

# **Exploring lessons from Covid-19 for the role of the voluntary sector in Integrated Care Systems**

**Report to:**

**Healthy Ageing and Care Network Steering Group**

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# Exploring lessons from Covid-19 for the role of the voluntary sector in Integrated Care Systems

## Summary

This pilot project in Oxfordshire has explored the lessons that can be learnt from the Covid-19 pandemic, for the role of the voluntary sector in 'Integrated Care Systems' (ICS). Taking a mixed-methods approach, using primary and secondary sources, the research examined the role of 'voluntary, community and social enterprise' (VCSE) organisations in Oxfordshire in supporting older and more vulnerable people, and the potential for voluntary sector involvement in ICSs.

The research highlighted a number of opportunities and barriers to joint working, which can be summarised as follows:

### Opportunities for joint working:

- The pandemic has brought different organisations together in crisis mode, and relationship building that can normally be time-consuming and complex, has happened relatively quickly and with little friction.
- New partnerships have formed that can be built upon in the future.

### Barriers to joint working:

- Speaking different 'languages'.
- Different cultures and mindsets in health and VCSE.
- A lack of understanding between the two different cultures.
- Financial constraints in the VCSE sector which limit their capacity to reach out beyond their core mission.

### Health-sector related headline recommendations

- There is a need for **broad engagement with the VCSE**, to ensure that all **voices, both large and small**, are heard and integrated within the BOB structures.
- There are plans to integrate VCSE more closely into BOB, through **the BOB-wide Alliance** that is currently being created (see Annex 4). This important initiative should be given priority, ensuring that it is adequately funded, and its principles are shared at all levels within BOB. This will involve a culture shift within the organisation.
- It is essential to ensure that the **VCSE has adequate representation** on the Senior Leadership Group of BOB, as well as within its main work programmes and workstreams. These individuals would be representing the interests of the broader sector, rather than individual organisations.
- There are important lessons emerging from the nationally-led **VCSE Leadership Programme**, run by NHS England and NHS Improvement. These lessons coming

from the programme should be noted, as they can provide key learning points for the evolution of networks between health and the VCSE, for more equitable partnerships and better integration within the BOB area.

- **The role of social prescribers** is key to forging the link between the health and VCSE sectors at the neighbourhood level. It is critical to ensure that these roles are adequately funded and supported, to maximise their benefits.

### **VCSE-sector related headline recommendations**

- At a local level in an urban setting, one of the keys to successfully linking health needs and VCSE activity is **the existence of a 'Community Worker'** embedded within a neighbourhood. These roles are critical, acting as an intermediary between different organisations and sectors, having an overview of hyper-local needs and potential VCSE provision in the locality. These roles should be well-supported and well-funded, with adequate training and support infrastructure in place to ensure successful recruitment and retention of these key roles.
- **Funding is critical to the VCSE sector** as a whole, and dictates the depth and breadth of the sector's work. Cuts over recent years in the sector have undermined its ability to meet local needs, and has created volatility in the sector. Adequate core funding is crucial to the future of the sector, to ensure more stable and long-lasting local activities and programmes and to address volatility in the sector.
- In a rural setting, **Parish Councils can play a key role as intermediary between local VCSE provision and the health sector.** A nominated Councillor would be well-placed to have an overview of local provision, and could sign-post enquiries from the health sector to appropriate local clubs and activities. Defining this role at the Parish Council brings stability, embedded within the structure of local government.

### **Other recommendations:**

- Adopt '**Participatory Grant-making**' more widely, as an approach to funding decisions, which involves communities more closely in grant-making decisions.
- Engage with a **mapping of VCSE provision**, combined with local on-the-ground knowledge from individuals in key umbrella organisations.
- Address the issue of **digital exclusion** by developing IT skills, confidence and connectivity in the community (acknowledging the limitations of doing this in a pandemic), which will mean older and more vulnerable populations will be able to participate more fully in online services and activities.

# **Exploring lessons from Covid-19 for the role of the voluntary sector in Integrated Care Systems**

## **1. Introduction**

### **1.1 Context**

Integrated Care Systems (ICS) are a long-term aim of the NHS (NHS Long Term Plan, 2019; DHSC White Paper, 2021). ICSs bring together different stakeholders, including the voluntary sector, local authorities and the NHS to provide more effective health and social care. ICSs will become statutory bodies in England in April 2022, and have already been introduced in certain areas, but they are relatively recent in many places, and research is needed to examine how stakeholders can work together more effectively for better health outcomes. The King's Fund (2021a) has identified an urgent need for research to ascertain how the voluntary sector can be meaningfully involved, contributing to health and social care needs. In particular, it is suggested that partnership working with the voluntary sector can contribute to people living longer in better health (King's Fund, 2021b), and avoiding hospital admission where possible (NHS, 2020).

Turning to the last year and the Covid-19 pandemic, one of the key features of the societal response to the crisis has been the rise in mutual aid organisations and activity through the 'Voluntary, Community and Social Enterprise' (VCSE) or mutual aid sector, particularly supporting vulnerable and older populations (NLGN, 2020). This present study seeks to investigate how the recent experiences of the VCSE sector responding to Covid-19 can be built upon, to strengthen integrated partnership working, in order to improve joined-up health and social care provision, particularly for an ageing population.

### **1.2 Aim and objectives**

The aim of the project was to investigate how the experiences of the VCSE responding to Covid-19 can be captured and capitalised upon, to strengthen integrated partnership working between the voluntary sector and the NHS, with a particular focus on the older and more vulnerable population.

The project addressed key three objectives, to:

1. Examine how local communities have responded to the pandemic through VCSE initiatives;
2. Assess the effectiveness of these initiatives in reaching older and more vulnerable people and addressing isolation, mental health concerns and wellbeing; and
3. Explore the potential for policy learning from these experiences, in order to strengthen voluntary sector involvement in local health and care systems.

This was a small-scale pilot project that ran from January to June 2021. The project was focused on Oxfordshire, part of the nascent BOB ICS (covering Buckinghamshire,

Oxfordshire and Berkshire West), with some stakeholder interviews and surveys also completed in the wider South East region and beyond. Analysis at this scale provided regionally-based experiences of the work of the voluntary sector and therefore gave rich data for analysis of the potential for deeper partnership working at a regional level.

### **1.3 Method**

The research was designed as a mixed-methods study, using primary and secondary sources to examine the role of VCSE organisations in Oxfordshire in supporting older and more vulnerable people, and the potential for voluntary sector involvement in ICSs. The project was designed to draw on the experiences of three 'communities': health providers; the community and voluntary sector; and local residents. Due to the pandemic, all methods were designed to be online only, rather than face-to-face.

The study was approached using a three-stage methodology. Building on an initial literature review, a series of in-depth interviews were conducted in the first stage of the research, with stakeholders in both the health sector and the VCSE. A total of 15 people were interviewed virtually on Zoom (13 from VCSE, one from health and one in social prescribing i.e. VCSE and health perspectives combined), to explore their different experiences of the pandemic, and how health and the VCSE could be more closely integrated.

The second stage involved sending out links to three online surveys aimed at GPs, pharmacists in the Thames Valley, and the VCSE sector in Oxfordshire, asking about their cross-sector engagement and support to older and vulnerable groups during the pandemic. The surveys were circulated through the NIHR Clinical Research Network (Thames Valley and South Midlands) for GPs, through Pharmacy Thames Valley, and through the OCVA (Oxfordshire Community and Voluntary Action). Unfortunately, response rates were relatively low, so the survey was relaunched to GPs through an alternative route, the health-focused survey and marketing company M3, who distributed the survey to GPs in the South East of England and beyond. In all, the response rates were: 6 VCSE out of a target of 12 (50%); 2 pharmacists out of a target of 20 (10%); 50 GPs out of a target of 50 (100%).

The third stage involved two case studies: one in the Oxford neighbourhood of Barton, and one in the rural village of Piddington, which is located south east of Bicester. It is worth noting that these two cases were selected as examples of strong community responses to the pandemic, where it is interesting to explore those elements that worked well, as well as aspects that worked less well, and why that might be. In Barton, a total of 9 interviews were completed: 3 from VCSE, 2 from health, and 4 residents (1 who received support and 3 who provided support). In Piddington, a total of 6 interviews were completed: 3 from VCSE and 3 residents (all of whom received support). Interviews were carried out either on Zoom or by telephone. In all stages, it was difficult to engage with the health sector, understandably, due to their overloaded work programme given the pandemic, the busy vaccination programme and most recently, many more people than previously who were coming forward for regular health appointments.

The research was also supported by an Advisory Board with 6 members across the health and VCSE sectors, who are listed in Annex 1, who met virtually three times during the study in February, April and June 2021.

This report summarizes the findings of these three stages of the research. It starts by presenting the findings from the VCSE stakeholder interviews and survey; it then goes on to outline the key points from the health sector stakeholder interviews, complemented by the survey findings. It then sets out the key aspects from the two case studies in Barton and Piddington, what worked well in each case, what worked less well, and what lessons can be drawn from their experiences during the pandemic. The final section outlines some recommendations that have emerged from the study, for the two sectors related to the research (health and VCSE), together with some pointers for the next steps of the research. A summary of the findings can be found in an infographic in Annex 5.

It should be noted that the research focused primarily on health and the voluntary and community sectors, rather than social care. Therefore, the study did not address issues of the gap between health and social care, joining up these two dimensions, or other issues related to local authority involvement and their contribution to health and wellbeing.

Furthermore, we did not include particular organisations that focus on the work of charitable not-for-profit organisations that provide specialist care and advice, although this would be an interesting addition to any further research in the area.

As a note on terminology, there are a number of different ways of referring to the 'community-related' sector, for example, 'civil society', 'mutual aid organisations', the 'Third Sector', the 'Voluntary and Community Sector (VCS)' and the 'Voluntary, Community and Social Enterprise' sector (VCSE). In this report, we have adopted the term VCSE, to include any organisation (incorporated or not) working in the 'social' sector, as this appears to be the current most commonly used term. Where possible in light of the research data, we make the distinction in the report between small community-based neighbourhood groups, such as local street-based Whatsapp groups that have sprung up during the pandemic, in contrast to large registered charities, such as Age UK and Mind, that operate locally, regionally, nationally or even internationally. In this report, we use the general term VCSE to cover these different types of organisation, although we recognise that there are significant differences between them, and that particular comments and recommendations in this report may not be relevant to all organisations covered by this term.

We also recognise that the "health sector" does not represent a single voice, but many voices, and referring to the "health sector" as a broad umbrella term will inevitably involve disparate cultures and perspectives. However, given the pilot nature of the study, we felt that this would be the most effective approach in the time available, to access a range of perspectives in a short period of time, without excluding certain voices in the broad sector of health.



## 2. Background

### 2.1 Issues and themes from the literature review

One of the aims of the NHS Long Term Plan is to forge new ways of working which involve a closer integration of health, social care and VCSE stakeholders through Integrated Care Systems (NHS, 2019). In the run up to the establishment of ICSs as statutory bodies in April 2022, a number of organisations have undertaken research into the opportunities and challenges of the closer integration between health and the VCSE sector. These studies were reviewed to identify themes to explore during this pilot research.

The Institute for Voluntary Action Research (IVAR) has carried out a series of studies drawing on lessons from the Programme “Building Health Partnerships”, which was run by the NHS Commissioning Board, together with the NAVCA (National Association of Voluntary and Community Action) and Social Enterprise UK (SEUK), from 2013-14<sup>1</sup>. Some of the key themes to come out of that programme were the need for a common language to talk about improvements to health and wellbeing at the local level, and the importance of co-designed, integrated and asset-based approaches to health and wellbeing that provide locally-relevant solutions (IVAR, 2014; IVAR, 2016).

The King’s Fund (2018) has also identified how co-production requires strong and mature relationships both within the VCSE and between the VCSE and the health sector, highlighting the benefits as well as the challenges of relationship-building.

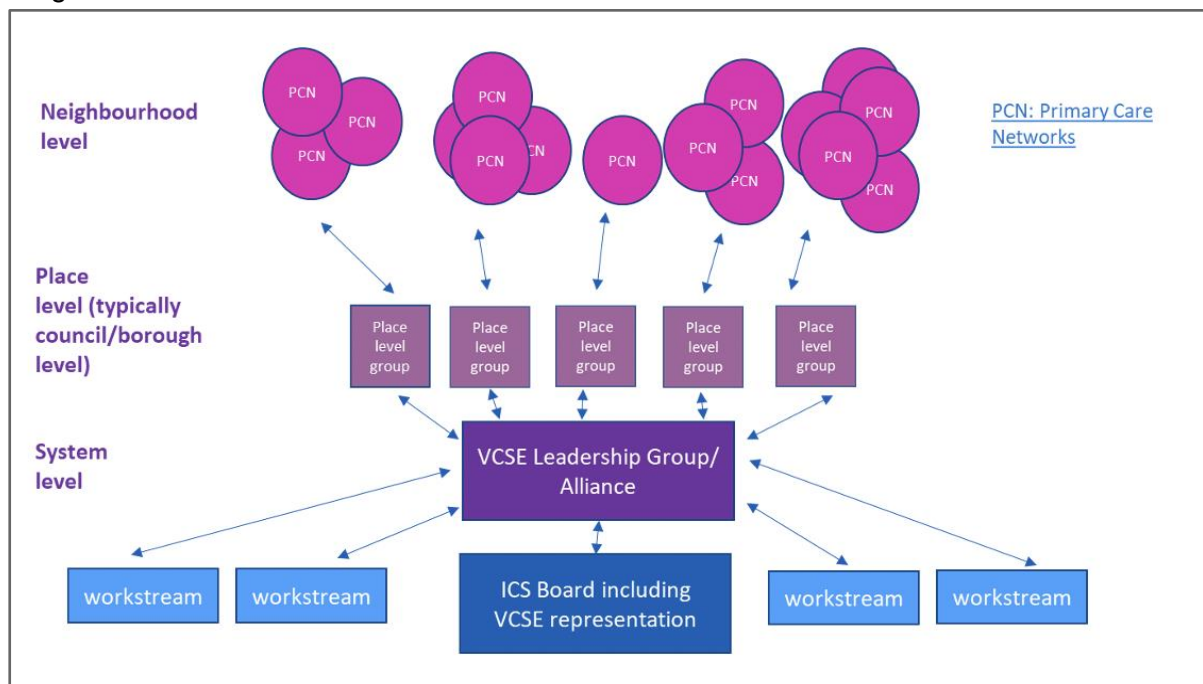
More recently, the AHSN (Academic Health Science Networks) has carried out research into how lessons from the Covid-19 pandemic can inform health and care systems of the future (AHSN, 2021). From the nine themes explored, they made a series of ten overarching recommendations, including the need to build on existing relationships and form new partnerships; the value of greater co-production that includes the workforce, patients and the public in multi-stakeholder partnerships; and the necessity to understand population needs and address inequalities. These were themes that we also explored in our pilot study.

Within the NHS, the VCSE Health and Wellbeing Programme was launched in April 2017, to promote co-production in the creation of person-centred, community-based health and care for more effective and equal health outcomes. One of the ways of doing this is through the ‘Leadership Programme’, where funding and facilitation support is available to develop place-based VCSE Alliances within ICSs. Building on work by the NCVO (2020), a series of Alliances have been funded from 2019, to build networks of VCSE and health stakeholders in particular areas. In our case study area, Buckinghamshire has recently been awarded funding to build an Alliance during 2021-22, and this was also an area of interest for this pilot study (see Annex 4 for more details).

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<sup>1</sup> <https://www.england.nhs.uk/2012/11/health-partners/>

Figure 1: A Good Practice Model of VCSE Engagement at a System, Place and Neighborhood Level.



Source: "Joined Up Care Derbyshire" <https://joinedupcarederbyshire.co.uk/get-involved/voluntary-community-and-social-enterprise-leadership-programme>

One such Alliance in Derbyshire has produced a good practice schema (Figure 1) of how the VCSE Alliance in their area can be embedded within the three different components of the ICS: system, place and neighbourhood.

In addition to identifying salient themes from the literature, we also drew on the experiences of the Advisory Board members to pinpoint additional issues to explore during the study. Themes identified as pertinent included:

- Digital exclusion and the impact that this is having on unequal access to health and wellbeing provision during the pandemic;
- The issue of VCSE funding, and how this impacts on the capacity to link with health, an issue which is likely to increasing in importance, going forward;
- How to capture the impact of the VCSE, and the need for appropriate 'measuring systems' to evidence their impact.
- The need to capture the 'mutual benefits' of offering and receiving support during the pandemic, and to understand how to enable this to continue, post-pandemic.

All these themes were taken on board, when designing the interview and survey schedules. The following sections report on the results, first for the VCSE sector and then for health.

### 3. VCSE stakeholder interviews and survey

#### 3.1 Interview themes

This section presents the themes that emerged from the stakeholder interviews with VCSE representatives. This included a range of stakeholders, some of whom work for large national charities in Oxfordshire, while others are involved in local neighbourhood-based groups. The diversity of voices and experiences provides a broad range of inputs into this pilot research, as a basis for understanding different perspectives on the issue of integrating VCSE into health and wellbeing.

#### ***Volunteer recruitment, experience and retention***

Experiences of volunteers were generally very positive in terms of social contact, being able to get out of the house, and the feeling of contributing.

*'It's been fantastic, the opportunity that Covid has presented in terms of, I suppose, igniting the community spirit.'*

*'They've been really looking for a way to, kind of, replace that interaction they might previously have had with work colleagues.'*

There was widespread recognition of the reduced time available for volunteering as the pandemic, and strategies to counter it, progressed. Due to furlough there was initially more time for volunteering. People used volunteering as a means to get out of the house during lockdown, so there was more time and appetite for volunteering. As furlough ended for some and people returned to work, there was reduced time available.

Engagement with volunteering was therefore seen as something not entirely controllable by VCSEs: *'There's far stronger forces at play. You know that a lot of those questions [about volunteering] are taken completely out of your hands'*. However, the pandemic was seen as an experience of radical change in how society functions and could function in the future, for example what the role of universal basic income could be.

People's positive experiences of volunteering and new priorities have led to a change of attitude to, and longer term engagement with, volunteering.

*'The likes of St John's Ambulance, you know, people have gone to join them and have found this fulfilling and it has improved their sense of wellbeing as well, involved in something voluntary.'*

A wider cross-section of people became involved in volunteering during the pandemic. In some cases this has resulted in significant and positive changes in the makeup of existing groups with new (younger) members being integrated into existing groups.

*'They had older volunteers, but a new group has formed of younger people and they're beginning to come together... and they've merged into one and that just helps sustain it, refreshes that group.'*

However, interviewees spoke about the need to take this further, with the necessity to engage more people at the margins and think about the nature of volunteering.

*'How do we... [make] the connections between people in their local neighborhoods and people feeling like they've got something to contribute and they can be part of that? It's, I think, part of the next challenge.'*

### ***Building bridges to the community is vital but takes time and resources***

Links between formal health providers and local communities were seen as vitally important in the future. There was the feeling that, in many cases, a 'bridge' is missing between health and more informal community-based support and networks, and that the existence of a bridge would help to create those partnerships.

The role of community workers was seen as key in developing locally relevant, bottom-up services. One respondent commented that these locally-embedded workers have a critical role in helping the community not only to define their own priorities, but also to identify appropriate solutions, and where the skills are available, to also contribute to delivering those solutions.

While such community workers have been highly effective in many cases during Covid-19 in Oxfordshire, there have also been challenges in terms of the offer that was available for social prescribers.

*'One of the impacts of Covid has been that a lot of the things that used to exist, that you could social prescribe to, just didn't exist anymore.'*

The Locality Hubs set up by Oxford City Council, and place-based working, were widely praised, linking with an asset-based approach to community development.

A very strong and recurring theme of the interviews was the time, resources and skills required to build understanding, trust and positive relationships with communities through partnership: *'That stuff takes time and it's easier to go it alone and it's harder and more resource intensive and everything else to do things in partnership.'*

This was seen as a challenging task particularly for primary care networks and busy GPs.

*[There's] 'a lot of onus on PCNs to set this stuff up and organize it, and they can't be all things to all people and they can't do commissioning or service design or partnership work all day long when they are GPs, so it does feel like a crucial part of the jigsaw is missing.'*

Investment in link workers within primary care networks was welcomed but some thought that more was required to maximise benefit from this, including providing infrastructure to support their work, as well as networking and training opportunities for the link workers.

Related to training, an ongoing need for joint learning and system development more broadly was also identified as important.

### ***Need for better focus on public benefit and partnership working in the voluntary sector***

Within the VCSE itself, there was recognition that funding was very tight but also that services could be better focussed on public benefit and that organisations could work more strategically to be more efficient and impactful:

*'We are going to have to start to coordinate some of our services because, one, there could be some overlap, but also we can be a bit more impactful.'*

Interviewees stated that there should be less duplication of activities by multiple organisations and more transparency and accountability of funding. However, greater security of funding would also help efficient working, without so much need for time spent on fundraising and competition between organisations. More collaborative bidding from VCSE organisations was seen as a likely way forward.

*'If you are just constantly looking for funding, knowing that actually there's going to be less funding in the future, then there's that possibility of becoming competitors, rather than complementing one another and that does change the whole dynamic of a partnership work.'*

### ***ICSs working with VCSEs***

From the VCSE perspective, ICSs were seen as needing to promote partnership working within the VCSE sector and especially to ensure the involvement of small/grassroots organisations at the hyper-local level, that might otherwise be neglected in favour of larger and more established organisations: *'An important lesson in terms of Integrated Care Systems is how they commission and create the environment and the conditions for partnership working.'* This was reflected by one interviewee saying that: *'I do hope that the ICS doesn't sit as a hierarchical organization at a very senior policy level, but it does do what in theory it is truly meant to be doing, engaging across sectors and is truly representative, primarily of the communities and individuals themselves.'*

One potential solution suggested was commissioning based on different reporting and funding models, such as Participatory Grantmaking, to fund and support hyper-local groups to develop appropriate services. This implies a culture shift within the ICS, and the need to share power and decision-making. *'From deciding on priorities together, and then designing and developing solutions together, [...] it's a big cultural shift, and it's about the sharing of power.'*

A related example is the Active Reach projects delivered by Active Oxfordshire using Sport England funding as part of their Tackling Inequalities Fund. The aim is to reach vulnerable communities, liaising through Third Sector partners who, critically, are at the heart of those communities and who know those communities' needs.

Working at a local and hyper-local scale was seen as a particular challenge for ICSs given their large geographical size.

*'BOB is like a huge area [...] to be doing this, and there's a real risk that we lose the ability to work in partnership and to do things in the community development, community capacity-building way, and everything gets reduced to bigger service providers which loses so much.'*

There was also concern that there could be a potential 'postcode lottery' of provision, dependent on the priorities and enthusiasms of particular PCNs. This has implications for ensuring equitable provision, especially in more deprived areas where VCSE support may not be so readily available, or be able to engage volunteers. As one respondent noted, there is a potential disparity,

*'between PCNs where there's a real willingness and a drive and people kind of work all hours to make it happen because they really care about their patient population and it's a kind of personal agenda for them, and other PCNs that have a totally different personal agenda, maybe cancer or something that isn't specifically about addressing health inequalities or isolation or some of the things that there would have been a bit more focus on.'*

The pandemic was seen as having been positive in terms of developing partnership working but the momentum needs to be maintained: *'Covid has created a lot of opportunity really, because of the fact that organizations have worked really collaboratively, [...] -, and now the challenge for ICSs is how to harness that and resources, and support it for the longer term.'*

Allied with this is the need for improved understanding of ICSs by the voluntary sector. Despite some developments in terms of the creation of a role that focuses on collaborative work with the VCSE sector, there was a limited understanding of BOB: *'The world of the BOB and transformation and ICS generally is fairly opaque'*. Similarly, it was felt that there was a lack of understanding within BOB of the VCSE sector.

It was suggested that there needs to be a 'single point of access' between the ICS and VCSE. A BOB-wide VCSE Alliance is being developed within BOB, with its first meeting on July 13th 2021, that aims to respond to that need (see Annex 4 for further details). Membership is open to any VCSE organisation across BOB that signs up to Alliance principles (e.g. collaboration, transparency etc). This will provide representation and advocacy for the VCSE within the ICS and BOB workstreams.

*‘Obviously, as part of the integration process [...] we can actually be starting to develop priorities, we’re all around the table together, working on the priorities together, and then talking about what the shared targets can be and how we can achieve those targets as a group of commissioners, providers and planners, and people hopefully, at some point... It’s about setting up, establishing and embedding the systems across BOB, that bring the VCSE as equal partners to the table, to the ICS.’*

The BOB ICS is clearly in development, and these moves to engage more fully and transparently with the VCSE sector were welcomed by respondents. But as many recognised, it will take time to put systems and structures in place, to embed the VCSE sector within BOB, and to shift mindsets to embrace the VCSE in decision-making around the table.

## **3.2 Survey results**

The survey to the VCSE sector was distributed via the OCVA to their members, as well as to other VCSE stakeholders who had taken part in the research. Despite the low response rate (6 respondents to date out of a target of 12), some interesting insights have emerged. The six responses represented the different geographies of the study area: two from central Oxford, two from market towns in Oxfordshire and two from rural Oxfordshire villages.

### *3.2.1 Pandemic response*

In relation to the profile of those seeking support during the pandemic, most were female and over 55 years old (> 75%), with a mix of ethnicities although mostly white British. In relation to the profile of those providing support (volunteers), most (60%) were over 40 years old, with 25% being over 65 years old. There were many more female volunteers than male (on average, a 65:35 split), with around equal ethnicity of white and non-white.

Many of the services provided related to food shopping and delivery, prescription delivery, dog walking assistance, and phone buddying. The phone buddying scheme that some groups set up was seen as a vital service for older people to have someone to talk to, on a daily basis. Delivering services to those self-isolating was also seen as a way of checking in with those individuals face-to-face, socially-distanced, which went some way to countering issues of isolation and loneliness: *“Food delivery leads to a lengthy doorstep chat with the deliverer, so the food is the catalyst that enables our residents to connect socially.”*

### *3.2.2 Partnership working with the health sector*

All but one respondent highlighted the importance of partnerships to their work, collaborating with other VCSE organisations, as well as with the health sector: One commented: *“We work with the NHS eg Oxford Health, GP surgeries, and many local charities”*. Another mentioned working with *“the local advice centre, the social*

*prescriber at the local surgery, all local schools as well as the local Hub team [...] This has enabled a great deal of networking and cross referrals to take place and subsequently helping our community".* There were also other connections to health services, such as the case of one group that is *"currently arranging a series of exercise classes aimed specifically at older people with long term health conditions, so will be working with the surgery to create a referral system."*

In the words of one respondent:

*'For a long time now, we have realised that a great deal more can be achieved by working in strong partnership with other agencies and organisations. You create a fantastic pool of skills and because of that, you don't need to reinvent the wheel, just tap into the resources that are there for you. This way, you share the load and it's a win-win situation for our targeted audience within our community. One united team is all that is needed to succeed.'*

These examples from the survey illustrate the potential for linking the VCSE with health services in partnership at a neighbourhood level, to support the health and wellbeing of local residents.

### 3.3.3. Challenges

A number of challenges were identified by respondents. In particular, reaching out to people who were not on the internet was difficult, especially those who don't have a wifi connection, smart phones, or who do not use digital devices for communication. In these cases, information about those who needed support was hard to access due to GDPR laws. For those groups that did communicate digitally, Facebook and email were the most common routes. Many groups used leafleting to reach those not connected digitally. In one case, a leaflet and newsletter was hand delivered on a monthly basis to 1250 households.

The sheer volume of demand at the beginning of the pandemic was also a challenge, and which necessitated sign-posting to other sources of support in the area and beyond. There were also concerns, in the case of more formally constituted groups, about funding to support the additional work that was needed, to respond to the surge in demand. *"Funding is by far and large the biggest barrier to us being able to reach out to as many people who would benefit from our support."*



## 4. Health stakeholder interviews and survey

This section summarises findings from the interviews with health stakeholders and from the GP respondents to the survey. However, it is recognised that the 'health sector' isn't a single voice, and has many complex and multi-faceted elements. Due to the nature of this pilot research, we have canvassed views from a broad range of health stakeholders, with the aim of hearing diverse perspectives, from different standpoints. Further research will build on this overview for a more targeted approach to involving health stakeholders.

The following subsections present the themes that emerged from interviews with stakeholders in one particular urban neighbourhood surgery, as well as more general comments from the survey from a range of other health stakeholders in the wider study area.

### 4.1 General perspective from a neighbourhood surgery

Due to restrictions on face-to-face contact as the pandemic took hold, most surgeries switched mainly to telephone consultations. In one health respondent's case, video conferencing was used in the very rare cases when the general practitioner felt that they needed to visibly see the patient. Text messaging was used extensively for things such as "... *appointment details, for coming to the surgery, for electronic sick notes, to reduce footfall, as well as information about upcoming appointments, blood tests, feedback of results, so that was quite large*". Social prescribing appointments also switched from face-to-face to telephone appointments. According to the interviewees, the telephone consultations worked well and substantially reduced footfall in the surgery. There were a small number of instances in which telephone consultations did not work, for example in cases of domestic violence, and for patients with a hearing impairment. For those, emails and text messaging were used instead.

At the beginning of the pandemic, in this particular case, the GP and the social prescriber contacted all patients they identified as being vulnerable or needing to shield, to offer them support<sup>2</sup>. As one explained,

*'...We contacted all of our shielding patients, just to be sure that.. they have enough support. If they need a medication collection, or if they need some delivery. We were aware that government was giving food parcels but, again, that was quite ambiguous, who received it, and there were so many patients who are not eligible to be shielding patients, but medically in a high risk group.'*

In this case, the social prescriber contacted Oxford Together, which is a volunteer programme initiated by the city-wide charity Oxford Hub that was set up in 2007 to work towards social change for Oxford residents. The volunteer programme, Oxford

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<sup>2</sup> The NHS Long-Term Plan set a target that by 2023/24 every GP practice in England will have access to a social prescribing link worker and by then, 900,000 people will be referred by a social prescriber (King's Fund, 2020).

Together, was set up in 2020 to help those in need during Covid-19 and after a few meetings, the social prescriber started referring patients who needed help to them. The work of Oxford Together was seen as essential for the health and wellbeing of local patients, because they not only helped with the collection and delivery of medication and food, but also with combating social isolation.

According to the social prescriber, the response from the voluntary sector, through Oxford Together, was put together much more quickly than the response from government and statutory bodies. In their words,

*'Oxford Together actually built up really quickly, and it was just so straightforward how to refer, and their volunteers were really good, they have an even quicker response time, I will say that. Like how they set up everything and how everything was up and running so quickly. It was so much quicker, before the NHS or local government started to do anything.'*

The work of Oxford Together was also deemed effective by Oxford City Council who, after a few months, joined forces with Oxford Hub in delivering support for those in need of help.

Having Oxford Together as the main port of call for referrals allowed social prescribers to respond swiftly to requests for help while keeping patient confidentiality: *"Once we referred to Oxford Together, it was the volunteer and the pharmacy who needed to sort it out between them"*. For the social prescriber, Oxford Together was also considered a safe option, as their volunteers were checked by the Disclosure and Barring Service (DBS). The social prescriber also liaised with pharmacies, noting that they have become more flexible and more likely to provide assistance in terms of medicine collection and delivery. Some pharmacies were described as *"super flexible. So, if a patient was housebound, they were like, if it's needed immediately, and if it is about a resident, they were happy to deliver it, [as a] one off"*.

### **Importance of the role of the voluntary sector**

Volunteering was seen as having many positive impacts on the individual and the wider community. Both the GP and social prescriber interviewed expressed positive views about the rise in volunteering in response to the Covid-19 pandemic. Volunteering was also described as being crucial to the delivery of the vaccination programme in their area. Without volunteers from the local community, and particularly from St John's Ambulance, the surgery would not have been able to deliver the programme of vaccinations as they did.

*'So it's been really fantastic having them involved, because of the workload, otherwise, it would have been too much for the surgery to handle. And quite often that happening at the same time as our usual clinical work, or on weekends, and you've got the risk there of our usual staff being diverted from their own work or doing extra work, with the risks of getting tired or burned out.'*

### ***The need to find innovative ways to enable volunteering***

Both the GP and social prescriber were mindful of the need to harness the volunteering effort that has been spurred by the Covid-19 pandemic; however, both were conscious of the fact that much of the volunteering took place during lockdown and while people were furloughed. In their view, volunteering could be encouraged by improving knowledge and access to volunteering and by using innovative strategies such as the matching volunteers with those in need of help by postcode. According to the social prescriber, this method was used by Oxford Together and appears to have enabled a quick support response and used volunteers' time more effectively. In their view, such innovative approaches could stimulate more people who have busy lives to do some volunteering.

*'I think that if you're full-time working, you have two kids, you would like to do volunteering, but you can't find time. But if it is a neighbour two doors down, who needs shopping once in a while.. That will be something that I believe many, many people can fit either in the evening, or in their lifestyle. But if you think that "Oh, you need to go somewhere, park and then need to spend two or three hours somewhere else", that would be totally different. So, again, finding that kind of flexibility on how to do volunteering.'*

### ***Voluntary and community sector organisations can be volatile***

Despite the positive results regarding collaboration with VCSE organisations, one of the problems relating to social prescribing before Covid-19 refers to volatility of the availability of local services and activities to refer patients to. The fleeting nature of some activities and initiatives means that social prescribers have to be continuously up to date with what is happening locally. This volatility was explained as being directly linked to the ability of these organisations to secure and maintain funding, volunteers and specialised personnel, as noted by a GP interviewed:

*'There were one or two smaller organizations that dealt with youth in the area as well. Some of them came and went a little bit, and then there were projects that were funded externally and, for example, we had one organization [...] who used to do exercises for people who had problems with mobility. So, this had to do with some physical therapy, occupational-therapy-type exercise which includes, say, hydrotherapy for them. But again, that would be the sponsored projects, not necessarily volunteers from the local area.'*

Funding is critical to the VCSE, and the current funding climate means there can be volatility in the sector, which is destabilising for social prescribers.

### ***The importance of social prescribing***

The work of social prescribers has been found to be important in providing preventive and all-encompassing healthcare services. The GP, however, highlighted that work of social prescribers is currently based on *"quite a bit of form filling and dealing with each case, closing each case"*. Instead, it should be structured around building:

*‘...[a]n ongoing relationship between social prescribers and patients, [...] based on an assessment [of] the need to help patients through the process of identifying the problems, prioritizing them, and then seeing linkages and being able to strategically pick out the problems that we could solve.’*

### **The need for more cooperation between the NHS and Public Health England**

The GP emphasised that more cooperation between the NHS and Public Health England needs to happen for a more successful integration of healthcare services. They highlighted how, for example, the treatment of diabetes type II can be much more effective through an approach that deals with some of its main causes, such as obesity or poor diet. In their words,

*‘... [W]e need to have, I think, you know, Public Health working closely with general practice to look after population need, rather than just your own, sort of, you know, the disease aspect so to speak. We go back to primary prevention.’*

## **4.2 Partnerships between health and VCSE**

In other interviews with health stakeholders, it was recognised that stronger partnership working between health and the VCSE was essential, going forward. One interviewee thought that the level at which services were commissioned and organised in ICSs was important. The contrast was highlighted between the potential benefit of, on the one hand, organising specialised secondary care, which might be delivered more effectively at the BOB level, and on the other hand, services addressing issues such as health inequalities, health and wellbeing, the prevention agenda and social care (e.g. supporting people as they get older and people with disabilities) that could be better delivered with VCSEs at a more local level. Interviewees explained that there also needed to be a strategic means of linking things that can happen most effectively at a local level with, for example, County level adult social care commissioning.

## **4.3 Survey results from GPs<sup>3</sup>**

### **4.3.1 Context**

The survey was completed by a total of 50 GPs, mainly covering Oxfordshire and the wider South East region. Some 40% of respondents had been qualified for over 20 years, and around half had been in their current position for over 10 years.

When reporting on their contact with the VCSE, there was a distinction made between informal community groups (such as local community groups), and more formal voluntary groups (such as Age UK). For more informal community groups, GPs reported having quite a lot of additional contact with informal groups since the start of the pandemic, whereas for more formal voluntary groups, the amount of contact that

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<sup>3</sup> Given the low response rate of pharmacists, with just two completed surveys, their responses have not been included in this analysis.

GPs had before and after the pandemic did not change significantly. Much of the contact with the VCSE was through volunteers at Covid-19 vaccinations centres (42%) with other contact through food collection services, delivery of prescriptions and Good Neighbour schemes (befriending), amongst others.

#### *4.3.2 Social prescription as a link between health and the VCSE*

Integrated working through social prescribing was identified as a useful way of connecting with the VCSE, with over half (54%) saying they used it some of the time. A further 8% of respondents said they used it most of the time. However, the majority (70%) said they only linked up with one organisation, with a further 18% saying they used two organisations. This suggests that there is considerable scope to enlarge the pool of VCSE organisations that provide social prescribing services to GP practices. Of the organisations mentioned, many (over 30%) were large national bodies (e.g. Age UK, Mind, Marie Curie), with the remaining ones mostly locally-based small-scale voluntary sector organisations.

It was felt by GPs that social prescribing worked well for mental health issues including helping to conquer loneliness (20%), support with other mental health issues and anxiety (8%), as well as keeping people connected and promoting lifestyle changes. Practical benefits included advice on housing, personal finances and benefits, accessing additional care, patient transport, delivery of shopping and prescriptions, and generally keeping connected to the surgery.

However, since the pandemic, it was noted that there has been reduced funding and less resources for organisations offering social prescribing. VCSE organisations have become more difficult to contact, because staff and volunteers have mostly been working from home. Tackling loneliness has become difficult, not only due to the lack of resources for social prescribing organisations, but also due to the lack of face-to-face contact. The volume of need has increased, at a time of reduced services. GPs also reported a lack of awareness of social prescribing services available, the difficulty of bringing organisations together during the pandemic, and a perceived lack of training of the volunteers with appropriate skills.

#### *4.3.3 Benefits and challenges of working with the VCSE*

Many GPs reported on the benefits of working with the voluntary sector. In particular, they cited increased goodwill, with greater community cohesion through helping people to get support at a time when family were unable to help vulnerable members of the community. They became a point of referral and support, helping people with both social and practical aspects of need. The most common benefits reported were support for the isolated elderly, support for mental health and supporting the vaccination centres. GPs felt volunteers were enthusiastic, flexible, helpful, and good team players. They felt that working together improved communication and helped take pressure off GPs, at such a busy time.

However, there were also challenges reported of working with the voluntary sector. As well as reduced funding and staffing of voluntary groups, and the loss of face-to-face

interactions, there was also concern around confidentiality and volunteer safety checks. One GP referred to the challenge as 'crossing boundaries'. GPs also reported concerns around the level of knowledge that the volunteers had, and the need for training. Furthermore, some GPs reported that they were unsure of which voluntary organisation to contact, and felt the voluntary organisations did not promote awareness of their services within healthcare services. This suggests the need for more comprehensive signposting of local VCSE organisations and the services that they provide that could be useful for social prescribing.

#### *4.3.4 Factors necessary for integration of health with VCSE*

GPs were asked to suggest elements that would be necessary for the integration of the voluntary sector into health and social care services. The factors fall into four categories, listed below, as provided by the GPs:

##### **1. Information and communication**

- More awareness of what is available and what they can do
- Greater awareness of role
- More information on what's available and what they can do for us and our patients
- Awareness of need and to match it with available volunteers
- More information about how they work for patients and healthcarers
- Discussion between health and social care and the voluntary sector to ensure the right services are offered for the local population
- Better communication and transparency
- Communication and transparency
- Shared vision
- A central signposting service
- A friendly and supportive approach
- Awareness of the benefits.

##### **2. Processes**

- Easier access to referral forms/pathways
- Commissioning from the PCN
- Shared protocols/procedures equitable distribution of tasks and responsibilities
- Joined up systems and easier communication pathways
- Formal roles, guidelines and targets
- Continue the current links after the pandemic to benefit the patients
- Ease of access, especially self-referral, both online and print information for patients (e.g. posters/leaflets in waiting rooms)
- More active cooperation with services like social prescribing
- Sound referral pathways
- Confidentiality of information
- Care navigation.
- Be part of the NHS
- Employed by a governing body to do DBS checks.

### 3. Funding

- Reliable source of funding
- Funding & personnel
- Recruitment & retention of their staff
- Consistent resources and funding
- End user needs analysis
- Money, time and flexibility.

### 4. Willingness

- Willingness of patients
- Patient education
- Recognising their value and treating them as equal partners
- Willingness to accept change
- Dialogue-ensuring the benefits are highlighted and problems solved - good protocols and training
- Expectation that the roles will change and develop according to the needs of the patient population.

## 5. Barton case study

### 5.1 Context

Barton is a mixed-tenure housing estate originally built in the 1940s as social housing and is located 3 miles east of Oxford City Centre on the edge of the city. Barton is a close knit community and is appreciated locally as a good place to live with many facilities including the neighbourhood centre in the centre of the community (containing Barton Community Association, [Hedena Health](#) Doctors Surgery, a Café, Sports Hall, Advice Centre and a busy programme of activities) and also a separate Sports Centre, a swimming pool, family center and an active church, St Mary's.

According to Indices of Multiple Deprivation data, Barton is one of the most deprived areas in Oxford and in England as a whole, and healthy life expectancy is lower than that for both Oxfordshire and for England. In 2011, its population was 3,700 but this has expanded since the development of Barton Park, a new housing development created in partnership between Oxford City Council and the property developer, Grosvenor. Since 2017, the planned 885 homes, and various facilities including a new primary school, have started to be built out across the 90 acre site. Barton Park was selected to be one of ten demonstrator sites nationally for the [NHS Healthy New Towns programme](#) with a vision that: "All Barton residents (Barton and Barton Park) have an equal opportunity to good physical and mental health and good health outcomes" ([NHS 2021](#)). The Healthy New Towns programme led to the consolidation of existing strong links between formal and community health systems, with a community development worker and Health and Wellbeing Partnership in place alongside a recently established community partnership.

### 5.2 Pandemic response

Barton's pandemic response was built upon an already strong web of networks and partnerships, spearheaded by the Barton Community Association (BCA), which has been in operation for over 60 years and is well respected in the neighbourhood. BCA was at the heart of initial discussions in early 2020 with Oxford City Council to set up the volunteering and support infrastructure that was key to the success of the pandemic response.

In March 2020, six "Locality Response Hubs" were set up by Oxford City Council across the city, in reaction to the pandemic. The Barton Hub covered the wider area of Barton, Sandhills, Risinghurst, Headington, Quarry, Northway and Marston. The Locality Response Hub included the Barton Community Association, Hedena Health (a group of Health Centres in North East Oxford), social services, the police, St Mary's Church and VCSE organisations. This included a Community Health Worker who is employed by Oxford City Council using Community Infrastructure Levy (CIL) money raised from the development of Barton Park, through the Healthy New Towns programme. The Barton Hub held weekly coordination meetings, to ensure community needs were being met.



Oxford City Council worked together with Oxford Hub to set up the infrastructure for the Oxford Together campaign, Oxford Hub's volunteer programme, which encouraged people to become 'street champions', organising mutual aid and grassroots volunteering. Oxford Hub was active in Barton with a local team of volunteers in the neighbourhood.

At the end of March 2020, the Community Association teamed up with the Didcot-based charity SOFEA ([South Oxfordshire Food & Education Academy](#)) to distribute around 300 food boxes each week plus fruit and vegetables. There had previously been a Food Bank in Barton, and this evolved into a Community Larder run by Barton Community Association, which opened in September 2020 with 27 members. There are currently around 175 members. The Community Larder supplies surplus food provided by SOFEA for a charge of £3.50 per week. Around 40 volunteers from a wide range of backgrounds made deliveries for the Larder during lockdown. A Community Café was also opened in an outdoor space at the Community Centre, where people could stop for refreshments (socially-distanced).

Other food support was provided by the kitchens at Blenheim Palace, who in May 2020 prepared 75 meals twice a week that were delivered by BCA volunteer drivers to older people in Barton. Drivers' rounds were scheduled to enable informal checking-in on the doorstep.

Other support to the local community was provided by Barton Advice Centre volunteer staff, who rang round their existing clients to check their needs during the lockdowns. Some 75% of their clients have mental health needs and 50% have physical disabilities. The Advice Centre also provided IT training, so that older people could connect with family and friends online to help combat issues of loneliness, or feel more confident with, for example, online food shopping. They received some referrals from Hedena Health via the social prescriber located there, and from Oxfordshire Mind, the mental health charity and were also able to refer people to those organisations. Hedena Health had established a social prescribing service around six years ago, a service which has continued throughout the pandemic. It has been an important way to link patients with services provided by the VCSE.

In addition, St Mary's Church in Barton also opened a phone line for members of their congregation to get in touch, and were able to reach groups who didn't want to engage with the Community Association or Oxford City Council. They contacted all of their congregation weekly to check they were ok, and also held online services and prayer groups, and helped older people with IT.

Barton was the first community venue in Oxford to offer Covid-19 vaccinations, through a centre established with Hedena Health in the Neighbourhood Centre Sports Hall in December 2020. Volunteers who supported the movement of people being vaccinated through the clinic were successfully recruited and managed by the Community Association. The initial short term plan for the clinic was extended due to its success.

## **5.3 What worked well**

### ***Valued volunteering***

Being able to volunteer was seen as very important for residents giving them a focus and purpose after, for example, being made redundant. Overall residents reported how the sense of community had also improved with more people looking out for each other and organisations having a wider range of volunteers.

### ***Strong existing social infrastructure and leadership***

As illustrated above, there was an existing and robust social infrastructure with good partnership working between organisations that had strong links to and very good knowledge of the local community.

*‘Because we’re all community-based. we all know the residents in Barton, we can identify those ones that would need the help very, very early on in the process.’*

There are long-established and trusted leaders in Barton, who were available to contact and known to get things done quickly and effectively. This meant that in addition to organisations being able to check-in with potentially vulnerable people, local residents also knew whom to contact, and were happy to do so.

### ***Community space and physical proximity***

Many organisations were co-located in the recently refurbished Barton Neighbourhood Centre which multiple interviewees noted made communication and action easier. With easing of lockdowns, the Neighbourhood Centre also offered an adaptable space to provide a vaccination centre, the Community Larder and an outdoor drop-in Community Café.

### ***Improved understanding of different work cultures***

Working directly together on projects and in some cases sharing physical spaces enabled different work cultures to be understood and adapted.

*‘Now they’ve sort of got to know us and how we work, we’ve got a much better working relationship with them... that’s where I say this “one team” approach comes in, because now it’s taken us a good few months, but I feel that the NHS trainers, managers are now sort of working on the same level as us, rather than thinking that we’re secondary to them and there to just jump when they click’*

### ***Variety of programmes - and food as a catalyst***

In addition to the services described above, a range of other Covid-specific programmes included an email newsletter and competitions. The success of the meal deliveries to older people, the Community Café and Larder led to recognition of the

importance of food as a catalyst to social contact and wellbeing beyond the nutritional value of the food itself. The Larder and Café became an informal contact point for a range of organisations to reach the community, including the Advice Centre, City Council, Aspire Oxford, gardening organisations, Hedena Health and Thames Valley Police.

### ***Addressing dependency***

The Community Association introduced nominal charges for some services such as the delivery of meals and the Community Larder. This was a policy decision in order to address the issue of dependency that it was felt can impact some residents. It was also addressed through, for example, increasing IT skills through training, helping residents to set up online banking and training in the use of online communications.

### ***Variety of communication channels and organisations***

Phone check-ins, Zoom, face-to-face doorstep discussions and the drop-in Community Café provided a range of different means of communication. Detailed and overlapping knowledge of the community by a range of organisations including Barton Community Association, St Mary's Church, Barton Advice Centre, Oxford City Council and Hedena Health, combined with collaboration and support of specialist agencies dealing with e.g. visual impairment and mental health along with the appropriate communication channels meant contacting and support of the whole community was possible.

The Barton Advice Centre radically changed its approach from face-to-face to phone and online services, including three-way calls with support workers where required. It was acknowledged that this was greatly preferable for some clients.

### ***Cementing relationships between formal health and other partners***

Hedena Health was praised for identifying needs and signposting to support services through social prescribing. Skilled community development workers were also seen as vitally important with recruitment, training and retention highlighted as key, given that *'community's messy, community work is hard'*.

*'We're so lucky in Barton. We have two community development workers. One is for St Mary's Church... and the other one is a Housing Community development worker... Both development workers see enough people around when they are out and about, so they will find patients as well (inaudible). But all these logistic parts of setting up something, meetings, training when somebody needs it, and all these emails... this is, this is a full time job. Just for sorting all this. They are more doing this kind of work while we are seeing patients one-to-one and seeing how we can refer patients to these groups. But if they don't set up these groups, there wouldn't be enough places to refer patients to. So it works pretty well.'*

The six City Council Locality Hubs across the city were seen as very effective with Barton as probably the most effective of these.

## **Data sharing and protection**

Organisations stated that they had existing policies and practices in place pre-pandemic that were robust and practical during the crisis.

## **5.4 What worked less well**

### **Impact of the pandemic on access to health services**

Some respondents found that it's *"been a struggle [...] not being able to see a doctor or speak to one."* But there was praise for pharmacists during the pandemic. *"They'll listen to you. They'll give you advice. They'll try and sort a few things that we couldn't get through the doctor, they'd get on the phone and speak to the doctor's surgery and just went out of their way for us."*

### **Digital exclusion**

Although opportunities for face-to-face contact were acknowledged, some residents felt that a lot of services went online and this made life more difficult for older and more vulnerable people who had not got internet access or skills.

Organisations recognised that digital inclusion was important and worked towards this but it was noted that improving IT skills during periods of lockdown was difficult when direct tutoring wasn't possible.

### **Wider range of volunteers**

There was a comment about the relatively narrow profile of volunteers. One respondent noted that their organisation was *'trying to move volunteering away from this middle-class thing to do, to be something that anyone and everyone can do... I'd say that there's a culture in Barton of just not volunteering and we've changed that a bit, but we've got more to do on that.'*

### **Evaluation and monitoring**

Organisations said that this had been challenging during the pandemic due to resources being stretched even further than usual. Some had managed to undertake evaluation through interviews with stakeholders and some were planning to carry out retrospective evaluation.

*'What we're going to do is we're going to use one of our volunteers to contact clients that we've spoken to over the last year, and not all clients but a percentage of clients, and do a feedback evaluation form to see how we performed.'*

## 5.5 Factors that contributed to the success of Barton's pandemic response.

Barton was seen by all respondents as an exemplar of a community coming together in its response to the pandemic:

*'I think the lesson learned was "Follow Barton next time!"... This has been an absolute perfect example of how community can come together during a really difficult time.'*

A number of factors were identified as being key to the success of Barton's response to the pandemic:

- Previous long-term investment, and a strategy for collaborative community working, including community development workers, recognising the time, skills and resources required: *'There's no shortcuts to anything, and if you want to make a real difference, you have to do things properly'*;
- Strong and respected local leaders with the skills to get things done quickly and efficiently
- Strong and established links between the GP surgery and community; investing in social prescribers and also community development workers
- Using a variety of communication channels including online, phone and face-to-face
- Having physical community spaces where residents, staff and volunteers can meet safely face-to-face, outside and socially-distanced
- Detailed knowledge of community needs. Cross-checking with partner organisations that potentially vulnerable people were supported and referring to appropriate services
- Engaging with a wide range of volunteers and finding fulfilling roles for them.

These factors are picked up again in the final section of the report, in relation to recommendations.

## 6. Piddington case study

### 6.1 Context

Piddington is a rural village and civil parish located in the southeast region of Cherwell District in Oxfordshire, approximately 4.5 miles from Bicester and 13 miles from Oxford City Centre. It occupies an area of approximately 3.68 square miles, encompassing agricultural and woodland and areas owned by the Ministry of Defense (MOD). According to the 2011 census, Piddington had a population of 370 people in 160 households. A higher-than-average proportion of working-age residents work from home and over 50% are in managerial or professional occupations. The Census also showed that residents aged 65 and over comprised 22% of the population, a figure that is 6.1% above the national average, according to the Community-Led plan for Piddington, published in 2019.

Piddington has a Parish Council, which has the power to raise money by precept (a mandatory demand) on the District Council. However, the village currently has no amenities and residents need to travel above national average distances to access key services. The public bus service was cancelled in 2016 but after pressure from some residents, it was reinstated to a one-day a week service, coinciding with Bicester's market day. Since the village's public house closed in 2011, the main places for socialising are now the Village Hall Committee and St. Nicholas Church. According to a resident who, at the start of the Covid-19 outbreak was involved in the Parish Council, Piddington could be described as:

*'... a) it's very rural [...]; b) it has no services or facilities. So it's a category C village. That basically means that we don't have anything, we don't have a pub, there's no shops, the bus service that the village has, is only one day a week to Bicester market. [...]. So we would probably be the complete opposite of an urban environment, in that it's actually, it's quite a self-contained unit, revolving around the Village Hall, which I would say is the hub of the village, and to a lesser degree, the church.'*

Since the village has no shops, in 2011 a steering group initiated a community market, which they named the Pantry Market and Coffee Shop, selling local produce and crafts. Despite being considered a success by residents, the gradual fall in attendance over the years contributed to a reduction in the frequency of the market to three times a year and, in 2019, the steering group announced that the market would cease after Christmas.

### 6.2 Pandemic response

Two local women were at the forefront of putting together and leading the response from the Parish Council to the pandemic. At the start of the Covid-19 outbreak, they created leaflets and distributed them to every house in the village asking for anyone interested in volunteering and anyone needing help to contact them. The leaflets led to the creation of a WhatsApp group of around 40 people willing to volunteer. The group was formed by the time the first lockdown was announced, and formed the basis of a

'buddy system' matching up vulnerable residents (mostly residents with health issues or those aged 80 and over) with two volunteers. According to one of them, their plan revolved around *'communication, creating a volunteer base, and looking at what issues were going to impact people'* and focused on providing support in three fields: the supply of medicine and food, connecting households to the internet and communication technologies, and maintaining residents' mental health and wellbeing through the lockdown.

The plans for a support network in Piddington received substantial backing from the Parish Council and soon became its official response. It was widely accepted that the Parish needed to initiate some sort of response due to the lack of an official plan from Central government, as explained by one interviewee: *'And it became obvious that there was no real central planning and nothing was going to come down from government or local authority, certainly not down to Piddington level'*.

The Parish bought and distributed PPE products such as gloves, masks, and sanitizing equipment for residents. They also received £500 funding and bought ten Facebook Portals—video-calling tablet devices sold by Facebook. These were distributed among households who did not access the internet or communication technologies, to reduce their social isolation. The Parish Council negotiated with GigaClear, the internet provider for the village, to lower broadband prices for vulnerable and elderly residents. Overall, the main initiatives of the group are described in the table below.

| Support activities   | Description   |
|--|---|
| 'Buddy' system   | Two volunteers were assigned to each individual/household identified as vulnerable. |
| Medication collection and drop-off                                 | Run by volunteers but stopped once chemists started to provide this service.        |
| Delivery of foodstuffs, including fresh vegetables, milk and bread | Organised with local businesses.  |
| Creation of a pop-up shop in the Village Hall                      | Sale of non-perishable foodstuffs (tea, coffee, flour, etc.) at cost.               |
| Purchase of 10 Facebook portals                                    | To enable residents to contact their families and friends during lockdown.          |
| Coffee mornings and tea sessions                                   | Invitation for people to come to their front gardens/driveways.                     |

|   |   |
|---|---|
| Creation of a radio station with a Sunday morning slot for the local church service | Station accessible through Piddington's village website.  |
| 'Piddington Five-a-Day' Emails  | A daily email with positive pieces of news, showcasing poetry, music and art to show the "positive side of humanity." |
| 'A day in the life of a village lockdown'   | Request for residents to share photographs showing what they were doing during lockdown.                              |

### 6.3 What worked well

#### ***Residents were satisfied with the Parish's Covid-19 response***

All interviewees were satisfied with the support structure put in place. The structure was based on the work of volunteers and contacts with local businesses, as one interviewee explained:

*'No, we didn't really interact with charities because we felt that we could supply the needs of the village, without having to call on charities, who were very hard pressed in different areas, because we know there's food banks in Bicester and surrounding areas. [...] So I think we felt that we were able to provide the needs of the village, whether that was a pride thing or whether that was just purely an economic thing I'm not sure, but we felt that we could cover that ourselves, without imposing on charities. You know, I'm sure, had we felt that we weren't able to cope, we would have reached out for additional assistance.'*

#### ***Fast response due to the village's stable and small population***

The identification of potentially vulnerable households was made easy by the fact that the village has a small and stable population. According to one member of the Parish, most residents have lived in the village for around 15 years or more. Those organising the response strategy noted that they were able to compile a list of the most vulnerable people/households very quickly as a result.

#### ***Email address database and social media used to disseminate information***

An existing email address database used for the village monthly's newsletter was used to disseminate the Parish's response strategy. The village's website and Facebook page were also used to disseminate information about the support network.

#### ***Digital exclusion***

The Parish used £500 funding to purchase approximately 10 Facebook Portals which were distributed among households identified as having no access to communication



technologies. They also negotiated lower prices with their internet provider. Volunteers visited residents outside their homes, and taught them how to use the portals.

### **More interaction between residents**

Besides volunteering, there were other initiatives that also generated further interaction between residents. For example, 'A Day in the Life of a Village Lockdown' was based on residents taking a picture of themselves doing an activity, and sending it to the village email. Another initiative 'Saturday Night at Home', involved residents sending an hour's worth of their favourite songs and the reasons why they liked them, to be broadcast on the village radio on Saturday evening, and every evening the following week. These 'virtual' initiatives helped to keep connections between residents, during a period where there was little face-to-face interaction, and was seen as extremely valuable in helping residents through lockdown.

## **6.4 What worked less well**

There were no examples of interaction between the support network created in Piddington and the NHS health services. The system to collect medication for vulnerable residents was based on establishing relationships with local pharmacists. The approach, however, conflicted with the plan put together by Cherwell Council which, according to one of the organisers, relied on formal methods of identity verification for those who were collecting prescriptions. As she puts it,

*'I got contacted by somebody from, I think it was from Cherwell, who was then trying to coordinate it all across the region. And then it started to get a bit more complicated, in terms of needing photo ID and things'.*

The view was that such requests would make the collection of medication more complex and would potentially negatively impact on the volunteering programme put in place. The organiser's response was to send emails to pharmacists with the names of all their volunteers, as she explained:

*'So that, you know, I contacted all the pharmacists by email and said, "Right, these are our named volunteers". And actually, quite a few of us were already involved in other volunteering things. So therefore, we've got DBSs, and stuff. That made life slightly easier.'*

## **6.5 Reflections on the pandemic and maximising links between VCSE and health**

Although the support network still exists through the WhatsApp and Facebook groups, many initiatives such as the pop-up shop that ran during the first and second lockdowns have ceased to exist, as restrictions started to ease and requests for assistance started to dwindle. For one of the organisers of the support network, this was to be expected. In her words,

*'...I just feel that what we put together, it's almost like a warlike mentality. It's being under siege. But it's not necessary in a normal life. And you saw that in terms of, even towards the end, with doing our "Five a Day". And with the music, as things opened up, and people's worlds started to widen, their need for that thing became less and less.'*

The work of the two women was highlighted as crucial for the success of Piddington's response. Setting up the strategy, however, was described as equivalent to a full-time job, as explained by one of the women:

*'I would say, for the first six weeks, my husband said "you literally, you were out all day, either trying to sort things out or trying to get people on board to help", but it was very worthwhile. It really was, in terms of how, as a community, we've all survived it.'*

One interviewee observed that there are clubs and other activities run by village residents that could potentially be referred to by social prescribers. In her view, reliance on the voluntary sector to make those links to health is problematic, because of the nature of volunteering. It relies on people's willingness and ability to devote time to volunteering, and to think more widely about links with health. Instead, the integration between the health sector and voluntary services would best be coordinated—or at least overseen—by the Parish Council via a nominated Councillor. In her words,

*'We have a Parish Councillor who deals with the allotments. Bigger Parish Councils will have someone that deals with planning. Maybe what you're talking about could be tied in, because you've got the whole pyramid then with a Parish Council, because they have a direct link on a daily basis with their District and County Councillors. So, you've got that pyramid in place. And that is very stable, that pyramid doesn't go away [...] That's how you could get your Parish Councils to have a Councillor on board, who is looking at the voluntary sector, the health and mental wellbeing or liaising with practices, etc.'*

The role of the Parish Council was identified as potentially acting as the linchpin in a rural setting between local VCSE organisations, and social prescribers, or more generally health providers. Their role would be to identify and signpost local community-based clubs and activities that can help to address health and wellbeing issues in the local context.

## 7. Summary and Recommendations

In this final section, we present a summary of opportunities and barriers to joint working, together with a number of recommendations that have emerged from this pilot study, based in Oxfordshire. We recognise that in the limited time available to us, we have only been able to speak to, and to survey, a small selection of stakeholders. Furthermore, these recommendations that have come out of these interactions, may not be relevant in other contexts across the country. Nevertheless, we feel that given the respondents' understanding of the local context, the recommendations presented here provide useful guidelines for how local stakeholders in Oxfordshire and the surrounds, perceive that deeper integration of health and VCSE can be achieved in the future.

To summarise in relation to the barriers and opportunities to joint working, respondents in interviews and the surveys identified the following issues:

### *Opportunities for joint working:*

- The pandemic has brought different organisations together in crisis mode, and relationship building that can normally be time-consuming and complex, has happened relatively quickly and with little friction.
- New partnerships have formed that can be built upon in the future.

### *Barriers to joint working:*

- Speaking different 'languages'.
- Different cultures and mindsets in health and VCSE.
- A lack of understanding between the two different cultures.
- Financial constraints in the VCSE sector which limit their capacity to reach out beyond their core mission.

## 7.1 Health-sector related recommendations

### *Headline recommendations:*

- There is a need for **broad engagement with the VCSE**, to ensure that all **voices, both large and small**, are heard and integrated within the BOB structures.
- There are plans to integrate VCSE more closely into BOB, through **the BOB-wide Alliance** that is currently being created (see Annex 4). This important initiative should be given priority, ensuring that it is adequately funded, and its principles are shared at all levels within BOB. This will involve a culture shift within the organisation.
- It is essential to ensure that the **VCSE has adequate representation** on the Senior Leadership Group of BOB, as well as within its main work programmes and workstreams. These individuals would be representing the interests of the broader sector, rather than individual organisations.

- There are important lessons emerging from the nationally-led **VCSE Leadership Programme**, run by NHS England and NHS Improvement. These lessons coming from the programme should be noted, as they can provide key learning points for the evolution of networks between health and the VCSE, for more equitable partnerships and better integration within the BOB area.
- **The role of social prescribers** is key to forging the link between the health and VCSE sectors at the neighbourhood level. It is critical to ensure that these roles are adequately funded and supported, to maximise their benefits.

***Other recommendations:***

- Address the current lack of **understanding of VCSE within BOB**, and of **BOB within the VCSE**, through information and communication between the two arenas.
- Update **BOB website** to provide a more transparent overview of governance structures, Senior Leadership Group and key players, with contact details.

## **7.2 VCSE-sector related recommendations**

***Headline recommendations:***

- At a local level in an urban setting, one of the keys to successfully linking health needs and VCSE activity is **the existence of a ‘Community Worker’** embedded within a neighbourhood. These roles are critical, acting as an intermediary between different organisations and sectors, having an overview of hyper-local needs and potential VCSE provision in the locality. These roles should be well-supported and well-funded, with adequate training and support infrastructure in place to ensure successful recruitment and retention of these key roles.
- **Funding is critical to the VCSE sector** as a whole, and dictates the depth and breadth of the sector’s work. Cuts over recent years in the sector have undermined its ability to meet local needs, and has created volatility in the sector. Adequate core funding is crucial to the future of the sector, to ensure more stable and long-lasting local activities and programmes and to address volatility.
- In a rural setting, **Parish Councils can play a key role as intermediary between local VCSE provision and the health sector**. A nominated Councillor would be well-placed to have an overview of local provision, and could sign-post enquiries from the health sector to appropriate local clubs and activities. Defining this role at the Parish Council brings stability, embedded within the structure of local government.

***Other recommendations:***

- Adopt **‘Participatory Grantmaking’** more widely, as an approach to funding decisions, which involves communities more closely in grant-making decisions.
- Engage with a **mapping of VCSE provision**, combined with local on-the-ground knowledge from individuals in key umbrella organisations.

- Address the issue of **digital exclusion** by developing IT skills, confidence and connectivity in the community (acknowledging the limitations of doing this in a pandemic), which will mean older and more vulnerable populations will be able to participate more fully in online services and activities.

### 7.3 Further research:

From the research, as well as from discussions within the Advisory Board and at the Stakeholder Impact Event, a number of ideas have emerged, to take this pilot project forward, including:

- Building on the pilot to examine these issues at a national level, taking different case studies to explore how ICSs are integrating VCSE in different parts of the country, and what lessons can be learnt from that.
- Exploring how social care fits within Integrated Care Systems, and how the VCSE can contribute to that.
- Involving different voices within the health sector in the research, in particular those from primary care and secondary care.
- Examining in more depth the issue of neighbourhood support, 'neighbourliness' and the role of mutual aid organisations, as responses to the pandemic.

An infographic summarising these findings can be found in Annex 5.

## Annex 1 - Advisory Board members

### Advisory Board members

The Advisory Board met virtually three times during the project, to advise the research team on the different stages of the project, in February, April and June 2021. There were six members, from across health and the VCSE sectors:

|                   |   |
|-------------------|---|
| Sue Brownill      | Oxford Brookes University   |
| Angela Cristofoli | OCVA (Oxfordshire Community and Voluntary Action)                           |
| Diane Hedges      | Oxfordshire CCG   |
| Volker Kellermann | BOB ICS (Buckinghamshire, Oxfordshire and Berkshire Integrated Care System) |
| Sophie Kendall    | Oxford Hub  |
| DeeDee Wallace    | Oxfordshire Innovation Hub  |

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## Annex 3 - Stakeholder Impact Event: Feedback

The Stakeholder Impact Event was held on 22nd June 2021, with a total of 23 participants. Following a presentation of the draft Final Report, participants moved into Breakout Rooms, to discuss three questions:

1. From the findings presented, what three issues from the report stand out as having relevance for your sector?
2. Is there anything that doesn't ring true, or is missing?
3. What do you think are the three key factors that will contribute to the integration of VCSE in ICS, going forward?

The discussions were captured on the collaborative online tool, JamBoard, and can be summarised as follows:

1. Issues of relevance for your sector:
  - Participants recognised the importance of the Alliance being set up in the BOB ICS area, and there was clear interest in being involved. Participants wanted to know about the practicalities for getting involved. The Lead for the Alliance, Rachel Stanton, attended the Stakeholder Impact Event, and gave details of the Alliance Launch Meeting, to be held on 13th July (see Annex 4 for more information).
  - The value of localised models of health and social care was noted, identifying 'hyper-local' needs.
  - The issue of balancing power relations between the VCSE and the NHS/statutory bodies was reiterated as being an important issue to acknowledge and address.
2. Findings that don't ring true, or gaps in the presentation of the report:
  - The lack of focus in the report on social care was noted by participants. It was explained that social care wasn't included in the study, due to the limited time and resources available for the pilot. However, this could be a useful addition in the following wider research project.
  - Another gap in the presentation in relation to the VCSE was the need to measure outcomes, in order to justify resources. This is often challenging for the VCSE sector, and is an area that warrants further attention.
  - There was concern that the report risks repeating the view that "volunteering is good, and we can rely on the voluntary sector to step in". It's important to make clear the challenges for the VCSE of the lack of resources, funding and time available, which hinder the work of the sector. There was consensus that it's getting harder to find volunteers.
  - There were calls to reflect the different voices within the health sector, in particular voices from primary care and secondary care. This could be included in any future research project.

3. Key factors that will contribute to the integration of the VCSE in ICS going forward:

- The issue of resources and funding for the VCSE was considered key. Short term funding makes it difficult to plan long term. Small-scale VCSE organisations won't necessarily have the resources or administrative support to engage with the BOB ICS.
- Members of the voluntary sector feel that they are not valued for providing the services that they deliver. Greater recognition of the value of the VCSE will contribute to embedding their work more effectively into ICS. Ideally there would be a 'Code of Practice' for how the ICS engages with and funds the VCSE, to build and maintain relations between the two sectors.
- Communication will be a key factor between the VCSE and ICS / the health sector, for the successful integration of the two worlds, including addressing the issue of the different 'languages' that the two sectors use. The strategy should include digital communications and talking to people. This will help to build trust between the two sectors.
- Relationships are key, but they need to link with strategies. This may involve reorienting strategies to link with what's happening in hyper-local areas.
- It will be important to engage with Commissioning Teams, and to understand what links they already have with their local VCSE organisations, and to build on those links.
- There is the need for a 'new architecture' that is nimble and flexible, to take account of the unique characteristics of the VCSE and their potential role in the ICS.

## Annex 4 - VCSE Alliance Launch Meeting - 13th July 2021

The details below were provided by Rachel Stanton of Community Impact Buckinghamshire, during the Stakeholder Impact Event, who is leading the BOB-wide Alliance, which aims to engage with community partners from the VCSE sector, working towards health and care outcomes.

Contact: Rachel Stanton, Community Impact Buckinghamshire  
([rachel.stanton@communityimpactbucks.org.uk](mailto:rachel.stanton@communityimpactbucks.org.uk))

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## VCSE Alliance Launch Meeting - 13th July 2021

### About this Event

This meeting aims to bring together Community Partners, from the Voluntary, Community, Faith and Social Enterprise sector to build a formal alliance of organisations working towards Health and Care outcomes.

The event will inform and develop the framework of how we collaborate together as VCSE organisations strategically at a regional level, and how we integrate and embed VCSE representation in the BOB ICS (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System).

We will hear about latest developments within BOB ICS and how the VCSE Health Partnership Project has developed. We will establish:

What membership of the VCSE Alliance means?  
Which topic areas / priorities we wish to develop as sub groups to the Alliance?  
What representation within the BOB ICS will look like?

Who is this Event for?

Representatives from Voluntary and Community Groups  
Representatives from Faith Groups  
Representatives from Social Enterprises

This is your opportunity to participate in shaping the future of the regional VCSE and health partnership structures.

Register here: <https://www.eventbrite.co.uk/e/vcse-alliance-launch-meeting-tickets-160178922469>

## Annex 5 - Infographic Summary of Key Findings from the Study

