we CAN address concerns.
        - This is the first step to actually addressing their issues/needs
- We find it difficult to evidence it
    - How can we say "by stopping X from ever happening I saved you £Y".
        - [Presenting a counter-factual universe isn't easily done]
    - We need to emphasise the benefit of getting people support ***before*** they reach crisis.
- We may need to be the ones to start the communication

- Those with clinical training end up not seeing the benefits of this approach
- Honestly, it [AO] happens by default, just informally.
    - However, it is challenging, and the informality leads to differing results
- We are already doing some of this with community anchors
    - We simply haven't previously recognised it as a named approach. Having a name attached to the approach could help. Make it more formalised
- How do we make this something that health practitioners want to engage with?

Person-Centred Approach vs. Area-Centred Funding

- Would a pot of money from SP work?
    - What if someone brought it along with them?
- This was once tried w/ disability, but it didn't work as planned.

10. CLOSING REMARKS

These six workshops were designed to meet the need to disseminate the findings of the Inspiring Ashfield Initiative, as well as helping to foster the place-based partnerships between the local stakeholders. The presentations within each of the workshops helped to deliver the information in a clear, concise way without overwhelming the stakeholders with irrelevant information.

Meanwhile, the discussions helped highlight some of the key take-aways from the Inspiring Ashfield Initiative that are useful for not only local partners, but also district-, county- and national-level governments. For example, highlighting what some of the challenges with integrating services are will help the larger organisations with addressing these challenges. We believe that highlighting the importance of the role of the third sector organisations, their volunteering, and how to encourage the sustainability of Social Prescribing as a whole is a key outcome of this set of workshops.

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