

The Mid-Notts Social Prescribing Pathway: A Scoping Study

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Nottingham Trent University, December 2020.

Executive Summary

1. From 1st of November 2019, Mid-Notts operates an all age Social Prescribing (SP) model (16+) that follows the NHS England SP model. NHS best practice guidelines and a co-production approach guided the development of SP service specification. The Pathway runs across the six Primary Care Networks in the area, covering a range of more and less affluent communities as well as more and less urban areas.

2. The economic and social characteristics of the communities served by the Pathway have shaped the demand for SP. Low job density, earnings, and education attainment across Mansfield and Ashfield contribute to higher levels of referrals with more complex social and economic backgrounds while Newark and Sherwood report higher levels of referrals reporting loneliness, anxiety and depression. Moreover, the catchment areas encompass both rural and urban areas, though ‘rurality’ is a complex concept including both geographical remoteness and ability to access different services.

3. In the Mid-Notts model, a system has been identified that can enable effective transfer of knowledge about patients’ needs along the Pathway, and monitor patients’ progress. GP practices compile a digital SP referral form with information about patient characteristics, reason for referral and service use in the three months prior to referral. Referrals are passed on to PICS via Ardens on SystmOne and then electronically allocated to the appropriate link worker in the PCN or at monthly MDT meetings within each GP practice. A system has been established for the practice staff to remain informed about patient progress, with a discharge letter sent to GP practices upon completion of the SP course.

4. At the core of the model is the dual role played by the Link Worker: they support individual clients as well as map and support the development of local community assets. This dual approach is essential in facilitating connection and efficient referral of patients from GP

practices to community support groups. Should the level of referrals be similar to the first two months, it is likely that the eight Link Workers employed in Mid-Notts will work with nearly 1,200 referrals annually. Link Workers aimed to offer the first appointment to those referred within two weeks of first contact (although this can be dependent on waiting lists for the service, and how many link workers work within each PCN) and then offer 6-12 appointments for up to 3 months.

5. Community group leaders unanimously described the positive impact of their groups for group members. Groups were reported to be beneficial because they were supportive and inclusive. For many groups, equity, non-hierarchical structure, shared group norms and careful management of group dynamics were important factors for maintaining the supportive nature of the group.

6. SP poses a challenge as well as an opportunity for local community groups. Both members of the public and group leaders agreed on the importance of integrating SP into existing community groups as well as the value of the careful matching of needs to existing provision, compatibility between new patient and group, and ensuring the existing groups can meet the needs of the most vulnerable. However, SP comes online at a time in which groups face a strain on resources. Financial support and sustainability of the groups were a serious concern.

6. There was variation in awareness of SP among the public and group leaders. Those that were familiar with SP, believed it aimed to address mental health and connection needs, as well as long-term conditions, highlighting the potential benefits it can bring. However, it does require a shift in understanding among patients away from the traditional model of medical support. Other potential barriers to uptake included the stigma of admitting to mental health or

financial difficulties and the belief that it is the individual's responsibility to address such issues, rather than relying on medical support.

7. The COVID-19 situation required prompt changes in how SP was delivered. Focus was shifted towards Link Worker supporting extremely clinically vulnerable to COVID-19 shielding patients, and other cohorts of patients identified via the CCG, GP surgery or Local authority, such as age range 70-90, living alone, learning difficulties, a diagnosis of dementia or with a high frailty score). Link Workers were encouraged to contact patients and discuss needs and create personal care plans remotely. Similarly, the support provided by the community sector was moved toward remote methods of delivery. While many residents have adapted to using online technology to keep in contact with family and friends, engaging in online groups and activities was reported to be more challenging. Group leaders also had concerns over funding and sustainability of their groups. However, a positive indicator of local community resilience under lockdown been a stronger sense of community spirit, with some participants reporting that they felt more connected than before the pandemic.

8. One crucial aspect in any newly established SP intervention is systematic evaluation of its effectiveness in addressing the needs of the patients and changing engagement with healthcare systems. This would require an assessment of the level of demand, the efficacy of identification and referral of patients, and a monitoring and examination of the experiences of patients as they progress through the pathway. A more detailed multi-method investigation would consider the dynamics of each service-use interaction with different healthcare and community group personnel and the role of SP staff in managing caseload and the emotional demands of their role. This knowledge could then be used to enhance the programme by providing enhanced advertising for the Pathway as well as tailored training and support to SP staff to enhance their provision.

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Preface

Social Prescribing is a potentially transformative approach to understanding and addressing holistic health needs within community settings. The roll-out of this initiative across England in 2019 has led to the development of many innovative and ambitious new models of Social Prescribing. The current report examines the Social Prescribing Pathway emerging in Mid-Nottinghamshire. Drawing on a variety of information sources, we have put together an initial sketch of the pathway design and implementation along with some assessment of how it is viewed by the community groups and members of the public. This is intended as a preliminary scoping study on which a more systematic and thoroughgoing evaluation can be based. Based on this work, we identify some of the strengths and early successes of the Pathway as well as some of the generic, locality-specific and emerging situational challenges faced.

Section 1: Background to the Programme

Introduction to the Report

Social Prescribing (SP) is a holistic approach to health service delivery which allows local agencies (such as Primary Care Staff) to refer people to a Link Worker who connects them with community-based support (NHS England, 2019). It is intended that SP will benefit individual health and wellbeing, improve community resilience, and reduce inappropriate health service usage. SP is a key part of how NHS England intends to mainstream personalised care as outlined in its Long Term Plan. Mainstreaming of this service across England has begun with the aim of making SP services available to the entire population by 2023.

As part of Nottingham Trent University's broader initiative to engage with Ashfield and Mansfield, the *Groups, Identities and Health Research Group* from the Department of Psychology undertook a scoping project in January 2020 in collaboration with Mansfield and Ashfield Clinical Commissioning Group. The *Groups, Identities and Health Research Group* has extensive experience of research into social factors affecting health and wellbeing and has conducted large-scale evaluations of NHS-based and community-based forms of SP in Nottinghamshire. SP is in the initial stages of roll-out in Mid-Notts (Link Workers in the region began accepting referrals from GPs on 1st November 2019). Therefore, the purpose of this scoping study was to capture the implementation of SP in Mid-Notts (including appropriate local variations among the 6 PCNs in the region). This report outlines the findings of the scoping study conducted between January and May 2020. We provide a detailed description of the Mid-Notts SP pathway (including how this is implemented in the 6 PCNs) generated from discussions with NHS staff involved in SP development and delivery. In addition, we report interviews and focus groups with members of the public and community group leaders to offer an overview of local people's understandings of and experience with SP, what SP currently

looks like within the community, what SP-related challenges are being faced, and how local SP initiatives could be improved in the future. This scoping study was in progress during the COVID-19 pandemic which impacted significantly on the work being conducted by Link Workers and community groups as well as the daily life of residents across the region. As far as practicable, the study team endeavoured to capture some of the COVID-19 impacts in interviews and focus groups with group leaders and members of the public.

1.1 Overview of Social Prescribing within the NHS

SP sits within the NHS Model of Personalised Care – an all-age, whole population approach that brings together a range of services (including those in the voluntary and community sector) to help support and empower people to manage their physical and mental health. SP is best thought of as a complex system comprising multiple stakeholders (Husk, Elston, Gradinger et al., 2019):

- The main method of **referral** is currently via primary care. Patients with complex social, emotional, and physical health needs are referred by their **GP** to a Social Prescribing Link Worker. NHS England guidance stipulates that in future all local agencies should be able to refer people to a Link Worker including (but not limited to) local authorities, pharmacies, the Fire Service, Police, social care services, and housing associations. In time, people themselves should also be able to self-refer.
- **Link Workers** work with clients to explore their personal needs and support them to select from and access a range of community supports. These supports range from community art classes to singing groups, from walking clubs to gardening, and include many other interest groups. They may also include self-help groups to support people managing specific health conditions. Finally, clients are also supported to engage with specific organisations and government departments for assistance with issues such as housing and finance support along with support with more complex issues such as

social care referrals or setting up care packages to remain independent within their home. NHS England recommends that Link Workers have a case load of up to 250 people per year and that their support for individual clients falls between 6-12 contacts over 3 months (this includes phone calls and meetings). Link Workers also have a role in supporting the local community and the Voluntary, Community and Social Enterprise (VCSE) sector including identifying gaps in local community provision. Link Workers should have excellent knowledge of local community groups, map community assets, recognise gaps in community provision and work in partnership with others to address these gaps.

- **Community groups** are an essential part of the SP system. As noted by NHS England (2019), they have significant expertise in the delivery of interventions that are aligned with the aims of SP and are embedded in their local communities. As such, they play a key role in the delivery of SP interventions and should be supported locally to receive SP referrals.

It is suggested that SP is appropriate for a broad range of people, particularly those who have one or more long term conditions, require mental health support, are lonely or socially isolated, or who have complex social needs (e.g., dealing with debt or housing issues).

As part of its SP guidance, NHS England (2019) has set out what good SP looks like for individuals, communities, and the health and social care system. At the **individual** level, there should be high levels of awareness of the availability and purpose of SP among the public, ease of referral, and a personalised approach to care that includes support to join and integrate into local community groups. **Community Groups** should host activities that provide a sense of meaning and community belonging as well as opportunities for SP beneficiaries to ‘give back’ to their communities through volunteering. **Communities** should become more resilient over time as greater numbers of people become involved in local community groups and

community development which ensures that these meet local support needs and are accessible to all. Finally, at **system** level, there should be collaborative design and commissioning of SP pathways to ensure that these are tailored to local needs. These partnerships should involve Primary Care Networks (PCNs), Clinical Commissioning Groups (CCGs), and local authorities, and representatives from the VCSE as well as members of the public. Community groups should be actively included SP and supported through funding.

1.2 The SP Pathway in Mid-Nottinghamshire

The Mid-Notts region comprises four areas: Mansfield, Ashfield, Newark and Sherwood. At the time of the scoping study, these areas fell within the responsibility of two CCGs (Mansfield & Ashfield and Newark & Sherwood). General practices are organised into six PCNs (Mansfield North, Rosewood, Ashfield North, Ashfield South, Newark, and Sherwood). See Appendix One for an overview of the demographic characteristics of each area.

The first aim of this scoping study was to describe the development and implementation of the SP pathway in Mid-Notts. This was compiled through conducting background discussions with NHS staff (including one PCN Clinical Director and eight Social Prescribing Link Workers) and one CVS representative as well as accessing documents describing the adopted SP model and updates on referral numbers as of 31 December 2019. Background discussions were conducted between 10 January and 8 April 2020.

When developing the Mid-Notts SP service specification, staff endeavoured to take a co-production approach and drew on NHS best practice guidance (outlined in Section 1.2) and local experience. They visited with existing Vanguard schemes in the Nottinghamshire area as part of a Nottinghamshire-wide SP Link Worker Task and Finish Group co-ordinated by the Nottingham & Nottinghamshire ICS. Those involved in developing SP in Mid-Notts met regularly as part of the Mid-Notts Partnership Board (including representatives from Local Authorities and local CVS) and subsequently decided to establish a dedicated meeting to

discuss SP provision. This allows for the monitoring of SP as it is rolled out in the region, including how it impacts other existing services and initiatives. Through this forum, funding (£35,000) was made available to support community groups to address specific SP development needs they had identified (e.g., volunteer ‘passports’ and mental health training for volunteers). The SP development process determined how many Link Workers to recruit, how to best place them in PCNs, the Link Worker induction offer, as well as issues relating to the pathway itself such as development of referral criteria, a referral process, and identifying opportunities and mechanisms for feedback.

It was decided to take a combined approach to SP across all 6 PCNs. Initially, seven Link Workers were recruited (1 Link Worker per PCN except for Newark which recruited two Link Workers). It was important that there was room for local flexibility (e.g., PCNs could decide to focus on a specific patient cohort initially and determine where Link Workers would be based). PICS (Primary Care Integrated Services Ltd.) carried out Link Worker recruitment (with the support of the Project Manager for the Personalised Care Programme) and hold responsibility for Link Worker line management. In accordance with NHS England guidance, Link Workers work with individual patients as well as supporting the local community. Knowledge of local assets is a key part of the Link Worker role (and was incorporated into their induction training). Over time, it is envisaged that Link Workers will identify gaps in community provision and work with community to develop services to address these gaps. Most Link Workers began in their role during September to October 2019 and participated in induction training. During their induction, they were required to:

- Complete all PICS mandatory training
- Complete Patient Activation Measure (PAM) training
- Visit each of the locality district councils (Newark and Sherwood, Mansfield, and Ashfield)

- Visit each of the locality CVSs
- Visit Nottinghamshire County Council
- Have an introductory talk with an ICS representative to highlight the wider system support available for Social Prescribing Link Workers
- Shadow their corresponding Network Navigator
- Attend Multidisciplinary Team (MDT) meetings
- Have an introductory meeting with CCG representatives
- Have a ‘walk-about day’ to identify lesser known community groups and present findings to the team
- Approximately one month into their post (towards the end of the induction period) to visit each practice within their PCN to introduce themselves

Mid-Notts operates an all-age model (18+) that follows the NHS SP model. The service is available to those with one or more long term conditions, who need support with mental health, who are lonely or socially isolated, or who have complex social needs. Referral to the Link Worker is initially through the GP Practice, in order to assess the volume of referrals from this source.

1.3 Pathway in Practice

1.3.1 Referrals

Link Workers began taking referrals on 1st November 2019. In practice, the primary care referrer (typically the GP but can be any practice staff member) completes a digital SP referral form (see Appendix A) that has patients’ demographic and clinical information, verification of consent to the referral, frequency of presentations to primary care in the previous three months, and reason for referral (physical health, mental health & wellbeing, social isolation, lifestyle change, self-care/management of long-term condition, benefits/financial advice, housing, employment/training, practical support). This is received by PICS where patients are allocated

to the caseload of the appropriate Link Worker. Through our discussions with Link Workers, we have also identified that referrals come through MDT meetings.

As noted earlier, a decision was taken when developing the pathway (in accordance with NHS England guidelines) that referrals initially would come only via GP practices. This would allow PCNs to determine the impact of this referral route on Link Worker workloads. It appears that demand for the service is high with all Link Workers reporting the use of waiting lists. An additional Link Worker was recruited in Ashfield North to deal with the high level of demand. In this PCN, work was also done to ensure that referrals were equitable between practices.

Referral criteria are in keeping with NHS guidance and encompass a wide range of issues and vulnerable groups. Ashfield North and Newark reported focusing on those patients that frequently attended primary care to build an initial caseload. While Link Workers across PCNs deal with a wide variety of referrals, they did suggest that some issues were more pressing in some PCNs compared with others:

- Social isolation and mental health issues such as anxiety and depression, particularly among young people were noted as prevalent concerns in Newark
- Financial issues were of particular urgency in Ashfield North
- Complex cases with multiple, overlapping problems were noted in Sherwood
- Similar cases in Mansfield were attributed to social deprivation
- Ashfield South reported seeing a lot of older adult referrals.

According to information supplied to the team, Link Workers received 196 referrals between November 2019 and December 2019. The top four reasons for referral were: mental health/wellbeing, social isolation, lifestyle change, support with benefits / financial advice.

1.3.2 Working with Patients

Once the referral is received, Link Workers engage in a triage process whereby they review patient medical information (including any health conditions, contact between the GP and the patient, frequency of A&E attendance and as well as any letters or notes on the system). Link Workers then contact patients by telephone to arrange an initial appointment. While there is a waiting list for Link Workers, they endeavour to ensure that there is a maximum of two weeks between this initial contact and their first appointment with the patient.

Patients are offered six to twelve interventions over a three-month period. At the end of this period, patients are discharged. Patients are encouraged to attend their first appointment at the GP surgery. Home visits are also available if appropriate, but Link Workers tended to discourage these to deter 'dependency' among patients. Appointments can also take place in community centres (when these are available and can be paid for). Link Workers tend not to favour these locations for the first assessment appointment due to privacy concerns. The first appointment typically lasts for sixty to ninety minutes. The Link Worker explains SP to the patient and explores their needs with them, focusing on what matters to the patient. Patients also complete the PAM and EQ-5D-5L (a measure of self-reported health) at this first session (though Link Workers report using their discretion as to whether these tools are appropriate for all clients).

Patients often present with multiple, complex issues and in these cases (assuming the absence of safeguarding issues), the Link Worker works with the patient to prioritise their concerns. Some patients can be easily signposted to local groups and supports. These patients were reported by Link Workers to typically show an insight into the issues they face (e.g. social isolation) but might need some guidance in specific areas (e.g. groups they can join in the community). Consequently, these patients require primarily signposting support and may only need two to three appointments. Those with more complex needs and low levels of activation

(as measured by PAM) tend to need more intensive support (e.g., confidence building to get to a stage where they could start to build community connections). Multiple sessions are often needed to build a trusting relationship whereby the patient feels comfortable discussing the challenges they face.

When supporting patients to build community connections, Link Workers tend to connect patients to groups with whom they are familiar. Matching the patient to a group is achieved through a conversation with the patient, considering their physical health (e.g., whether there are any mobility issues) and their interests. Link Workers will speak to group leaders in advance to check that the information they have for the group is correct and to notify them that a new patient will be attending or check that the group has capacity. For those who need it, Link Workers will attend the first group meeting with the patient. These steps are taken to facilitate a smooth first contact with the group. In addition to supporting community connections, Link Workers also reported that they provide one-to-one support to connect patients to services that can assist with housing, debt and benefits.

1.3.3 Community Development Work

As noted earlier, Link Workers also have a role in supporting the local community, including identifying gaps in local community provision. In Mid Notts, it is recognised that this aspect of the Link Worker role is in its early stages. Link Workers do build on their existing connections and local area knowledge by networking with local organisations and CVSs as well as walking around the local area to identify groups that might be suitable for SP referrals. Each Link Worker collates and shares this information with their colleagues. However, many groups are 'hidden' and so mapping of local assets is needed. CVSs can access funding to support Link Workers in this exercise. Link Workers have already identified some gaps in provision (e.g., groups to help with social isolation in young people in Mansfield) but have not

yet at this early stage been involved in developing new groups (for which funding might be required).

1.3.4 Working with Practice Staff / MDTs

There are some spaces in which Link Workers can feedback to other healthcare professionals on patient progress (at MDT meetings) and the service more generally (at PCN meetings in the case of Ashfield). As noted earlier, they are involved in MDT meetings where they can provide feedback on patients. In some instances, they also attend practice ‘protected learning time’ (PLT) where they present patient case studies. Their attendance at PLT events is seen as important in helping practice staff understand who should be referred to SP and deter inappropriate referrals (especially in the area of mental health). On discharge, referrers are provided with a copy of a letter detailing the interventions offered to patients and their progress. Before this point, referrers can access the Link Worker notes on SystemOne to review patient progress.

1.4 COVID-19 Pandemic and Social Prescribing in Mid Nottinghamshire

In March 2020, the emerging COVID-19 situation necessitated a swift response by primary care teams. NHS England detailed a specific COVID-19 primary care operating model and guidance on its implementation. This included guidance on how Link Workers could support patients identified by practices as high-risk. This involved support of individual patients (making contact, discussing their needs, creating a plan, mobilise local volunteers/groups to support the person, making follow-up calls) and engaging with the community sector by co-ordinating VCSE, local authority, NHS Volunteers, and community groups to implement personal care plans. It also entailed supporting voluntary organisations and groups to move to virtual service delivery and supporting local public health teams to provide COVID-19 training to volunteers/community groups. GPs/PCNs were also advised to ensure that patients who were identified as vulnerable (i.e., with significant social and emotional needs but not on the high-

risk list) should be supported to ensure their condition did not deteriorate. PCNs/GPs were advised to build SP Link Worker capacity within their practices to support this.

While most of our background discussions were completed before the pandemic, we were able to speak with one Link Worker afterward to gain an overview of the work being done in Sherwood PCN. As per the guidance, the Link Worker noted that face-to-face attendance at surgery was being limited and they were primarily providing telephone support. They were still working with their existing caseload and regularly phoning these patients. A large part of the role was reported to be liaising with the community sector such as food banks and community services offering volunteer support (e.g., phone calls to those isolating or helping those shielding/vulnerable to access food and other essentials). Finally, the Link Worker had also offered to generate a list of practice patients that were housebound in order to complete wellness checks.¹

1.5 Conclusion

NHS best practice guidelines and a co-production approach guided the development of the Mid Notts SP service specification. The Pathway began receiving referrals in November 2019 and runs across the six Primary Care Networks in the area, covering a range of more and less affluent communities as well as more and less urban areas. Link Workers noted that the economic and social characteristics of the communities served by the Pathway have shaped the demand for SP. While Link Workers have responsibility for both supporting individual patients

¹ The team were provided with additional information following completion of background discussions with Link Workers on the additional work they completed during the first national lockdown. In addition to their own caseloads, link workers also completed wellness checks on cohorts of patients identified via GP surgeries as well as responding to GP referrals for immediate crisis work. Potential referrals were also identified via the CCG and the Nottingham County Council COVID Support Hub. Link Workers worked with a range of patients including: those aged 70-90, those who held a diagnosis of dementia or learning difficulties, and those who were housebound or severely frail. Between March and June 2020, eight link workers across Mid Notts completed 2561 telephone wellness checks supporting patients with food and medication deliveries, telephone befriending, and assisting with support around emotional well-being and isolation.

and local community development, the former currently takes up a greater proportion of their workload.

Section 2: Views from the Community Groups

In this section, we explore the experiences of those leading and participating in community groups in the six Mid Nottinghamshire Primary Care Networks. This qualitative study includes interviews with group leaders with a variety of experiences and knowledge of SP. It includes group leaders who have accepted patient referrals through SP or alternative referral routes, e.g., via social care and local charities, as well as those who operate locally and independently, without links with the community and voluntary sector. The study also includes the accounts of group leaders who have initiated contact with the social prescribing pathway but who, due to current restrictions related to the COVID-19 pandemic, have been unable to start receiving referrals into their groups. Finally, the study includes group leaders who are not currently involved in social prescribing but are interested in doing so. Details of the groups included, and their current referral pathways are provided in Table 2.1.

These interviews provide deeper insight into the functioning of third sector organisations within Newark, Sherwood, Mansfield and Ashfield and explores their perceptions of the key benefits and challenges involved in SP service delivery. This includes responding to local community needs; the challenges and opportunities involved in running the groups; supporting patients and community members; the future of the groups in relation to SP programmes; and suggestions for effective management of community referrals.

Semi-structured interviews were conducted between February 15th and June 24th 2020 with thirteen group leaders from eleven groups (5 male and 8 female, ranging in age from 39 to 72 years, average age: 54 years) and lasted between 23 minutes and 51 minutes (average length = 37 minutes). Twelve of the interviewees lead groups on a voluntary basis and one is paid to run sessions. One of the volunteers interviewed defined herself as a previous social prescribing service-user. Originally, interviews were conducted based on group location (four interviews). However due to COVID-19 social distancing restrictions, eight interviews were

conducted either over Skype (two interviews) or over the telephone (seven interviews). For two groups: ‘One Conversation’ and ‘Mansfield Veteran’s Support Group’, two group leaders asked to be interviewed together to share their views and to aid clear communication. In addition, two group leaders led multiple groups such that all three MIND groups were led by one group leader, and the same volunteer led ‘Blidworth on the Move’ and the ‘Abbey Medical Centre Patient Participation Group’.

Table 2.1 below includes details of the groups or activities that interviewees help run or lead. Of the groups represented within the analysis, three received most or all their group members via referrals and signposting. The remaining eight groups currently have few or no group members who have come to their group via signposting or referral. Additionally, some groups are relatively new whereas others are more established in their communities; some have been supported by social prescribing or the VCSE from their outset and others have been set up independently. Due to this, their experiences are varied and the group members they discuss are not always social prescribing service-users.

Transcripts were analysed using ‘thematic analysis’. This provided a systematic overview of the ways in which group leaders understand and respond to community needs within their groups and their knowledge and recommendations for integration with the SP Pathway. This approach enabled identification of common features within the accounts and a comparison of where these understandings and experiences converge and diverge across the participants. The following section outlines the findings of the analysis.

Table 2.1: *Characteristics of interviewees' groups and activities*

Group/activity	Year group was set up	Typical no. of session attendees	Current attendees signposted to groups via other routes (Average %)	Attendees signposted through SP (Average %)	No. of additional volunteers at group/activity	Primary Care Network Location
Peace of Mind Allotments	2002	12	91%	9%	0	Mansfield
One Conversation	2019	14	0%	0%	0	Mansfield
On Your Doorstep	2014	200	95%**	5%	5	Mansfield
Pilates and Callanetics	2017	7	14%	0%	0	Ashfield
Eastwood Arts and Crafts Group	2017	12	83%	Unknown	0	Ashfield
Diamond Hub Special Needs and Seniors Group	2019	25	0%	0%	4	Ashfield
Eat Bake Sing	2015	20	100%**	0%	0	Ashfield
Dance Is Yours	2019	20	Unknown	Unknown	1	Ashfield and Newark
MIND Groups:		7				
i) Banterbox,						
ii) Chatterbox	2019	10	70-80%	Unknown	0	Mansfield & Ashfield
iii) Friends Together		10				
Mansfield Veterans Support Group	2015	11	91%**	9%	11*	Mansfield
Blidworth on the Move/Abbey Medical Group PPG	2020	16/12	0%	0%	16/12*	Newark and Sherwood

* Group leaders described all members as volunteers in these groups; **These referrals were described as 'self-referrals'.

The results of the interview study are captured across four primary themes with associated sub-themes presented below in Table 2.2

Table 2.2

Results of thematic analysis of interviews with group leaders/volunteers

Primary Theme	Sub-themes
1. Responding to community needs	1.1 Community needs 1.2 Supporting community members in groups
2. Challenges in running community groups	2.1 Practical issues and resources 2.2 Group dynamics
3. Responding to Social Prescribing	3.1 Knowledge and experiences of social prescribing 3.2 Moving forward with social prescribing
4. The impact of the COVID-19 pandemic on community groups	4.1 Current impact on groups 4.2 Responding to COVID-19

2.1: Responding to community needs

2.1.1 Community needs

Whilst interviewees led groups in different areas, they often shared similar views around the needs of individuals living in their areas and considered their groups to be helpful for addressing those needs and improving health and well-being. A key feature of group leaders' accounts was a recognition that communities, particularly Mansfield and Ashfield, struggled both social and economically with issues such as poverty, unemployment, loss of services, lack of infrastructure, and fear of anti-social behaviour. These issues were observed in tandem with an acknowledgement of a growing need for services to address increasing difficulties with poor mental health within communities. There was also a sense that the communities, and marginalised subgroups within them, such as older people, people with learning difficulties and disability, and people from specific populations within them (e.g., veterans), needed support.

Extract 1

Mansfield is an ex-mining town. There is a lot of umm... underlying health problems as a result of that. I know it's very low down on the list as far as umm... poverty and deprivation, obesity and by lots of social measures Mansfield and Ashfield don't rate that well, but part of that is the underlying problems from mining and we got lots of people with breathing difficulties... so how do you resolve that well, you either spend an awful lot of money on it or you come up with new idea ... you notice very quickly that quite a few of the people coming were actually looking to make new friends and wanted an excuse to get out the house on a regular basis... and what we were trying to do with it was to reach out to people who are lonely, isolated, low self-esteem (Group Leader 3, Mansfield),

Extract 2

The direct local community was an ex mining village umm... and there are large pockets of poverty, deprivation umm... families living on benefit, low income, health issues are high both in respect of long term conditions and short term conditions... and respective resources for employment success in education umm... the number of health issues in the population umm... so this raises all sorts concerns. (Group Leader 12, Newark)

As well as recognising the importance of tackling the wider determinants of ill-health, there was also recognition that community members needed to forge new friendships with people they had something in common with, enhance their social networks, and find new opportunities for development.

Extract 3

I feel like there's a lot of value in trying to offer new things... and I feel that it's worthwhile to... particularly to offer dance because there's also quite a lot of health issues ... um I think that this areas got the lowest, one of the lowest take ups for creative or artistic activity in the country and quite high level of unemployment and poor health. They [the Ashfield group members] are really supportive with each other ... and so they will maybe need to chat and get together and talk about what they've been dealing with that week. I think it's a real lifeline for that group. At Newark that's more like a group of friends... and I think it's a support network. They run their own groups... so it also means that the participants have active roles within the group which has an impact on their sense of identity, sense of worth in the community, sense of self... (Group Leader 8, Ashfield and Newark)

Extract 4

It's promoting independence the opportunity to meet likeminded people in a group setting and meeting new people

(Group Leader 9, Mansfield and Ashfield)

Extract 5

...maybe people who come through the advent of the more choice about things, they can move on to other groups easier... we've been able to push our members to different groups, if they wanted to go on to other groups. (Group Leader 5, Ashfield)

However, group leaders argued that many communities did not have enough resources to meet their community's diverse needs. These issues were commonly described as being 'social problems' that impacted negatively upon the lives of residents in terms of both well-being and opportunities.

Extract 6

I wouldn't say there's an awful lot of um sort of mental health support in Ashfield itself. In Mansfield it's a lot different but in Ashfield [there] is not an awful lot of support for

people that are struggling you know like different groups or diverse groups. I've done a variety of different umm... sort of groups, you know I just think there's a need for it you know, it's just one group doesn't fit all so I like to put as much... different things in there to suit everybody's needs really. (Group Leader 9, Mansfield and Ashfield)

2.1.2 Supporting community members in groups

Group leaders unanimously described the positive impacts of their groups for group members. Although some groups 'vetted' new members and operated in-house referral systems for those joining via word of mouth, most groups were described as easy to access and flexible in terms of required attendance, and all stated that they were welcoming towards new members. They typically gave accounts of their groups as supportive, inclusive, and relaxed, and as places where members could speak openly about their experiences and form new friendships. Even when groups congregated to take part in focussed activities, such as dance, cooking, or art, space was purposely created for conversation and support during the sessions and emergent friendships often extended outside of the groups.

Extract 7

It just seems to be a lot of friendships that they make between people umm... people keep in touch and I've made a lot of new friends that are you know they're not just my [group members], I value them as my friends. (Group Leader 7, Ashfield)

Extract 8

They contact each other on a Facebook group, they are a younger group so they keep in touch with each other, and the older group, less technology involved, but they will ring each other and check upon each other whether they are coming out or are the okay and that sort of thing ... it's really nice that they're all concerned about each other - they care.(Group Leader 6, Ashfield)

Group leaders frequently identified shared experiences and understanding between group members as underpinning the successful impact of group membership. Group members' empathy, kindness, and an appreciation of other members' complex circumstances (as well as that of their families and carers) was seen as important to group functioning. These characteristics were also deemed important for group leaders, some of whom reported having been the beneficiaries of community referrals in the past. Indeed, group leaders' own past experiences were often cited as reasons for engaging in their activities as a means of paying something back to their communities and in recognition of the challenges associated with experiences of marginalisation and/or mental and physical ill-health.

Extract 9

As I said I set up... set up with [an employee] from the NHS and umm... because I felt that there was a need for [a] support group specifically for [this population] from Mansfield and the Mansfield district because I thought we [were] sort of like excluded and sort of like...

Interviewer: And why did you feel excluded?

I just didn't feel that there was anything there for the people of Mansfield... its more me... the fact that there is no umm... I think it's because I don't drive and I find it difficult to communicate... I sort of like... I've been self-isolating for decades you know... (Volunteer 1 (previous Group Leader), Mansfield)

Their commitment was evidenced in their desire to expand their work in the communities by creating new groups and engaging in activities to support further 'hard to reach' populations, e.g., new parents, people experiencing food poverty, and people experiencing insecure housing/homelessness. Given that most group leaders run their group(s)

on a voluntary basis, this sustained commitment is vital to the future of community group provision within the four PCN areas.

Extract 10

Oh it can keep going for a long time I think it's just gonna, just keep going... I want to expand and do different sessions; um I mean I've done one at the homeless shelter in Nottingham before ... that was really good because it's basically... it's about building confidence and self-worth. It's going to help a lot of people, ahh, I just can see it you know the amount of people that could come and benefit from just being with other people, because I feel really isolated now to be honest... and I'm ready to go back out there and do something so, and I used to feel like this when my children were small.

(Group Leader 7, Ashfield)

2.2 Challenges in running community groups

2.2.1 Practical issues and resources

Whilst the groups were viewed by all interviewees as valuable and important community resources, group leaders did experience a series of challenges associated with running them. These challenges tended to vary with location. Where group leaders felt the group was in more of a rural location (Peace of Mind allotments, Mansfield; One Conversation, Mansfield; Diamond Community Hub, Ashfield; Blidworth on the Move, Newark), they commonly cited issues with lack of transport to the groups. Group leaders were concerned that this would mean they could not be accessed by everyone who would benefit from attendance. Group leaders sometimes reported having transported members to group sessions in their own cars to overcome this.

Extract 11

We had a gentleman that used to come but he couldn't get here on his own. When somebody brought him, he used to come and enjoy it and then a couple of times the helper would say 'I'll meet you here' and he would come and I would say 'Where's [group member]?' and he would say 'He ain't come, he must be still in bed' ...the helper said 'we can bring him for a couple of weeks but after that he's got to make his own way', but if you're coming from somewhere that needs two buses it's not as easy as people think (Group Leader 1, Mansfield).

A second frequently cited challenge to the running of groups related to availability of premises. Whilst some groups benefited from local spaces that housed multiple groups, e.g., the Diamond Hub, several described struggles with both locating and maintaining a permanent venue for groups. For others, their problems with finding premises has been solved via connections with local authorities or other community and voluntary sector organisations. Although at times, the loss of these links or changes to the nature of the group meant that new venues and ways of working had to be found.

Extract 12

Groups, they always ran in the centre, so the actual community is brand new and it's not been easy to get people into the community; it's been it's been really difficult to be honest. I think umm... everybody's got quite comfortable in the centre setting, they feel safe, they've got the privacy and going into the community that they don't feel as safe, they don't feel that they've got that privacy to speak how they want to speak.

(Group Leader 9, Mansfield and Ashfield)

However, ongoing links with organisations proved particularly advantageous when groups were faced with resource and administrative challenges such as securing funding and setting up a constitution.

Extract 13

Logistically I suppose... the money thing although I've you know I'm sorting that now with having the bank account and applying for funding you know before I self-funded everything and I've always been out of pocket but I've stuck with it because I thought it would lead to something and you know it is leading something. (Group Leader 7, Ashfield)

Extract 14

One particular challenge was setting up as a charity umm... knowing the what you needed to do and we were fortunate there because [Resident] who runs the Community Church - that's a registered charity - so at the moment we were piggybacking, ...you need to have an organisation that like sponsors you, you know just trying to be a charity straight away isn't that easy but we've been told you know normally what we did in three weeks takes two or three months umm... we've had problems getting a bank account... it actually took us 2 weeks ... and if you go for grant funding umm... they want your bank account. I've been doing the work I do as a volunteer for the last 10 years and before I worked in the community, so I got the links (Group Leader 12, Newark)

Finally, several group leaders stated that the engagement of group members, both in the initial stages and in terms of sustained attendance, was a concern for them because of the potential impact of a lack of members to the sustainability of their groups. Whilst, one group

leader in Ashfield felt that this was an issue with a general lack of community engagement in new activities in an area she described as having lots of ‘social problems’, others felt that this could be a result of group dynamics and/or the ways that group members were introduced to new groups.

2.2.2 Group dynamics

Several group members described their groups as non-hierarchical in structure and emphasised the importance of equity and shared responsibilities between group leader, volunteers, and members. They cited the role of clear, shared behavioural group norms for maintaining the supportive nature of the group. For example, group members understood they needed to treat others with kindness and respect, and responsibility for welcoming new members was shared across the group.

Extract 15

We are all kind of in it together, I don't see myself as like the leader we are all just there together...With a community group that we do, you know the normal community [activity], I think it's just being welcoming and being...kind to one another sharing and helping... (Group Leader 7, Ashfield)

However, most group leaders described the management of group membership and group dynamics as being a central part of their role. For instance, group leaders described the removing group members who had proved disruptive within the groups by being domineering or disrespectful of other members. Group Leaders intervened if they observed cliques forming at the expense of other group members.

Extract 16

We don't just let anybody come and do it, you've got to be like-minded (Group Leader 1, Mansfield)

Extract 17 –

I make sure that there's no segregation, there's no little cliques, because I am very very conscious of the fact that somebody new walking through the door, they get greeted, they get made welcome, and they get included, because there's nothing worse than someone [being] like an outsider especially when you've made the effort to come out because you need help or support. Yeah, so, we are very very careful to make sure that there's no cliques no nastiness of any description. (Group Leader 6, Ashfield)

As well as monitoring interactions within the group, group leaders also made sure that new members were assessed for their 'fit' with the group. For example, group leaders ensured that new members would not adversely alter existing group dynamics, that they would be accepting of established group behaviours (e.g., honesty, trust/confidentiality, language use), and that their needs and behaviours were able to be effectively supported.

Extract 18

Whenever we're having conversations with people coming in and we say 'would this person would be good for the group' umm... because it is a group for social change umm... not a babysitting service in a sense and I think that though that sounds and [can] be interpreted as a kind of harsh way of looking things, we think it's incredibly important to narrative changing around this population because if you're thinking about this would be good for you, you'll be kind of looked after... then that's not going to work. (Group Leader 2, Mansfield)

As well as controlling any negative behaviour to reduce problematic group interactions, the group leaders also described taking an active role in supporting members' well-being and

some described providing one-to-one support and advice for some of the group members. Many of the group leaders considered themselves as critical in the welcoming and settling in of new members. They provided accounts of their careful management of introductions into the groups during new members' first visits and several described meeting new members individually in advance of their first group session to help overcome issues with anxiety or shyness.

Extract 20 –

I always ask them at the end of the session 'now I will be seeing you again won't we?' and I say 'if you feel like coming, you must come and if you want to come by yourself, just come in a wee bit earlier and then you could come and see me cause I'm always there a bit earlier.' Because I know what it's like to walk into a group and feel a bit intimidated... you've got to make people feel comfortable and that's part of my job.

(Group Leader 5, Ashfield)

These behaviours were considered essential to the experiences of groups members, the impact of the group on their health and well-being, and the sustainability of the groups.

2.3 Responding to Social Prescribing

Group leaders' recognition of the importance of community needs, the challenges of running groups, and the positivity of group dynamics and members well-being were all closely linked to their feelings towards the challenges and opportunities offered by social prescribing and its implementation in their areas. However, knowledge of the details of social prescribing processes and resources varied widely.

2.3.1 Knowledge and experiences of social prescribing

Many group leaders had heard of social prescribing and were aware that it was part of the NHS Long Term Plan. Few had a good understanding of the details of the current social prescribing model and this tended to be characteristic of group leaders who had been referred to SP

themselves, had links with the CCG in relation to other roles, e.g., PPG groups, knew Link Workers within their own social networks, or had received help from link workers or community navigators in their area. Other group leaders were aware that GPs had signposted to their group and they had used this knowledge to recruit new group members but stated that this had begun before the inception of current social prescribing initiatives and that VCSE connections had brought their group to the attention of local link workers informally.

Extract 21

I've always been involved with the local community because umm... previously I've been an umm... governor for a hospital trust, I've been umm... a chair for the local GP PPG (patient participation group) group so I have always been involved. Part of being involved was social prescribing, because I came across social prescribing the first time about 10 years ago as a result of that...and to me it just seemed to be a no-brainer of an idea. (Group Leader 3, Mansfield).

A few group leaders stated that they were already receiving social prescribing referrals and that Link Workers had attended their groups to help facilitate entry into the groups. However, this was limited to only a few interviews, and in some cases where group leaders felt they might be receiving GP and Link Worker referrals, they could not be sure because data protection regulations meant cases had not been disclosed. This lack of information was perceived as a barrier to monitoring and providing accurate support.

Extract 22

We don't know who the social prescribers are the working with... because of GDPR I only get, they refer some people to me if they've got a specific need, particularly if they need food or umm... if they need a bit more befriending and that again is because of

trust and past knowledge of what you can provide you know. (Group Leader 12, Newark)

Many more group leaders were familiar with community referral processes in more general terms because their group had received community referrals from other sources, such as local branches of charities (e.g., Framework, MIND, NottsHelpYourself, and Self Help UK) and social care providers. Whilst others were generally familiar with social prescribing through more complex and remote pathways, for example, because they had received group members from organisations that had received those referrals from Link Workers at an earlier stage.

Extract 23

Interviewer: Are you aware of Social prescribing?

Group Leader: I am aware of it but not under that name if you know what I mean...I just knew that people were moved around by social workers and things I didn't specifically know about the doctor although I knew you could go to the doctor and get things recommended for you.

Interviewer: So, do have patients refer to your group from those social workers and things?

Group Leader: Yes, I do, most people with learning disabilities are prescribed and some of the mentoring... the MIND people are the same...

(Group Leader 5, Ashfield)

Finally, some group leaders had little knowledge of social prescribing but expressed a willingness to become involved and make connections with Link Workers and GPs, because they felt it would be an effective way of attracting new group members. Although some

believed that there was a need to be recognised and registered and this constituted a barrier to full integration with the SP model.

Extract 24

The [Link Workers] that we are already in touch with that works fine, the question is: are there other people with GP practices more generally? If they got patients who would benefit from socialising or low level activity then as well as sending them to everyone health or Active Notts or whatever, then it might be that some of them are suitable for us, but how do you actually tap into that because it would appear that you need to be formally recognised and accredited whereas basically I've got track record and that's it? So, you know, we're never going to take a lot as a result. (Group Leader 3, Mansfield)

2.3.2 Moving forward with social prescribing

Group leaders suggested some recommendations for how social prescribing and Link Worker interactions with their groups should proceed. A frequent concern regarded Link Workers' knowledge of the groups and their ability to make good matches between groups and potential members and to identify patients that would fit well with these groups. Several group leaders suggested that Link Workers would be well advised to attend their groups on several occasions before making any referrals to them. However, it was recognised by some that Link Workers may not have the time to do this given their workloads.

Extract 25

Well obviously we would like to meet the Link Workers for one and have that conversation with them and obviously I would make them aware of what are groups sort of consist of, what they are for you know, and obviously get a picture of what that the patient my might need you know - is it supportive listening, is it community? - so

just having all the information possible to so I can make that decision as to which service that I would put that person in (Group Leader 9, Mansfield and Ashfield)

Extract 26

I think if you are on the social prescribing pathway the Link Worker would not bring the person first, they would bring themselves and see what the group's like, talk to you about the group and if they find people that need a voice then those people might be the ones that are referred in, not just any Tom, Dick and Harry. (Group Leader 2, Mansfield)

Group leaders also identified Link Workers' role in the introduction of group members to groups as being an area that could be improved. For example, it was noted that Link Worker attendance on the patient's first visit to the group was valuable and effective at helping patients to settle in and overcome anxiety but it was noted that this is not always possible or that these visits can be brief and typically only occur once, which can lead to patients not returning. Whilst others echoed these concerns, they also felt that patients introduced through Link Worker and GP referrals may not fit in quite as easily as those who made links via word of mouth as they would be less likely to know people.

Extract 27

They rang up and I said we'll bring him with this, his carer or helper, what you call it... yeah Link Worker, and [Link Worker] came with him took him around and he enjoyed it and he came a couple of weeks [but the Link Worker said] once we've introduced him to- we can't take him all the time. (Group Leader 1, Mansfield)

Extract 28

The Link worker will pass them [patients] on but usually it's done by her giving them one of our leaflets and she will explain what we are, what we're about and send them along...she doesn't come along formally to introduce them to us but to be fair...she's very busy at the moment so we don't actually see her on any of the walks. (Group Leader 3, Mansfield)

Extract 29

I think that somebody who's been referred rather than come through word of mouth as a friend of a friend will possibly just- it might take a bit longer for somebody to... to settle in and to become a part of the group ... I just think sometimes if people know that somebody is a friend of someone that they already know I mean it's a shame in a way but that's the reality of it. (Group Leader 8, Ashfield and Newark)

Other Group leaders cautioned against Link Workers not spending the time to get to know their groups, potentially resulting in them introducing a member that may disrupt group dynamics. In addition, some felt they should know the history of the new members where appropriate to ensure effective safeguarding of their existing members.

Extract 30

If they've got like a serious issue you know depending on their mental health umm... problem I mean, and obviously if someone's being mentally or physically abused we've come across people in the past umm... sort of we've got quite a few ladies ... that have been abused physically in the past and then obviously we've been sent them and then without the full information ... sometimes within the past we've not always had the full picture of the information and then maybe this persons been put into a mixed group. So obviously if somebody comes with a problem like that then we have to be very careful. (Group Leader 9, Mansfield and Ashfield).

For some group leaders, concerns were more practical and related to issues such as the costs associated with some groups, the need to ensure referred patients have reliable transport links to groups, and that groups run at appropriate times for them. For instance, one group leader highlighted that groups typically do not run in the evenings and this is not appropriate for referred patients who are employed during the day or are experiencing mental health problems. Whilst one group leader also expressed concern over whether her areas (Mansfield and Ashfield) had enough groups to meet the diverse needs of the communities.

Extract 31

Yeah, it's not the evenings and weekends [when Link Workers are supporting patients], seriously man this is what needs to happen! ...if you're going to do something that's going to make a change, do it properly ... it's tokenistic otherwise because it is just, you not thinking of these people as humans you're just thinking of it as all numbers in boxes and ticking and 'look at us changing, people aren't killing themselves as much', well they will be because they still are on their own in the evening and weekends!
(Volunteer 2, Mansfield)

Finally, one group leader suggested that the social prescribing model itself was not appropriate for some patients who did not enjoy social situations and suggested that alternative provisions need to be created to respond to their needs.

Extract 32

Not everybody wants to go to a group and is not a group person and this is where one model doesn't fit all'. (Group Leader 12, Newark)

However, despite these concerns there was a general positivity in relation to the opportunities that social prescribing offers and a desire for information on how to contact GPs

and Link Workers to become known to them. There is also recognition of the benefits offered by social prescribing to their groups in terms of both the size and diversity of group members. Finally, across interviews there was a consensus that by attending to the impact of social issues and utilising community referrals, social prescriptions can provide an effective source of support for community members that is sensitive to their needs.

Extract 33

We've got these social prescribers being appointed and I'm very optimistic that it will make a difference because basically social prescribing in my view is nothing short of a revolution for GPs, because until now GPs have addressed symptoms, whatever patients have presented, social prescribing should hopefully make them see the patient rather than symptoms.(Group Leader 3, Mansfield)

2.4: The impact of the COVID-19 pandemic on community groups

2.4.1 Current impact on groups

The COVID-19 pandemic and associated restrictions have placed an unprecedented pressure on community groups who are used to meeting in person regularly. Whilst some group leaders have set up online groups using social media and messaging platforms and have hosted online meetings; others have struggled to maintain contact with their members and describe a feeling of hopelessness and concern.

Extract 34

I can't make contact with anybody, I can't umm... because of groups I work with are so vulnerable and on the whole don't have access to Facebook Lives and YouTube and things like that. They are older vulnerable people I don't have contact with people and I'm really really concerned about the impact it is having on the people with dementia...

because of the lack of routine... and there's nothing I can do...(Group Leader 6, Ashfield and Newark)

Several group leaders have tried to engage with their chosen group activities using online videos and tutorials, for example, arts, cooking and crafts but it is recognised that this is a poor substitute for in-person interaction and there is a concern that some parts of the groups and communities are less likely or able to engage with these activities.

Extract 35

I'm just trying to do the lessons online, trying to set up Zoom for umm... doing lessons online but because I am not very good on the Internet, so we have the first trial today the same time that we have the lessons at 3:30. So I hope that I am going to work like that because they are very, very happy to start again, even online. (Group Leader 4, Ashfield)

Extract 36

I try and be positive. In my newsletter sent out some positivity and they can keep in touch with what's going off but I just... I've had this conversation with someone the other day that not everyone's online. (Group Leader 7, Ashfield)

Whilst group leaders have tried to adapt to the needs of these members of their groups, for example, by calling older group members on the telephone, most report experiencing communication difficulties with some of their members. Where this has combined with concerns over funding and sustainability and lack of group leader support, it has led to an extremely difficult period for group leaders.

Extract 37

I'm looking for funding at the moment actually looking for funding to bridge this gap but at the same time... FareShare who we have our food delivery from every fortnight I've said to them look with the centre is closed we have no money to pay you, but they chased funding there still going to hopefully be able to supply us with food so that we can help these people that need it. The landlord, I've said to him I'm very sorry but we are not going to be able to pay the rent ...I turned off the gas completely...and I cancelled BT broadband and phone... (Group Leader 6, Ashfield)

Most group leaders who were familiar with the Link Worker role were aware that referrals were on hold and Link Workers were primarily taking part in well-being phone calls rather than appointments with patients. The unpredictability linked with this, and the structure and nature of the pandemic recovery phase left many group leaders concerned about the future of their groups.

2.4.2 Responding to COVID-19

Several group members shared their worries over the future health and well-being of their group members whilst groups are unable to meet. However, in some cases group leaders had made plans for the future. For example, one group member outlined plans to support the development of computer literacy for her older and less technologically able group members using intergenerational support from young volunteers. Whilst others described software they were using currently and how they hoped it would be developed further to improve group communications.

Extract 38

All of a sudden we have this pandemic and now it's finding different ways of working so you know going online and having to get a bit more techie but it's been really good

and everybody has adapted to it really well; it's very positive. I've set a group up online and it's called 'GroupMe', it's fantastic, it's just absolutely amazing...so it's running now and...this is the third week we've been running it now umm... and we put some structure into it...on a Monday we have a challenge day so...it could be a drawing, it might be baking a cake. (Group Leader 9, Mansfield and Ashfield)

Others described a sense of concern that COVID-19 related restrictions to Link Worker practice would mean that their integration with social prescribing would be delayed and their groups may not receive the referrals they need in the future. Further concerns relating to funding and social distancing in the future were also shared. However, one group leader shared an optimistic perspective by suggesting the current crisis had meant that previously unknown groups were now making links with link workers, local authorities, and the VCSE sector to gain much-needed support and that this may eventually result in a better connected network of community groups.

Extract 39

Before COVID-19 the support groups weren't sort of easy to identify, now with COVID-19 they are being able to identify more that's out there because of need and people talking together so I know that they're... because they both [Link Workers] were new to the area before this [and] had no knowledge of this area at all. So, it was all knowing what was out there. The knowledge previously came from CVS, which is fine in one way, but each village has its intricacies and support groups and actually for years the NHS tried to develop a sort of a book of support groups but it never happened because it's an ever changing scene (Group Leader 12, Newark)

2.5 Conclusion

Our interviews with group leaders have demonstrated their shared understandings of the needs within their local communities. These understandings commonly involved a recognition that

residents' needs involve both physical and psychological issues and can be the result of wider social and community determinants. There was also a recognition that some areas, particularly Mansfield and Ashfield, had additional issues relating to poverty, lack of infrastructure, and lack of opportunity, whilst other areas (for example, parts of Newark and Sherwood) had relatively better transport links and were more affluent (although this was not consistent across these areas). There was also a shared appreciation of the role of community groups and community referrals in addressing community members' needs effectively to empower and develop confidence.

It was also evident that groups were considered to have had a positive impact on members due to the social and interpersonal bonds created within them, despite the variety of activities and support offered at these groups. Effective groups were characterised by open, trusting, supportive and respectful relationships between members and group leaders were pivotal in managing group dynamics and the introduction of new members.

Group Leaders were keen to continue the work they were doing and thus shared some concerns around the future and sustainability of their groups. This concern may be justified given that some groups leaders reported issues with engagement and barriers such as transport links, especially within rural areas. Additional challenges such as the need to access funding and venues for group activities were also shared and it was evident that links with the VCSE, local government, and Link Workers helped in addressing some of these issues. Building effective networks therefore benefitted both their organisations and service users within the community by unlocking resources, information, funding sources, and access to members via referrals. Group leaders' experiences often varied in accordance with whether groups were set up in partnership or with support from the local council or VCSE or whether they pre-existed in the community. In the latter case, group leaders expressed a desire to build more

connections and engaging with social prescribing was viewed as one way of doing this, whilst also becoming more familiar to GPs and Link Workers and gaining more group members.

Those already involved with social prescribing shared recommendations for more effective Link Worker practice to ensure a better fit between patients and groups, minimal disruption to groups, and sustained patient attendance. There was also a desire for open communication with Link Workers workers concerning who was coming into their groups and when in order to facilitate targeted support.

Finally, in relation to responses to the COVID-19 pandemic, it was reported that many groups had instituted online meetings and several had plans for further adaptations. However, it was not uncommon for group leaders to report that communication with group members had been difficult, particularly in groups with older members or those with limited computer access or skills. This lack of communication, along with concerns about funding and the sustainability of groups has resulted in a challenging period for group leaders and group members. Nevertheless, the building of community resources facilitated through social prescribing was felt to offer a means of ensuring future referrals into their groups. Group leaders were therefore eager for social prescribing practices to resume, albeit with attention paid to their suggestions and recommendations.

Section 3: Focus Groups with the Public

This section details the findings of two focus groups conducted with members of the public in April 2020 to explore their awareness of and opinions towards SP. The three participants in the first focus group were all members of the same Pilates and callisthenics group based in Kirkby and were recruited for the focus group by the group’s leader. The two participants in the second focus group were recruited due to their membership of the Trent Ageing Panel (a Nottingham Trent University database of Nottinghamshire people aged over 60 who are willing to participate in psychological research). They were from Kirkby and Ravenshead. Although the method of participant recruitment was diverse, both groups featured participants who engaged in activities taking place in their community. The participants were all White British and 67 years or above (see Table 1 for further demographic information). This means that their experiences are likely to reflect those of older Nottinghamshire people.

Table 1 Focus group participant demographics

Focus Group	Pseudonym	Gender	Age	Ethnicity
1	Angela	Female	80	White British
1	Jennifer	Female	74	White British
1	Sue	Female	76	White British
2	John	Male	67	White British
2	Abigail	Female	79	White British

A focus group schedule was developed, which covered all the key topics of interest (e.g., the participants’ awareness of SP, their attitudes towards it, and their thoughts on how to ensure that those most in need of SP are able to access it). Two researchers co-led both focus groups, with both asking questions and guiding the discussion. Due to the COVID-19

pandemic, both focus groups took place via video conferencing. Participants were encouraged to discuss their views and opinions on a range of topics, while also commenting on each other's views. This dynamic allowed for rich and in-depth discussions, where participants made sense of ideas through discussing them with each other. The first focus group lasted one hour ten minutes, while the second lasted one hour forty-seven minutes.

The analysis of the focus group data was conducted by looking for common patterns within the participants' responses, with a focus on the issues that were central to the scoping study. This included the participants' experiences of loneliness (including whether the COVID-19 pandemic has exacerbated any feelings of loneliness), their awareness of SP and their attitudes towards it, their thoughts on how to ensure that those most in need of SP are able to access it, their opinions about how SP is advertised, and their awareness of local groups within their community.

Although the participants in the two focus groups were recruited in very different ways, a number of broad similarities were evident across the two focus groups, especially in terms of the participants describing themselves as not feeling lonely due to them drawing on family and other social groups as sources of support and companionship. Participants in both focus groups also highlighted that they would be unwilling to speak to their GP if they were lonely, and shared the ethos that it is the individual's responsibility to address such issues within their own lives, rather than relying on medical support. Within both groups, participants had little awareness of the term 'Social Prescribing', but most were aware of the general concept behind it, even though few had direct experience of it. Participants in both groups were also aware of the range of social groups within their local community.

Unsurprisingly, there were also differences between the participants in terms of their levels of social engagement. These variations in engagement mean that the participants brought

a range of perspectives and opinions to the focus groups, creating rich and useful discussions. In the analysis that follows, the participants' discussions are grouped by theme. Within each theme, key points of agreement and disagreement are highlighted.

3.1 Coping with loneliness

Participants were first asked to discuss how they cope with loneliness, and whether they would be likely to approach a health professional when feeling lonely. While none of the participants reported feeling lonely, they said that they would be unlikely to visit their GP if they did. For instance, in the first focus group, Angela described how she felt that "it's up to me to take some steps to put it [feelings of loneliness] right, rather than use the health service", and that she would only visit her GP "if all other things had failed" and loneliness was severely impacting her health. John agreed in the second focus group, feeling that he should do "some checks on himself first" before visiting a doctor with symptoms of loneliness. Both he and Abigail argued that this reluctance to approach one's GP over loneliness issues may be generational, as they were alive during the NHS's inception and early days, making them highly aware of the need to only use the service in case of emergency, and not to be overly-demanding on its limited resources.

3.2 The Effects of The Covid-19 Pandemic on Loneliness

As both focus groups took place during the COVID-19 lockdown, discussions around loneliness quickly turned to exploring the impact of lockdown on participants' social worlds. In general participants talked about having to adapt to the restrictions imposed on them. Anne in the first focus group described using video conferencing to contact friends and family. However, participants also noted downsides to these new methods of communication: in the second focus group, Abigail mentioned the importance of her family in helping her stay socially connected, and highlighted her frustration at only living a few doors away from her daughter and grandson, but being unable to interact with them. While she was able to use video

conferencing to see them, her grandson's severe autism limited the efficacy of virtual interaction, leading her to worry that he would forget who she was during lockdown:

Extract 1

It is very frustrating. I know I can go out and meet them outside but in the case of my little grandson, he happens to have special needs and he is very severely autistic and if he didn't get a cuddle from Gaga, his name for me not mine, he would have a... he would have a meltdown, so there is no point in us meeting you know even to wave so... we've not seen each other for the whole lockdown period you know. (Abigail)

However, participants also mentioned that they were experiencing a stronger sense of local community spirit during the lockdown, with John in the second focus group explaining that he actually felt more connected than before the pandemic: "everyone seems to smile and wave, you know, shopping at Sainsbury's is kind of bliss at the moment, because everybody seems to smile and miss you". Abigail also noted that efforts to support community members during the pandemic (such as the village bus being used to deliver groceries to vulnerable people) highlighted this stronger sense of connection. These feelings of connection seemed to be strengthened by the regular 'Clap for Carers' event at 8pm on Thursdays, with John describing how everybody in his street comes out of their houses to clap and socialise:

Extract 2

My wife leads the pan banging exercise and the whole... you know the cul-de-sac comes out and it probably then lasts the next social thing for 20-25 minutes as people, from a distance, talk to each other (...)you know I think the 8 o'clock community thing is, you know, for so many things it's a boon. (John)

Later in their discussion, John and Abigail also noted that the pandemic had highlighted how many people are willing to volunteer in their community, with John talking about how the crisis had perhaps raised the cultural status of volunteers:

Extract 3

Well in actual fact people now feel that you know they can do [volunteering], you know there is a lot of benefits from doing it, and it's not to be something... let's say just slightly looked down on (...) you know it is a part of- it should be a part of... you know, everybody's life. (John)

3.3 Awareness and Opinions of Social Prescribing

Once participants had discussed their broad understandings and experiences of loneliness, they were asked to talk about their understanding and experiences of 'Social Prescribing.' In the first focus group, neither Angela nor Jennifer had heard of it, while Sue understood it to involve "suggestions of things you could do to improve your mental health" but knew little beyond this. In the second focus group, Abigail was familiar with the concept, but had not heard the specific term, while John was the most familiar with SP, and the only one who had direct experience of it. John and Abigail described the term SP as "jargon" and "civil-servant speak" and felt that it was unlikely to resonate with the public. John also described how he had mentioned SP to his wife (a midwife), who said that she was involved in the linking of patients to the community, but that she did not think she would ever use the term SP to describe this activity. However, both Abigail and John liked the concept at the heart of SP, and John discussed his experiences of it in positive terms.

John's GP had encouraged him to lose weight and prescribed him a place on a privately-run weight loss group. Abigail's GP has also recommended weight loss for her, but she joined Slimming World independently of her GP. Both had been successful in their weight loss. In

discussing John's experiences of SP, both John and Abigail agreed that it was very important to avoid a 'one-size-fits-all' approach, and to ensure that patients are placed into groups that suit their interests, personality, and abilities (for instance, Abigail noted how it would be useless to send a non-swimmer to a swimming club). John also talked about the need for a continuous dialogue between patients and health professionals, to ensure that the group is appropriate for the patient, and continues to benefit them over time:

Extract 4

I think there needs to be a bit more dialogue between the health professions and the patients, a bit more respect for, perhaps sometimes, you know, rather than saying 'doctor knows best' or 'nurse knows best'. (John)

Both John and Abigail highlighted the need for good communication between health professionals and patients in order for this dialogue to occur but recognised that good communication was not always present in such interactions.

The participants in the first focus group had less to say about the topic of Social Prescribing than the participants in the second focus group, mainly because of their lack of awareness/experience of it. However, in the second focus group, John and Abigail thought more widely about the potential effects of SP on pre-existing community groups. John used his membership of the University of the Third Age (U3A) as an example (an organisation to which Sue and Angela in the first focus group also belong) and considered the possible implications of patients being prescribed membership of his group. In particular, he argued that there was a risk in health professionals sending severely unwell patients into pre-existing groups, as it could affect the groups' dynamics as they struggled to support such individuals:

Extract 5

you can open up a whole can of worms [by recommending] people to go to a group (...) well they have had quite big dislocation effects on the group because we can't deal with people with those kind of problems. (John)

Angela in the first focus group also noted that GPs are extremely busy, and may struggle to socially prescribe in addition to their other duties:

Extract 6

The only thing that I can think of that worries me slightly is that the doctors (...) are excessively busy (...) I wonder if they are going to manage to fit in this sort of work. (Angela)

3.4 Targeting Social Prescribing Towards Vulnerable Populations

Once participants had conveyed their impression of what SP entailed, they were encouraged to think about how SP initiatives could be promoted and targeted towards some of the most vulnerable groups in society, including those living in rural communities, those with mental ill-health, and those facing debt.

When thinking about those in rural communities, both John and Abigail in the second focus group agreed that having a car was important when living in a rural community, and that a car could make people feel less isolated, as a car makes towns and cities (and the social groups within them) more accessible. In the first focus group, Jennifer agreed, explaining that having a car meant that she did not really feel “rural”, as she could access places easily. However, as Angela noted in the first focus group, not everybody has a car, and Abigail in the second focus group commented that sporadic public transport is a significant problem, as rural busses often

stop in the evening, and many groups meet after 7pm. This can lead to people being able to get to group, but not being able to get home again, which can prohibit participation:

Extract 7

It's pretty difficult if the groups that you are told to go to only meet in the evenings, I know some of them are like that, and buses tend to finish at sort of 6:30 – 7 o'clock in the evening type of thing, and you know you can get there but you can't get back, you know that sort of thing has to be taken into account. (Abigail)

Abigail suggested that the use of video conferencing to allow people to 'call into' groups could help with this problem, as could having groups that specifically take place within rural areas could help with this problem.

Participants in the first focus group were all members of a Pilates/calisthenics group, so had specific concerns about being able to easily access their group. They discussed how social groups could make themselves more accessible to rural community members. Angela suggested that groups could move around, and use village halls in different rural locations:

Extract 8

What about the possibility of trying to set something up in the local area, so, for example, it depends how regularly you wanted to hold these things, but, if you had it in a small village hall or something (...), perhaps do that for say three sessions and then set something up in another one? (Angela)

Additionally, Sue noted that she has a relative who is involved in a car-share to allow people to attend her tai chi group, which is an effective way to solve transport issues. Ultimately, the participants agreed that people living in rural areas have specific needs and challenges that SP initiatives should be addressing.

When thinking about those with mental ill-health, Abigail in the second focus group talked about her daughter who experiences mental health problems, and the challenges she faces. Although she would like to join more groups, the practicalities of taking care of her young son limit her ability to do so (“she has only got a limited amount of time with the little lad that she has got to cope with type of thing, and that’s not helping either you know so, it is it is a very difficult issue”), highlighting the need to ensure that patients’ life circumstances are taken into account when prescribing community groups. John and Abigail also noted that the need for good communication between healthcare professional and patient was especially important in the context of patients with mental ill-health, as listening to the patients’ specific needs and challenges was vital. This point was echoed by Sue in the first focus group, who described how she had been recommended to attend Alzheimer Association Meetings to help support her late husband. Her concern was that attending these meetings and hearing about the illness might make her feel even worse (“somebody said it might make me more depressed than I was to start with”). As with people living in rural areas, the participants thus agreed that people experiencing mental ill-health faced specific challenges that would need to be addressed by an effective SP initiative.

When thinking about those facing debt, Abigail in the second focus group described how her local hospital had referred her to Age UK when she admitted to experiencing financial issues after her hip-replacement operation. A representative from Age UK had helped her to complete her benefits claim form, which meant that she received benefits which substantially enhanced her financial situation:

Extract 9

Because she [representative from Age UK] filled in the form properly for me, I have got that [extra money], and it’s thanks to that I now no longer have financial issues, I

can do things, you know, I can buy things for myself that I did need but I couldn't afford.

(Abigail)

While Age UK is a charity rather than a community group, Abigail's story highlights the need for SP initiatives to be aware of the relationship between financial health and physical/mental health, and to ensure that patients' financial issues are addressed where possible.

However, both John and Abigail discussed the sensitive nature of finances, which they agreed may make patients unwilling to discuss such matters with healthcare professionals. This was echoed by Jennifer in the first focus group, who discussed her previous employment with the Citizen's Advice Bureau; an experience which had made her aware of the stigma surrounding financial problems, and how people were often unwilling to discuss such issues, especially in a group context. Angela suggested that an initiative which focussed on health and wellbeing (which she noted are intimately related to financial issues) might allow people to feel less embarrassed, as the focus would be taken away from the sensitive topic of financial problems.

Angela in the first focus group also highlighted the fact that debt can make people lose self-confidence, which can hamper their attempts to join groups. These barriers were also mentioned in the second focus group, but here John and Abigail focussed on the idea that group membership can bring its own costs (e.g., transport costs, attendance costs), which can be prohibitive for those in financial difficulties. There could also be a risk of embarrassment if fellow community members see that the individual is struggling financially, and is unable to attend groups, a point echoed by Angela in the first focus group:

Extract 10

If they don't go to anything because they haven't got a penny to spare, then people say 'oh you could join this, and join that, and the other' then they've got to come up with some sort of, you know, reason why they can't, or they will feel a bit pressured I think.
(Angela)

Again, the participants recognised that those in debt experience specific challenges, and that effective SP initiatives need to address these.

3.5 Opinions about the Social Prescribing Advertisement

In both focus groups, participants were shown the NHS 'What is Social Prescribing?' leaflet and were asked to comment on it. All participants liked the leaflet's focus on colourful images of people in community groups, but noted that the pictures were predominantly of young and able-bodied people with healthy body mass indexes, which is perhaps unlikely to be an SP initiative's key demographic. Generally, participants said that they would welcome photographs that span a more diverse range of people, so that patients are more likely to conclude that the initiative is 'for them', with Angela noting:

Extract 11

I'm just thinking about those people who are, well possibly obese, possibly have some condition that makes them unable to do much movement, and you are looking [in the photograph] at two quite active-looking groups, and often they [obese people] feel socially uncomfortable because they are so large and they can't move properly, or get up and out of seats. So you know, was just thinking that maybe something that has somebody like that in the picture (...) 'cos the nice little group there [in the leaflet] looks nice and healthy, if you know what I mean, on the left-hand side (...) it looks like anyone's garden party (...) not somebody who is perhaps, you know, ill, shy,

uncomfortable, and extremely large and immobile (...) it looks frightfully healthy, this leaflet. (Angela)

Abigail and John in the second focus group also felt that the leaflet contained quite a lot of information, and that this could perhaps be simplified in places. John also felt that the message “Talk to your doctor, health professional or local authority [about SP] today” which appears in the leaflet could seem unrealistic to patients, as it can take weeks to get an appointment.

In terms of maximising the leaflet’s visibility, Angela and Sue in the first focus group felt that the leaflet needed to be placed in a wide variety of locations, especially those likely to be visited by vulnerable groups (e.g., those in debt or those with mental ill-health). They suggested places such as local supermarkets and other shops, the Citizen’s Advice Bureau, Voice (a local community magazine), the Post Office, Social Services, and related facilities such as Meals on Wheels, and Council offices. They also suggested sending the leaflets in envelopes with Council-related letters and bills, and advertising on local radio.

3.6 Awareness of Local Groups

Finally, participants were asked to discuss their awareness of local community groups, and whether they had any experience of these groups. Both John and Abigail in the second focus group mentioned that they were aware of a range of groups in their local area. Abigail mentioned her membership of her church (which has continued though lockdown via video conferencing: “My church is in Nottingham, I attend it at the present moment because it is live streamed, so I go to mass every Sunday online”), but linking back to their earlier discussion on issues within rural communities, Abigail also noted that the evening meeting time for many groups within her community was sometimes prohibitive for her, as well as the fact that she considered herself to be a ‘non-joiner’ (i.e., not a person who regularly joins new groups):

Extract 12

There is a lot [going on], but none of it is of any interest to me again because (...) I'm not a joiner, I've never have been, and so much of the stuff that goes on, goes on without me. (Abigail)

On the other hand, John's car ownership allowed him to attend group meetings with ease, and he described himself as a 'joiner', who belonged to many different groups, including cricket, tennis, and University of the Third Age. More generally, both were aware of a range of groups and events taking place in their locale (even if they chose not to join in), and they described how the community's monthly newsletter allowed them to keep abreast of these groups and events.

Like John, Sue and Angela in the first focus group had positive experiences of U3A and described the various U3A-organised events that they have attended, such as reading groups and walking groups. Jennifer talked about her membership of a Zumba group, as well as a Pilates/calisthenics group. Participants in the first focus group also discussed the numerous groups and events in their area, including a varied range of groups listed by Angela:

Extract 13

There is an Evergreen Club, there are one or two Men's Gardening Sheds, The Voice [community magazine] has got quite a lot of things, there is Rotary (...) Over-50s Club (...) and also in some of the church halls and things (...) there are activities, I think they have Mothers' Groups, they have Older People's Groups. (Angela)

In general, then, participants were aware of the wide range of social groups and events taking place locally, even if they chose not to attend.

3.7 Focus Group conclusions

The focus group participants talked about a wide range of topics surrounding SP initiatives, and the dynamic nature of the focus group methodology meant that they were able to think about and explore their attitudes towards SP, as well as taking other participants' attitudes on board whilst forming their opinions.

Although recruited in quite different ways, participants agreed about many issues, both within and across the focus groups. For instance, participants showed a clear awareness of the well-established relationship between loneliness and health/wellbeing but noted that they would be unlikely to visit their GP due to feeling lonely. These discussions suggest that an important obstacle for effective SP interventions is getting eligible participants to approach health professionals in the first place. Indeed, although not explicitly an issue for the participants in these focus groups, this raises the wider problem of people not perceiving loneliness as a health concern in the first place: research suggests that while people are well-aware of the important role played by behaviours such as healthy food consumption in affecting wellbeing, they generally underestimate the importance of social connection, and are rarely aware that such connections are just as important (if not more important) for health as engaging in activities such as regular exercise and smoking cessation (Haslam et al., 2018). This suggests a need for health professionals to make the public more aware of the health-related perils of loneliness and to encourage people to integrate social connection into their understandings of holistic self-care. Succeeding in these endeavours would increase the likelihood of patients taking feelings of loneliness seriously and discussing their concerns with a health professional. For now, however, the focus group data suggests that primary care staff will need to be proactive in asking patients about their social/emotional health during routine appointments, as it is through these more incidental conversations that people's eligibility for SP initiatives is likely to be revealed.

In terms of SP itself, few participants were aware of the term (with some even expressing active dislike for it), but all supported the ethos at its heart. This highlights the need for health professionals to think carefully about the branding and framing of SP initiatives: while the concept seems intuitive to patients, and is easy to grasp, phrases that are seen as ‘jargon’ and ‘buzzwords’ might seem off-putting or overly-complex. Conducting focus groups with patients who are explicitly asked to discuss issues regarding branding and framing may help to avoid such pitfalls.

While participants’ limited experiences of SP were positive, they also highlighted important reservations that they had with SP initiatives, such as the strain under which it might place both community groups and health professionals. In terms of challenges for community groups, these findings indicate that SP initiatives must be designed and implemented in a way which allows community groups to operate as they always have done, without feeling over-stretched by the arrival of many new members with complex health needs. It is also important that groups are able to maintain their sense of identity whilst being involved in SP: if SP changes the group’s ‘essence’, then pre-existing members are likely to become unhappy, and perhaps even leave the group.

In terms of the increased workload for health professionals, this links back to participants’ general unwillingness to ‘bother’ their GP about ‘unimportant’ issues such as loneliness, which is likely to be further exacerbated by an awareness that the GP is already very busy. This highlights the importance of considering primary care staff work-loads when creating and implementing SP initiatives: if patients get the sense that health professionals are already rushed and over-worked, they are unlikely to want to engage in sensitive discussions regarding loneliness and its impact on their wellbeing.

When asked to think about the people for whom SP might be most beneficial, the participants recognised that SP would be particularly relevant for vulnerable groups (people living in rural areas, people with mental ill-health, and people facing debt). However, they also identified that these groups face specific and complex challenges, and that any effective SP initiative would have to involve addressing these. For those living in rural areas, issues of transport and access to groups were paramount, with people potentially feeling more ‘cut off’ due to not having a reliable way to access social groups. SP initiatives may thus need to look quite different in rural areas compared to urban areas, as they will have to address these specific challenges of access (e.g., through ‘touring’ groups around different village halls, or integrating convenient transport or car-share schemes into the initiative as a matter of course).

The participants recognised that patients with mental ill-health are also likely to face important obstacles to SP engagement, and that their ill-health would need to be considered when they are helped to choose suitable community groups to join. This spoke to the more general issue of the need for there to be clear and frank dialogues between patients and healthcare providers, so that SP initiatives can avoid a ‘one-size-fits-all’ approach, and instead address patients’ needs and interests in a bespoke and personalised manner: an ethos which should be at the heart of all SP initiatives (NHS, 2019).

The participants also highlighted specific SP-engagement barriers which are likely to be experienced by people facing debt. Some of these were similar to the challenges faced by those in rural areas (e.g., not having access to reliable transport to access groups), but others focussed on the psychological impact of debt. For instance, people may be unwilling to speak to a health professional about such a sensitive subject, even though it may be at the root of social disconnection and various health problems, again making it unlikely that people would even visit their GP in the first place. This finding suggests that primary care staff need to be trained to understand the link between financial issues, loneliness, and health, and need to be

prepared to sensitively ask patients about their finances. Practically, debt can also mean that the costs of attending a social group become prohibitive, so SP interventions must be created and implemented in a way that ensures that patients with financial problems are not prevented from attending (e.g., through subsidising travel for these individuals, for example).

The participants' awareness of the challenges faced by vulnerable groups in accessing SP could also be seen in their discussion surrounding the 'What is Social Prescribing?' advertisement. Although participants reported that they liked it because of its bright images and eye-catching style, they felt that the large amount of text and the focus on healthy-looking and able-bodied people in the photographs meant that many people would see the initiative as 'not being for them'. SP advertisements need to be designed with a range of social groups in mind, so that nobody who reads them feels excluded. Again, it would be worthwhile organising a number of focus groups where participants are only asked to discuss SP advertising (e.g., what it should contain, how it should look, where the adverts should be placed), so that more in-depth data on this topic can be gathered, and advertising can be adapted based on participants' discussion. Care also needs to be taken in ensuring that SP advertisements are placed in locations where they are likely to be seen by the most vulnerable, including places such as the Citizens Advice Bureau and foodbanks.

Finally, when asked about their local community groups, participants reported awareness of a wide range of events and activities taking place, helped in part by the local community magazine (a resource described as helpful by participants in both focus groups), which lists the events and group gatherings taking place each month. Some participants chose to join many of these, while others engaged in very few. However, those who did participate highlighted the benefits they received from engaging with community groups, thereby providing support for the key idea at the heart of SP: that engagement with community groups brings a host of health and wellbeing-related benefits.

While joining and engaging with social groups was relatively easy for the participants before COVID-19, they noted that the pandemic had challenged their ability to socially engage. While some found video conferencing to be an acceptable alternative, others missed face-to-face interaction with friends and loved ones. More generally, the need to socially distance is likely to have a huge impact on SP interventions, as fewer people will be visiting their GPs due to infection risk (meaning fewer people will be placed on SP intervention pathways), while those who are already on SP pathways will face the challenge of trying to interact with their social groups in a remote manner. While this may be possible for some groups (e.g., reading groups, prayer groups), for others it will be impossible (e.g., walking groups, swimming groups). Moreover, the social, emotional, and economic impacts of COVID-19 are likely to be long-lasting, and are going to be felt particularly strongly by the already-vulnerable groups who need SP most (e.g., those in rural communities, those with mental ill-health, and those in debt). Going forward, SP initiatives will have to be designed and delivered in a way that takes the challenges of COVID-19 into account, not only in terms of how social groups operate, but also in terms of how society's most vulnerable groups are supported to join (and stay on) SP pathways.

One positive aspect that emerged from participants' discussions regarding the COVID-19 pandemic related to their strengthening of community belongingness, and their observations regarding a renewed zeal for volunteering in the local community. This suggests that while SP providers will have to address practical safety issues post-COVID-19 (e.g., ensuring social distancing), they should also capitalise on the rich community bonding that has taken place during the pandemic, and use this to increase the efficacy of SP interventions by encouraging more people to become involved in community volunteering. Indeed, since SP works best (and is most sustainable) when people who join groups eventually become volunteers and coordinators themselves, it would be useful to use the COVID-19-related boost in both interest

in volunteering and volunteers' social status to encourage more patients on SP pathways to consider engaging in these higher-level activities within community groups.

While this focus group study has raised some important issues regarding SP, it is not without its limitations. Most notably, although participants in the two focus groups did vary in terms of their engagement with social groups and awareness of SP, they were relatively uniform in other respects (e.g., they were all older White British people who belonged to one or more social groups). Future research should thus involve a wider range of community members, including younger people and people from ethnic minorities. With a quarter of young people stating that they often lack companionship (Mental Health Foundation, 2019), and people from Black and Minority Ethnic backgrounds being more likely to experience barriers to overcoming loneliness (British Red Cross, 2019), it is vital that these voices are heard in order to gain a full picture of community members' attitudes towards SP.

Nonetheless, the focus group participants' discussions raised many important SP-related issues, each of which has implications for how SP's design and delivery might be optimised. Perhaps most notably, the data show the 'bottleneck' points at which patients' continued engagement with SP initiatives is likely to be most fragile or uncertain, such as problems joining the pathway in the first place due to unwillingness to seek help for loneliness-related issues; lack of an effective dialogue with the healthcare provider meaning that an appropriate group is not prescribed; social vulnerability (e.g., rurality, mental ill-health, or debt) creating obstacles to group engagement; and the COVID-19 pandemic potentially exacerbating all of these challenges. The challenge for people who design and deliver SP interventions is thus to address these bottlenecks: to explore how to increase the likelihood of participants continuing to engage successfully from the start to the end of the pathway, and thereby maximising the chance of SP making a fundamental difference to their health and wellbeing.

Section 4: Discussion

4.1 The Mid-Notts SP pathway

This section draws together key insights from each strand of this scoping study and suggests areas for further systematic investigation as well as topics that could be incorporated into training for those involved in each aspect of the SP pathway (i.e., referrers, Link Workers, and Community Group Leaders).

The present scoping study focuses on the early stages of the development and implementation of an SP pathway in four Mid-Nottinghamshire areas (Mansfield, Ashfield, Newark, and Sherwood). Since November 2019, Mid-Notts has operated an all-age SP model (18+) NHS best practice guidelines (Section 1.2) and co-production approach guided the development of the SP Pathway. Co-production meetings included regular feedback from representatives from Local Authorities and local CVS. These enabled identifying specific areas of development for the community groups (e.g., volunteer ‘passports’ and mental health training for volunteers) which received additional financial support. At the core of the model is the dual role played by Link Worker: they support individual clients as well as map and support local community groups and community asset development. This dual approach is essential in facilitating connection and efficient referral of patients to community support groups.

The economic and social characteristics of each area within Mid Notts are important to consider in future development of the SP pathway. Low job density, earnings, and education attainment compared to national average in Mansfield and Ashfield, and declining economic support in Ashfield, are likely to contribute to higher mental health concerns (Thomson, Niedzwiedz, & Katikireddi, 2018). While, Newark and Sherwood were much closer to the national average in these attributes, they are still likely to face inequalities in specific areas, and issues with isolation, anxiety, and depression.

Future steps

It is important to establish systematically the needs and existing support in each area. This would enable identifying high-risk groups, service gaps, and areas of strength. Previous Nottingham Trent University research on social prescribing (Halder et al., 2018; Mair et al., 2019) highlights the wide range of services that can be available in local areas and the importance of systematically mapping these services, ways they can be accessed, supported and sustained.

A core part of the development of an SP pathway is the systematic understanding of needs and existing provisions at statutory and community level. Mapping the presence and characteristics of statutory and community services requires a sustained effort over time, as services change and are lost due to financial pressures, policy changes, or even availability of group leaders and resources. If Link Workers were presented with a core map of services in their area, they can spend their limited time establishing relationships with the groups and their leaders, so they can better understand what is on offer, group capacity, and what needs groups can (and cannot) meet.

A systematic way in which to gather this evidence would be an extensive and detailed mapping of existing services in each area using interviews with key stakeholders (group leaders, Link Worker, service commissioners, local authority representatives, GP practices, and members of public from different socio-economic backgrounds). This would enable mapping existing services, understanding awareness of services from different stakeholders, understanding each group capacity and ability to meet patients' needs, and exploring group needs and sustainability issues.

One crucial aspect of any newly established SP intervention is systematic evaluation of its effectiveness in each area in terms of addressing the needs of the patients and assessing

changing engagement with healthcare services. For this, all stages from identification of patients to full engagement with community groups will need to be investigated in detail.

4.2 Information flow and referrals

In the Mid-Notts model, a system has been developed that can enable the smooth transfer of knowledge about patients' needs as well as monitoring their progress. Referrers complete a digital SP referral form with information about patient characteristics, reason for referral and service use in the three months prior to referral. Referrals are passed on to PICS and then allocated to the appropriate Link Worker. MDT meetings are held monthly with a group of clinicians along with a link worker. There is an opportunity within these meetings to discuss a referral for SP and patients' needs as a team. This can be beneficial for a number of reasons: a) they can improve knowledge and efficiency of referrals from the practice to Link Worker, b) they can provide an understanding of capacity issues at any stage, and c) they can identify potential participants with more urgent needs. Finally, a system has been established for the practice staff to remain informed about patient progress. At discharge from the SP intervention, the practice received a copy of a letter detailing the interventions offered to patients and their progress.

There is some indication that the reasons for referral to SP reflect some of the socio-economic and health characteristics of the different areas. For example, the focus on financial issues in Ashfield North reflects the socio-economic attributes of the area. Group leaders reflected on these issues. They suggested that communities, particularly Mansfield and Ashfield, struggled with issues such as poverty, unemployment, loss of services and fear of anti-social behaviour. Group leaders also recognised the need to address poor mental health within communities and support vulnerable and marginalised groups such as older people, people with learning difficulties and disability, and people from specific populations (e.g., veterans) within them.

Future steps

A systematic evaluation is required to understand how the referral process works, what works best and if there are any potential issues. Several important areas need to be explored and evaluated. More information is required about how to best identify those that could benefit from SP during relatively short GP appointments. It is not clear how these processes take place when appointments are over the phone, face to face or when family members are present. As there are different potential service providers involved (GP, Link Worker, PICS member), it is important to ensure that all parties are fully informed about patients' needs, potential safeguarding/risk issues and patients' expectations about SP. Our past research has shown that clear flow of information across services can facilitate the process of referral. The way patients experience the referral process can influence engagement with the SP pathway. In particular, understanding the reasons for refusing the SP referral can help identify especially vulnerable populations or issues with expectation management, stigma, and individuals for whom SP is not appropriate. Any issues or successful strategies identified with the referral process can be integrated into training sessions for GPs and other pathway staff.

In our past work we found a successful SP programme requires good co-ordination and knowledge transfer across different professionals and clear expectation management of everyone involved (Kellezi et al., 2019). For example, we found that introduction of SP to patients had to be managed carefully as patients who did not understand its potential benefits, felt their health concerns were being dismissed by their GPs.

A further area for development is to explore systematically the unique context and needs of each of the Mid-Notts areas. There are several indications that there are differences in patients' needs and service gaps in the community. Given this, it is important to understand the breadth of offer within the SP pathway and consider how this breadth addresses the needs of those who are socially isolated, experiencing mental ill-health, and coping with debt.

In terms of exploring these issues, a mixed methods approach would enable a triangulation of the perspectives of patients and health professionals and their interactions. Interviews with different stakeholders (GP practices, Link Worker, patients that have gone through the referral system, local authority and organisation representatives that work with vulnerable groups) would enable exploring the whole process of referral, and potential gaps in identifying those at high risk from different groups. Observation of interactions with patients, referrers and Link Workers, and MDT meetings, will help understand the process and aspects of the interaction and information provision that facilitate successful SP engagement. A review of referral records at six-month intervals would help explore the patterns of referral across different practices with attention being paid to the characteristics of patients being referred.

Potential areas to include in practice staff and referrers training

One of the challenges in SP is being able to identify and engage hard to reach and high-risk groups, who have often complex needs and profiles. As part of a plan to increase patient engagement with SP, strategies that facilitate shared decision making with patients should be identified. Such strategies could be incorporated into training packages for referrers and Link Workers.

4.3 The Link Worker role

Across the Pathway, the initial mode of GP referral was shown to be effective as all Link Workers reported waiting lists. Should the level of referrals be similar to the first two months, it is likely that the eight Link Workers employed in Mid-Notts will work with nearly 1,200 referrals annually. Link Workers aimed to offer the first appointment to those referred within two weeks of first contact and then offer 6-12 appointments for up to 3 months.

Prior to COVID-19 restrictions, patients were encouraged to attend the first appointment in person. The first appointment involves in-depth assessment of needs, which ensures patients receive personalised support, discuss priority of more urgent needs, and

streamline a more suitable link with community groups. One-to-one support is especially beneficial for those needing support to attend groups, and those dealing with stigmatising and difficult issues (e.g. issues with housing or debt).

Mid-Notts is also working toward developing the second aspect of the Link Worker role, that of identifying gaps in local community provision. This task is specific to each location, but Link Workers can share knowledge with colleagues, and this ensures a more accurate mapping of services. There are early indications of support gaps in the community (e.g., for socially isolated young people in Mansfield).

Future steps

An in-depth evaluation is required to understand what aspects of the Link Worker role work best, and if there are any potential issues. As SP is rolled out across the UK, there is still little information about how the Link Workers are managing their workload. In order to support Link Workers, it is important to explore and capture the demands placed on them and understand how to support them in their role and career progression, as well as identify any training needs. Interviews with different stakeholders (Link Workers, group leaders, patients who agreed to participate on the SP intervention and completed it, patients who agreed to participate on the SP intervention but dropped out from intervention and patients who did not agree to partake in the SP intervention), would explore the success, gaps and issues relating to referral processes, and intervention delivery.

A longitudinal survey design would explore SP's impact on loneliness, anxiety and depression, financial difficulties and change in healthcare service use (see for example Kellezi et al., 2019; Wakefield et al., 2020). To explore the specific demands and challenges faced by Link Workers and generate possible solutions, a focus group can be organised to generate ideas and solutions.

Potential areas to include in Link Worker training

Link Workers will need support in terms of strategies to best engage in community development during COVID-19 restrictions and in the longer term. In terms of supporting patients, Link Worker training could include: support to identify and reach hard-to-reach and high-risk groups, strategies to best engage with different types of users with different profiles, support to connect to a full range of community groups, and strategies to ensure best match between existing community groups and patients.

4.4 Community groups and activities

Group leaders unanimously described the positive impact of their groups for group members. Groups were described as beneficial because they were supportive and inclusive. They were described as places where members could speak openly about their experiences and issues and be treated with empathy and kindness. Groups also enabled the development of new friendships, which were at times extended beyond the specific group meeting. The shared experience and understanding between group members were at the core of a group's success. The success of the group was also attributed to group members' desire to expand their contributions to benefit their communities. These community ambitions are essential for group sustainability.

Although some groups operated a vetting of new members, and in-house referral systems for those joining via word of mouth, most groups were reported to be easy to access and flexible in terms of required attendance, and all stated that they were welcoming towards new members. Some group leaders were aware of SP and had received community referrals. Group leaders as well as members of the public recognised the potential for groups to address loneliness and isolation or health problems. In general, the participants in the focus groups were aware of the wide range of social groups and events taking place locally, even if they chose not to attend.

Both members of the public and group leaders agreed on the importance of integrating SP into existing community groups as well as the value of the careful matching of needs to existing provision, compatibility between SP referrals and the group, and ensuring the existing groups can meet the needs of the most vulnerable. Several group leaders suggested that Link Workers would be well advised to attend their groups on several occasions before making any referrals into them. However, it was acknowledged that this would be time consuming and might not be feasible given the Link Worker workloads. A better match and successful attendance could be enhanced when Link Workers accompany newcomers to the new groups.

Some concerns around safeguarding issues were raised by group leaders. They believed that the success of SP relied on avoiding a ‘one-size-fits-all’ approach and ensuring that patients are placed into groups that suit their interests, personality, and abilities. This is supported strongly by our past research where we found that poor matching can lead to drop-out or additional concerns among patients (Kellezi et al., 2019). For group leaders, knowing the history of new members could enhance their ability to address the safeguarding issues for the whole group.

Group leaders did experience a series of challenges associated with running groups, which varied with location. Rural locations were harder to access due to limited transport, although this affected some members more than others. Shared carpools or even group leaders facilitating transport overcame the issues in some cases. Group leaders also reported issues with availability of premises for group meetings, which became more pronounced when they were not permanent venues for the groups.

Other challenges included financial limitations, group sustainability, and the need to maintain formal registration and structures. Group leaders argued that many communities did not have enough resources to meet their community’s diverse needs. Experiences in Newark illustrate how policies of cutting funding for social and cultural activities overall can affect

some groups specifically, in this case young people. Despite the potential challenges that SP could present for their groups, many group leaders expressed an interest in becoming involved in the SP Pathway.

Future steps

There are several important areas that need further investigation. It is essential to understand the current issues groups aim to address across each area and factors that could facilitate successful matching of patients with groups. It is also important to understand safeguarding provisions across the different groups and how areas of concern could be addressed (e.g., where those with mental health concerns disclose self-harm). Finally, there are challenges faced by community groups which need to be explored to understand their capacity to support patients and their sustainability.

The distribution of groups and their characteristics can be captured in a systematic mapping process. Interviews with group members and patients (who decide to frequent groups or drop out) would explore factors that make group attendance successful as well as the experience of integration into the group activities from the different perspectives.

A longitudinal survey design would explore the impact of group attendance and connection on loneliness, anxiety and depression, financial difficulties and change in healthcare service use (see for example Kellezi et al., 2019; Wakefield et al., 2020).

Finally, in terms of group sustainability, it is important to investigate financial challenges faced by SP services and community groups and how best to sustain services over time in the current financial context, in part by learning from current successful practice. As groups are area specific, the investigation needs to take area and context into account.

Potential areas to include in group leader training

Training modules for group leaders could involve topics on strategies to engage and maintain attendance of the hard-to-reach and high risk groups, ensuring patients receive holistic support

within the aims and scope of the group, ensure smooth integration of newcomers into community groups, and strategies to address safeguarding issues. The efficacy of the SP pathway would be increased by ensuring group leaders are trained on expectations and roles of patients, and Link Workers as well as their own roles within SP.

4.5 Enhancing public awareness of SP

There was diversity in awareness of SP among the members of the public. Those that were familiar with SP, believed it aimed to address mental health and connection needs, as well as long-term conditions, highlighting the potential benefits it can bring. However, a good level of awareness of SP and what is expected from each stakeholder (patient, referrer, Link Workers, and groups) is essential for the success of SP.

Part of the challenge of providing the SP service was reported to be the need for a shift in traditional medical support from the perspective of patients as well (something we have found in our past research e.g. Kellezi et al., 2019). Focus groups with members of the public indicate that patients might be unwilling to speak to their GP if they are lonely, believing that it is the individual's responsibility to address such issues within their own lives, rather than relying on medical support. Our participants indicated that this reluctance could be due to generational differences, whereby older people are concerned to not be over demanding to the NHS system which they believe has limited resources.

Members of the public suggested that stigma might make patients unwilling to reveal to health professionals that they were struggling with debt. This highlights the need for SP initiatives to be aware of the relationship between financial health and physical/mental health (e.g., Stevenson, et al., 2020), and to ensure that patients' financial issues are addressed where possible.

When discussing the SP promotional leaflets, participants highlighted that they would welcome photographs that span a more diverse range of people (ages, BMIs, disabilities), so

that patients are more likely to conclude that the initiative is ‘for them’. The amount of text and complexity of the information were also highlighted as important to ensure it was accessible and effective in advertising SP services. Accessibility of the information should also be improved. Participants suggested placing SP leaflets and information in a wide variety of locations, especially those likely to be visited by vulnerable groups (e.g., those in debt or those with mental ill-health). They suggested places such as local supermarkets and other shops, the Citizen’s Advice Bureau, Voice (a local community magazine), the Post Office, Social Services, and related facilities such as Meals on Wheels, and Council offices. They also suggested sending the leaflets in envelopes with Council-related letters and bills, and advertising on local radio. Some of the challenges related to physical and knowledge access relating to rurality, which we discuss in next section. The NHS England plan to include all local agencies to refer people to Link Workers (including but not limited to local authorities, pharmacies, the Fire Service, Police, social care services, and housing associations) would address some of the limitations.

Future steps

Further exploration is required to identify the best strategies to increase awareness of SP among the public. There is a need to understand how stigma specifically around loneliness and debt impacts help seeking and engagement. Our past research has shown the detrimental effect of stigma on help seeking in deprived areas (Stevenson et al., 2014). Challenges and lessons to be learned about distributing information about SP to hard-to-reach groups and those in need should also be explored.

In-depth interviews with key stakeholders could enable exploring all these issues in detail and identify successful practices across the different areas. All areas identified can be integrated in specialist training programs for all key stakeholders.

4.6 The challenges of delivering SP in rural areas

For Community Group Leaders and members of the public, the definition of ‘rurality’ was perceived as more complex than simple division between rural and urban areas. Members of the public argued that the definition of rural should include both geographical remoteness and ability to access different services. For example, having a car was important when living in a rural community, making towns and cities more accessible. For those who did not have a car, sporadic public transport was a problem, as rural busses often stop in the evening, and many groups meet after 7pm. While it might be possible to get to the group, returning home would be affected by limited public transport. Group leaders also recognised travel costs acted as a barrier to attendance for some members.

Participants suggested that the enhanced ability to connect remotely due to COVID-19 could become one of the solutions to accessibility issues relating to rurality. It was recognised however, that online meetings would not suit all types of groups or individuals. Participants offered several options that were acceptable to them as members of the public, which included changing the location of the group to meet the wider needs of members and the use of village halls in smaller communities to facilitate access.

Future steps

It is important to establish a clear and shared definition of rurality as this will impact on resource allocation and development strategies. Given the challenges faced when implementing SP interventions, consideration of the needs of the different contexts (urban and rural) is essential. Group leaders and service providers define rurality in part by transport and ability to access services. There are differences in transport links in affluent and less affluent areas.

To address these issues, a systematic examination would explore definitions of rurality in policy documents, healthcare, and community practice, and among the public through

interviews. In-depth interviews with key stakeholders would enable the exploration of challenges as well as the identification of strategies to overcome access challenges.

4.7 COVID-19 challenges and positive adaptations

As outlined in the introduction, the COVID-19 pandemic required prompt changes in how SP was delivered. Face-to-face appointments were replaced with telephone support and focus was shifted towards high risk clients. Link Workers were encouraged to contact these patients, discuss their needs, create personal care plans remotely, and mobilise local community support.

One of the core challenges identified with COVID-19 related to remote participation in activity groups, as reflected in the focus groups. However, many of our focus group participants (all of whom were over 65) reported being able to maintain contact with friends and family through videoconferencing. There were instances where this transition had to be supported by family and friends, and times where it was not feasible or successful due to multiple issues that those engaged in the remote conversations were experiencing. However, since data collection could only take place remotely, it is possible that our participants are amongst those that were more able to overcome the limitations of remote engagement.

Community groups have also been placed under unprecedented pressure. Some have continued to function through online communication, while others have struggled to maintain contact with their members. Group leaders had serious concerns over funding and group sustainability. They expressed worries over the future health and well-being of their group members whilst groups are unable to meet, as well as their group's ability to engage with SP.

A positive indicator of resilience under lockdown been a stronger sense of local community spirit with some participants reporting that they felt more connected than before the pandemic. Although frequency of interactions was reduced, some participants reported that when interactions did occur, they were positive. This was enhanced by community activities such as 'clap for key workers'. There were also examples of group leaders supporting group

members in activities that were valued even more during COVID-19 such as computer literacy support. There was also a suggestion that the crisis had encouraged groups to initiate links with local authorities and the VCSE sector (where they had not before) to gain much-needed support.

Future steps

While COVID-19 crisis is ongoing, little is known about its medium- and long-term impact on service use, SP initiatives, and community groups or how a return to normality will take place. Important issues to investigate include the impact that the relationship between social isolation, financial distress and mental health has had on healthcare service use during COVID-19. It is also important to explore the short and long term consequences of isolation and financial distress on mental health and the ability to establish and maintain social connections, especially among the most vulnerable groups (e.g. those shielding or those who cannot use technology). The medium- and long-term impact of COVID-19 on sustainability of SP and community groups also needs to be investigated, together with explorations of the effectiveness of the different adaptations that have already taken place relating to SP delivery and community group activities.

Interviews with all stakeholders would capture challenges and good practice. Particular attention should be paid to groups and activities that have been successfully maintained or transformed online, so that strategies of the success are captured, but also to explore what groups of patients can benefit and in what areas. Lessons learned can be integrated in the training programmes for practice staff, Link Workers, and group leaders.

4.8 Strengths and limitations of the present work

One of the strengths of the present scoping study is the collection and triangulation of information from different perspectives. This provides a more holistic understanding of issues and ensures different important voices are heard. We reviewed documents describing the SP

pathway, conducted background discussions with NHS staff, held focus groups with members of the public, and conducted in-depth interviews with group leaders.

The current situation impacted on the ability to collect all the data we wanted, and it has reduced the range of information we wanted to collect from a full range of community groups. However, the current crisis provided us with an unprecedented insight into how SP operated under COVID-19 and ramification of this crisis for the public and community groups in the medium and longer term.

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Appendix One: Area Descriptions

Mansfield & Ashfield

Ashfield (population 120,000) and Mansfield (population 172,000) are both former coal mining centres. The population of both is predominantly White (97.7% and 97.4% respectively). Since the decline of the coal mining industry with the final pit Thorsby colliery, closing as recently as 2015, Mansfield's job market declined with most new jobs having a low-value, low-pay employment prospects. Currently, the employment rate in Mansfield is close to the national average. The job density of Mansfield is 66% which is lower than the national (86%) and the regional (80%) average. 55,200 (80%) of people are in work. Within Mansfield, median weekly earnings (£470) are lower than both the national average (£587) and the regional average in the East Midlands (£547). Regarding educational attainment, 22.2% of the people of Mansfield have a NVQ4 or above compared to the regional average of 34.1%. These attributes have culminated into a low social mobility index ranking with Mansfield ranked 315 (Nomis, 2018a).

Similarly, the employment rate in Ashfield is close to the national average. The job density of 75% is higher than Mansfield but still lower than the national (86%) or the regional (80%) average. Overall, 66,400 (79%) of people are in work. Median weekly earnings (£501) are low compared to both the national average (£587) and the regional average in the East Midlands (£547). In Ashfield, 21.2% of the people have a NVQ4 or above compared to the regional average of 34.1%. These attributes have culminated into a low social mobility index ranking with Ashfield ranked 317 (Nomis, 2018b). Furthermore, due to the consensus that Mansfield is the main town in the rural Nottinghamshire area, the level of mental health support and economic support in Ashfield is steadily declining. This places Ashfield in a more detrimental position than Mansfield from 2019 (Integrated Care System, 2019), with Mansfield having more resources, particularly around mental health support.

Newark & Sherwood

Newark and Sherwood are similar in terms of population size and ethnicity (population 115,000, 97.5% White), but fare better in terms of employment, earnings, and educational attainment. The employment rate in Newark and Sherwood is close to the national average. The job density of Newark and Sherwood is 81% which is higher than the regional average (80%) and close to the national average (86%). Overall, 60,300 (77.9%) people are in work. Median weekly earnings (£524) are low compared to both the national (£587) and the regional average in the East Midlands (£547) but are higher than those in Mansfield and Ashfield. Regarding educational attainment, 33.1% have a NVQ4 or above compared to the regional average of 34.1%. These attributes have culminated into a better social mobility index ranking than both Mansfield and Ashfield with Newark and Sherwood ranked at 323 (Nomis, 2018c).

Appendix Two: Community groups in target areas

For the Ashfield PCN, link workers use an organisation called OurCentre which provides such groups which call themselves ‘cuppa and a chat’ for people who do not have specific interests yet still want to make connections with people. However, for service users who have specific interests, other groups within the Ashfield PCN include music groups, social lunch groups, coffee groups, board game groups and allotment groups. More specific groups also include: women's well-being, reflexology, soundbaths and meditation.

For the Mansfield PCN, link workers have connections with The Hive in the Four Seasons, as well as the Nottingham Co-production team. For social isolation, The Hive and Age Concern are two organisations who get referrals. Both organisations run lunch clubs with day centre hours which are run by volunteers. Lunch clubs are recommended for socialisation because service users have somewhere to go for the day and people to be with and they don't have to worry about food. For service users with dementia, Oaklands residential has received referrals due to a professionally trained team already working there who do dementia cafes for the residents and are happy for social prescribing users to attend. For anxiety and depression, there is a Mind Listening group in Mansfield. It's a safe place where service users can talk and is overseen by mental health workers. There is also a place called Ladybrook Community Centre which do a range of activities. An example would be the ‘friendship group’ on a Wednesday which is open to anyone. However, there is an issue which link workers have recognised. Most groups are designed for an older population mainly between 40-90 years old. Therefore, young people with social isolation have a limited number of groups they can be referred to. This suggests there is a gap which the social prescribing pathway needs to address.

For the Newark area, there are a lot of referrals to counselling services rather than local groups. Such counselling services are INSIGHT or CASY. CASY is specially designed for young service users between the ages of 6-25 whereas INSIGHT is suitable for all ages. There is also the REACH Newark centre which offer a range of courses and activities that provide people with learning disabilities the chance to learn, have fun and live well through a range of social activities. However, critically with most service-users being young adults, there is a conflict between when activities are available and when young adults can socialise, limiting the choices available to them. This is further hindered by the rurality of the location. Although recreational places are available, such as the cinema, areas that provide social spaces for young adults are sparse. The closure of youth centres adds to this issue and creates increased opportunities for anti-social behaviour, due to the current locality not providing services that meet the social needs of the young adult. Alongside this, the local link workers perceive Newark to have been left behind, due to most of the funding being allocated to Mansfield and Ashfield as they are perceived to be more deprived than Newark. However, although Newark does have more affluent areas, the town does have area of severe social deprivation which is beginning to overtake Newark's more affluent status. This combination of factors highlights the gap and need for youth services that link workers can refer to.

For the Sherwood area link workers seem to be connecting with a range of different services to cover as many issues within their PCN as possible. Examples of such organisations is the University of the third Age (U3A) which is a self-help organization providing educational and leisure activities for retired and semi-retired people. U3A currently provide 37 groups for their member for £60 a year with no waiting lists. Additionally, Sherwood is working with Macmillan Cancer where link workers signpost to the Hope Group which is for people who have had a cancer diagnosis whereas for Alzheimer's you have memory cafes. For debt, a service called Freedom Debt Relief provide a free debt evaluation

and provide a program to negotiate and settle debts with creditors. Furthermore, there is Step Change, who do online debt recovery and repayment plans on the service users' behalf. Finally, the Sherwood link workers also try to find local groups not advertised online such as craft groups, sports groups, leisure centres and libraries, coffee mornings and friendship groups.