Title: The impact of the Social Prescribing Innovators Programme on tackling health inequalities: A three-part qualitative study

Keywords	
Social prescribing Link Workers	
Health inequalities	
Quality improvement programmes	
Community development	
Abbreviations	
SPIP	Social prescribing innovators programme
SP	Social Prescribing
SPLW	Social prescribing link worker
PCN	Primary care network
GP	General practice
ICS	Integrated care system
DES	Direct Enhanced Services
QI	Quality improvement
TPHC	Transformation Partners in Health and Care

Abstract

Background: Social prescribing aims to tackle health inequalities by connecting people to support with the social determinants of health such as housing or employment. However, it isn't being accessed or benefiting those most impacted by health inequalities. Combing quality improvement and community development, the Social Prescribing Innovators Programme (SPIP) was designed to enable services to tackle inequality. To understand the impact of the approach in unlocking the full potential of social prescribing tackling health inequalities a three-part evaluation was undertaken.

Methods: One stakeholder focus group, eleven semi-structured interviews with project leads across 10 projects investigated impact at multiple levels and enablers and barriers of impact. Thematic analysis was carried out using Nvivo. A logic model developed to communicate the impacts and recommendations.

Results: Access, experience and outcomes was improved among communities impacted by health inequalities. They felt listened to and empowered in their own health and as a partner in healthcare. Social prescribing services coproduced for the first time; participants used community insights to influence the direction of services. Participants become leaders, influencing the system, and developing the capability of partnerships between services, communities, and sectors to reduce inequality in access, outcomes, and experience.

Conclusion: Combining quality improvement and community development approaches can unlock the full potential of social prescribing tackling health inequalities. SPIP should be tested in other areas to test and evidence impact across settings.

Background

People living in the most deprived areas of England die on average nine years earlier and spend 19 years less in 'good' health, compared to their more affluent counterparts due to health inequality (ONS, 2022). Health inequalities are defined as "unfair and avoidable differences in health across the population, and between different groups within society" (Kings Fund 2022). Social Prescribing (SP) aims to reduce health inequalities by supporting patients access community and voluntary activities that help improve conditions that make people sick, the social determinants of health, such as housing, employment, social connections, finances (NHS England and NHS Improvement, 2019, NASP, 2020, Buzelli et al., 2022). Social prescribing represents one solution to the question, "Why treat people and send them back to the conditions that make them sick?", (Marmot, 2015).

Social Prescribing is defined inconsistently and depends on the model in action (Polley et al., 2017). The NHS defines it as ''a means of enabling health professionals to refer people to a range of local, non-clinical services" (The Kings Fund, 2020, p1), however this doesn't specify who should access and how this relates to inequality. The primary model in the NHS is Social Prescribing Link Workers (SPLWs), hosted in GP (General practice) surgeries, employed by voluntary sector organisations such as Age UK, Local Authority, GP federations or by Primary Care Networks (PCNs). Support referred to through social prescribing includes debt advice, housing support, fitness activities and access to green spaces (South et al., 2008; Leavell et al., 2019).

In line with the NHS Long Term Plan ambition of 900,000 people accessing social Prescribing nationally by 2023/24 (2019), data suggests social prescribing is increasingly reaching more people (Jani et al., 2020; Drinkwater, Wildman and Moffatt, 2019). However, there isn't robust data on the demographics of who is accessing (Cartwright et al.,2022). A review indicated ethnic minority groups and men are being referred less to social prescribing (Cartwright et al., 2022). More granular data is required around barriers to access among specific groups and how this impacts the ability of social prescribing to tackle inequalities (Tierney et al., 2022). This questions whether social prescribing is targeting people impacted the most by health inequalities.

Research suggests GP based referral models are insufficient to provide access to populations who are most vulnerable, at the sharp end of health inequalities (Lawler et al., 2023). Few studies look at issues around access in more detail, often focusing on specific groups such as migrants (Younan et al., 2020). This is due to a lack of good quality demographic and social determinants data available to SPLWs, due to lack of collection at point of referral or poor linkage to data from other sources (Hudon et al., 2022). A wide variety of capture data systems

and a lack of mapping who could benefit from SP adds further challenge to understanding access (Herrmann et al., 2021).

Data collected on SP usually focuses on observed impacts on people already accessing, rather than assessing who has not accessed (Kimberlee et al., 2022, Chaterjee et al., 2018; Bickerdike 2017). Typical measures include health and wellbeing outcomes, health systems benefits such as cost savings and sometimes community benefits or social return on investment (Polley et al., 2019). There's no robust data showing how access to social prescribing impacts its effectiveness.

The Personalised Care DES (Directed Enhanced Service) contract aims to support access by asking PCNs to implement proactive social prescribing, targeting a specific cohort impacted by health inequalities, then expand this to multiple cohorts (NHSEI, 2022). Additionally, the Fuller report on primary care recommends "streamlining access to care and advice for people who get ill but only use health services infrequently" (Fuller 2022).

It is challenging to bridge the gap between policy and practice to enable meaningful change in the NHS, alongside partners including VCSE (Voluntary, Community, and Social Enterprise), local authority, PCNs, GP surgeries. Targeting 'those who need it most' requires co-production and careful consideration of local needs through partnership working and health inequalities focused leadership. NHS regional and national transformation bodies play a key role in enabling this.

Efforts across NHS and government to target resources towards those that need it most, especially deprived areas that experience 'under supply' of health care and support (Goddard 2009), haven't been as effective as hoped (Kings Fund 2022b). And data shows a widened gap in inequalities (Marmot, 2020). Learning from this, local leadership, partnered with national bodies and building community capabilities are proposed as ways forward (Kings Fund 2022b). The two major schools of thought for creating change in health and communities, quality improvement and community development should be considered.

Quality Improvement (QI) is widely applied in NHS services; outcomes have been positive but there are several challenges in applying approaches and assessing effectiveness (Nicolay et al., 2012; Dixon-Woods, McNicol & Martin, 2012; Ham, Berwick & Dixon, 2016). Community development approaches are less common but have become increasingly popular to reduce inequality and engage groups impacted by inequality (Smith, Hill and Bambra 2016; Nickel and von dem Knesebeck, 2020). They emphasise participation, co-production, and partnership with communities and all organisations associated with achieving good health locally (Minkler, Wallerstein & Wilson, 2012).

Rationale

Several programmes apply QI and community development approaches to reduce inequalities locally, however few combine approaches (Slater, Knowles and Lyon, 2008). There is a lack of data showing the impact of these programmes on the ability of SP services to tackle health inequalities and provide access to those who need it most (Griffiths, Hina and Jiang; Bickerdike et al.,2017).

Taking influences from QI and community development to achieve change (Bailey & Bevan, 2017; Tanhout et al 2017; South et al., 2019), The Social Prescribing Innovators Programme (SPIP) was developed by Transformation Partners in Health and Care (TPHC), a regional transformation unit. SPIP was a pilot, enabling twelve SP project teams to carry out projects to improve services' ability to tackle health inequalities (appendix A). Ten out of twelve projects focused on increasing access and tailoring the SP offer to specific communities impacted by health inequalities (Appendix B). This demonstrated social prescribing services reaching the right people is a key issue, even though it is not widely mentioned in the literature.

SPIP was evaluated as one example of a programme enabling services to tackle inequalities. It is important to have a systematic method of evaluation for all programmes, to better understand their full potential.

Understanding programme impact at multiple levels was key, including participants delivering projects, SP services, GP surgeries and VCSE, to understand how combining QI and community development can unlock the full potential of social prescribing. By understanding impact, barriers and enablers, the NHS is better informed to tackle inequality through social prescribing. Learnings will inform how primary care can evolve to meet local need and enhance access.

This is critical in the context of Integrated Care Systems (ICS) and PCNs developing a way for NHS to work alongside local partners to improve health. One of the core functions of ICSs is to "tackle inequalities in outcomes, experience and access" (NHSE, 2021, p. 6.). The Fuller Stocktake explains that one of three ways to achieve this is 'providing more proactive personalised care with support from a multidisciplinary team', which social prescribing is a main tenet (Fuller, 2022, p. 6.). This emphasises the importance of gathering data on the impact of SP services tackling inequalities and what enables this.

Research Question

What was the impact of the Social Prescribing Innovators Programme (SPIP) on social prescribing services tackling health inequalities, in terms of access and experience?

Research aims, objectives

The evaluation aimed to understand the full potential of social prescribing in tackling health inequalities and how to unlock this through community development and QI approaches.

A three-part method, including semi-structured interviews, collecting rich data and providing a framework for understanding impact was developed.

The evaluation aimed to understand the impact of SPIP and barriers and enablers of impact.

The objectives were to assess the impact on:

- Access to social prescribing services among specific groups impacted by health inequalities.
- The experience of social prescribing services among specific groups impacted by health inequalities.
- The ability of participants, social prescribing services and other partners in reducing health inequalities.

And map barriers and enablers alongside a logic model to explain how impacts were achieved.

Method

This three-part evaluation investigated the impact of SPIP on health inequalities. Stage 1 was a focus group to identify stakeholder priorities in assessing impact and design of an interview guide. Stage 2 used semi-structured interviews to measure perceived impact, barriers, and enablers. Stage 3 mapped themes against a logic model.

Setting

TPHC designed SPIP, combining QI and community development approaches, to enable SP services to tackle health inequalities. Twelve project teams spent six months and 10k funding (Oct 2022-March 2023), receiving QI training, coaching, support from board members, drop-in sessions, skills shares and more (Appendix A).

Ten projects focused on improving access for a group impacted by health inequality and tailoring the offer to them. One focused on retention, and recruitment of SPLWs, and one on SP services' ability to demonstrate impact (Appendix B).

Projects were led by SPLWs, Care Coordinators, managers in transformation, social prescribing (SP), or VCSE. This group is representative of a multi-agency approach to tackle health

inequalities (Kings Fund, 2022b). This is beneficial to capture a breadth of experiences through interviews, considering what supports a range of partners to have an impact on health inequalities.

Project leads were self-selected, motivated to innovate in their local area. Their written applications were assessed against six criteria including evidence for their challenge being widespread, existing solutions being insufficient, a thorough plan for co-production and engagement, potential for transferability and scalability, involving named social prescribers and ability to develop and learn new approaches.

It was important to engage stakeholders throughout the programme and evaluation to inform decisions around delivery, measurement, and recommendations, increasing credibility and validity (Palumbo, 2016).

Participants

Stage 1)

SPLWs, managers, training hub colleagues, ICS personalised care colleagues, academics and people with lived experience were invited to a 1-hour online focus group. Eighteen people attended, most were involved in strategic or wraparound support for SP (58%), work in related field to SP (17%) or manage social prescribers (17%) (Appendix D).

Stage 2)

All sixteen Project leads and co-leads from the twelve projects were invited to interviews, taking a non-probability purposive sampling technique to maximise responses (Campbell et al., 2020).

Design

Stage 1)

The online focus group in September 2022 helped me understand what people across the SP system considered important goals and what to evaluate (Jeffrey 2009; MacQueen and Harlan 2012). Findings are in appendix D.

The session influenced research aims to focus on patients and communities rather than just participants. This made the evaluation more impactful for decision makers in the NHS.

Ongoing support for the programme and evaluation is provided by a board of people (appendix J) across the social prescribing system. Feedback from the board shaped the interview guide,

ensuring the questions made sense and reflected the reality of participants, increasing face validity. The direction of questions was altered to reduce bias towards positive responses.

Interview guide

A semi structured interview guide (appendix E) was developed from the research aims, focus group and literature to ensure questions elicited detailed information on programme impacts on health inequalities (Bearman 2019). A five-step process to develop the guide was followed (Kallio et al., 2016), including piloting questions in the first two interviews. Additional questions asked for feedback on questions and interview style. From this, more prompts normalising negative experiences were included. As part of piloting, the board members (Appendix J), who are considered experts in this field, reviewed the guide (Majiid et al., 2017).

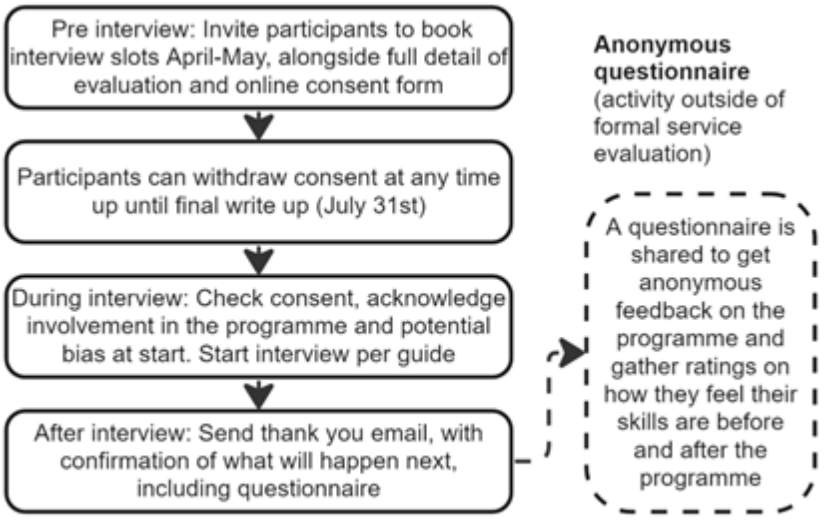
Stage 2)

Semi-structured interviews with project leads were carried out to understand the impact, barriers, and enablers. Impacts are a marked effect, influence, or outcome due to an intervention; impacts can be intended, unintended, direct or indirect (NHS England 2019b; Stern 2015). Interviews are commonly used to evaluate QI programmes and understand barriers and enablers (Lalani et al., 2018; Barrett et al., 2017; Lloyd-Evans et al., 2016). Interviews allowed for acknowledgment of impacts that are highly dependent on the local context (Itri et al., 2017, Walshe 2007), which was especially important for social prescribing services whose set up differs across geographies (Chaterjee et al.,2018).

Procedure

The process of conducting the semi-structured interviews is outlined in Figure A below.

Figure A – Interview process



Ethics

An ethics form (Appendix K) was submitted containing an evaluation brief and summary of ethical considerations, this was approved by UCL Institute of Informatics in January 2023 (3-IHILREC), and by TPHC.

The focus group had few ethical concerns as no information was shared that is not publicly available. Invitees were free to attend or decline. Views could be shared aloud or anonymously on Slido, an online platform, maximising confidentiality, and choice.

A potential issue for interviews was the researcher being known to the participants as they managed SPIP. This was mitigated by there being no repercussions for projects sharing negative feedback or not achieving project goals (McConnell-Henry et al., 2010). This was reiterated in the consent form and invitation to participate, to ensure people don't feel pressured.

Consent and storage

Informed consent was gathered via an online form (appendix F), based on UK Gov guidelines on informed consent (UK Gov, 2018). It sought consent for participation and use of data, making participants aware of their right to access their data and erase it (Data protection act, 2018). This was outlined in the information sheet (appendix G).

Data was kept for the shortest time, complying with GDPR. Raw data will be deleted three months after submission in December, in case extracts are requested by markers (Voigt and Von dem Bussche, 2017).

Sharing

Permission was given for sharing anonymised interview extracts with select individuals e.g. examination board. Quotes shared publicly included no personal information.

Analysis

Part 1)

Descriptive statistics were calculated for demographics of attendees and responses to questions on Slido including percentages. Average scores for ratings were presented in tables. Free text responses were analysed for themes and themes counted, to uncover the most popular opinions (Appendix D). Findings were presented back to the TPHC team internally to validate themes.

Part 2)

Data preparation

Transcripts were anonymised for personal information and pseudo-IDs used for each participant and project to protect participant confidentiality (Wiles, 2012). The key was stored separately from data in an NHS One Drive owned by the lead researcher.

Information that is not relevant to the evaluation was removed to reduce risk of identification.

Analysis

Thematic content analysis was conducted in NVivo, taking a conventional approach (Hseih and Shannon, 2005). Themes of impact relevant to research questions and inductively from the data were constructed (Hinder et al., 2021; Lalani et al., 2018). Two separate validation processes were carried out to ensure codes accurately reflect the data, increasing trustworthiness and ensuring findings are relevant to actual practice (Nowell et al., 2017; DeJonckheere and Vaughn 2019).

Stages of analysis

Figure B outlines the coding process including two validation stages to add rigour. Initially a check with two other researchers of codes to improve credibility and validity, referred to as ‘trustworthiness’ (Nowell et al., 2017), then a validation panel to improve transferability of findings (appendix I).

Technical solutions to improve validity of qualitative analysis have been criticised, therefore, the practical validation panel which gathers the views of real people is used (Barbour, 2001, Leung 2015).

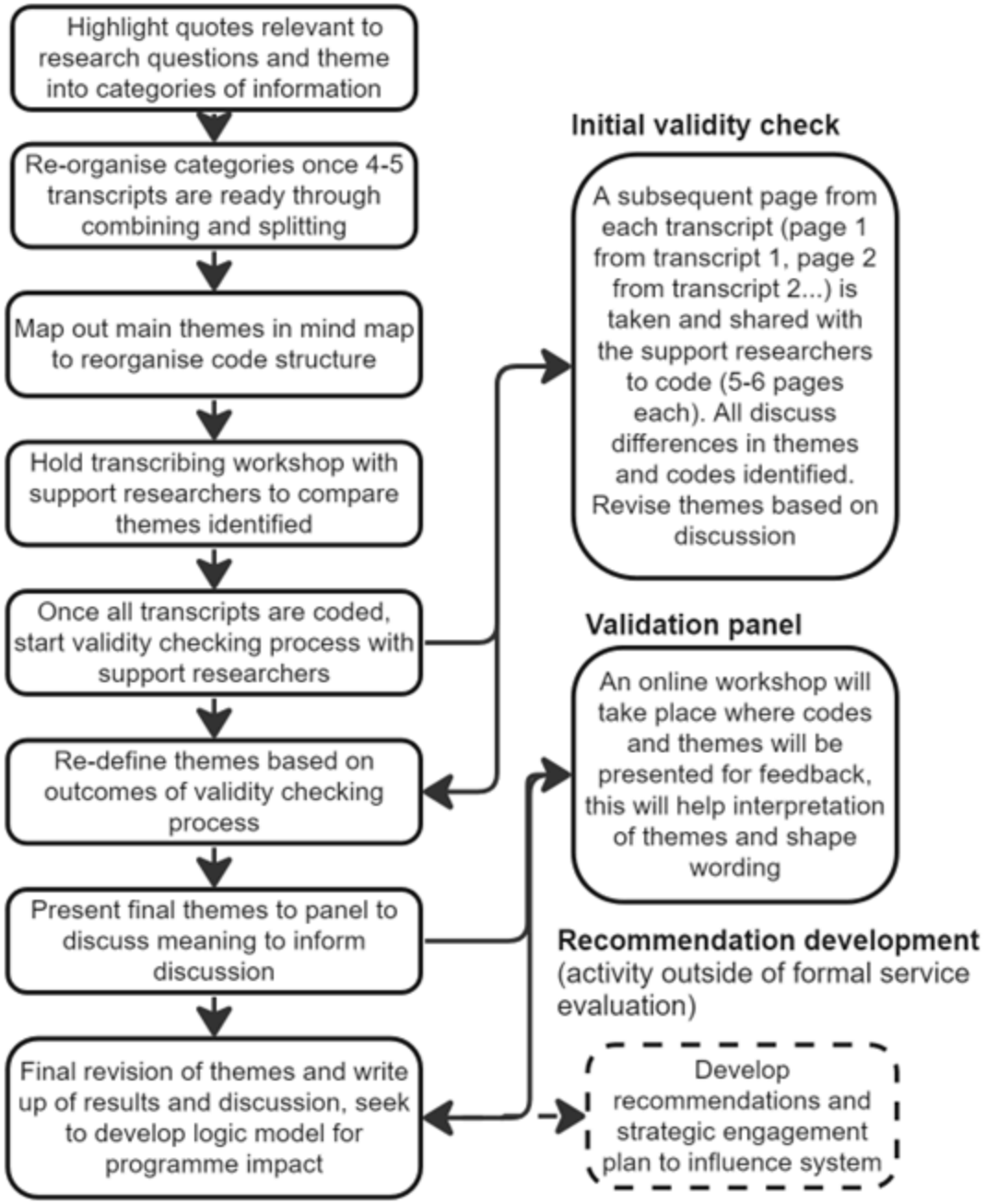
Initial validation

Credibility and validity of codes was explored. Comparing and discussing the codes created by two other researchers to my own, I understood how different perspectives interpret the same text in a transcript. I used our differing codes throughout as a reference to help my thinking when collapsing codes and summarising themes. This helped themes be less bias and increase credibility.

Validation panel

Four people attended, three work in regional transformation, one in innovation, based at a GP surgery. This session helped me understand what was most important, interesting, and useful from results through voting against key themes in Miro, an online platform, and discussion (appendix I).

Figure B – Coding, theme construction and logic model process



Part 3)

Mapping

Results were mapped against a programme logic model inspired by the EPOCH trial programme theories (appendix H), which is provided as an example in the latest MRC guidance for evaluating complex interventions (Stephens et al., 2018; Skivington et al., 2021. The structure details activities/enablers, outcomes and impacts using prompts, “If…Then…So that…So that…”. This allowed construction of a narrative of programme impacts in language to easily explainable to different stakeholders.

Results

Participants

Eleven 45-minute semi-structured interviews with project leads were conducted, out of sixteen invited (69% response rate), across ten out of twelve projects. Four participants were employed by VCSE, six by PCNs and one by local authority. Most participants (n= 7) were SPLWs (including three leads), one was a care coordinator and two in other VCSE roles.

Impacts are presented at five interdependent levels (figure C), the participants running projects, social prescribing services, GP surgeries, VCSE organisations and the impact on communities in terms of inequality. Barriers and enablers are in figures D-G.

Initial validation check

Differences between researchers included noticing different elements within one phrase, for example, an increased skill level versus learning versus having an opportunity to do something new. All factually correct, I ensured coding appreciated differences, but my focus was creating themes that answered research questions. Major impacts identified were consistent between researchers, including several code names used e.g., 'peer network developed'. Less negative themes were detected by secondary researchers, therefore I spent time looking only for negative codes, to offset any bias I may have also had.

Validation panel

Voting showed a higher importance of results around impact on participants, social prescribing services and communities, therefore, the discussion focuses on this. The interconnectedness between impacts and the participant was discussed. As a result, impacts were presented as a narrative that emphasised this. Themes for the discussion included the programme facilitating the broader culture shift social prescribing aims to enable and the generalisability of results to other services (appendix I).

Summary of impacts

Figure C gives the themes of impact at five interdependent levels.

Three core participant impacts; becoming a leader, recognising own personal value and increased personal effectiveness had three sub themes each. Most common was a greater ability to influence the direction of services, through more creative and strategic working, strengthening partnerships with PCNs and VCSE to tackle inequality.

GP surgeries were more effective and efficient. The key impact was greater engagement and referrals to social prescribing, generating increased capacity.

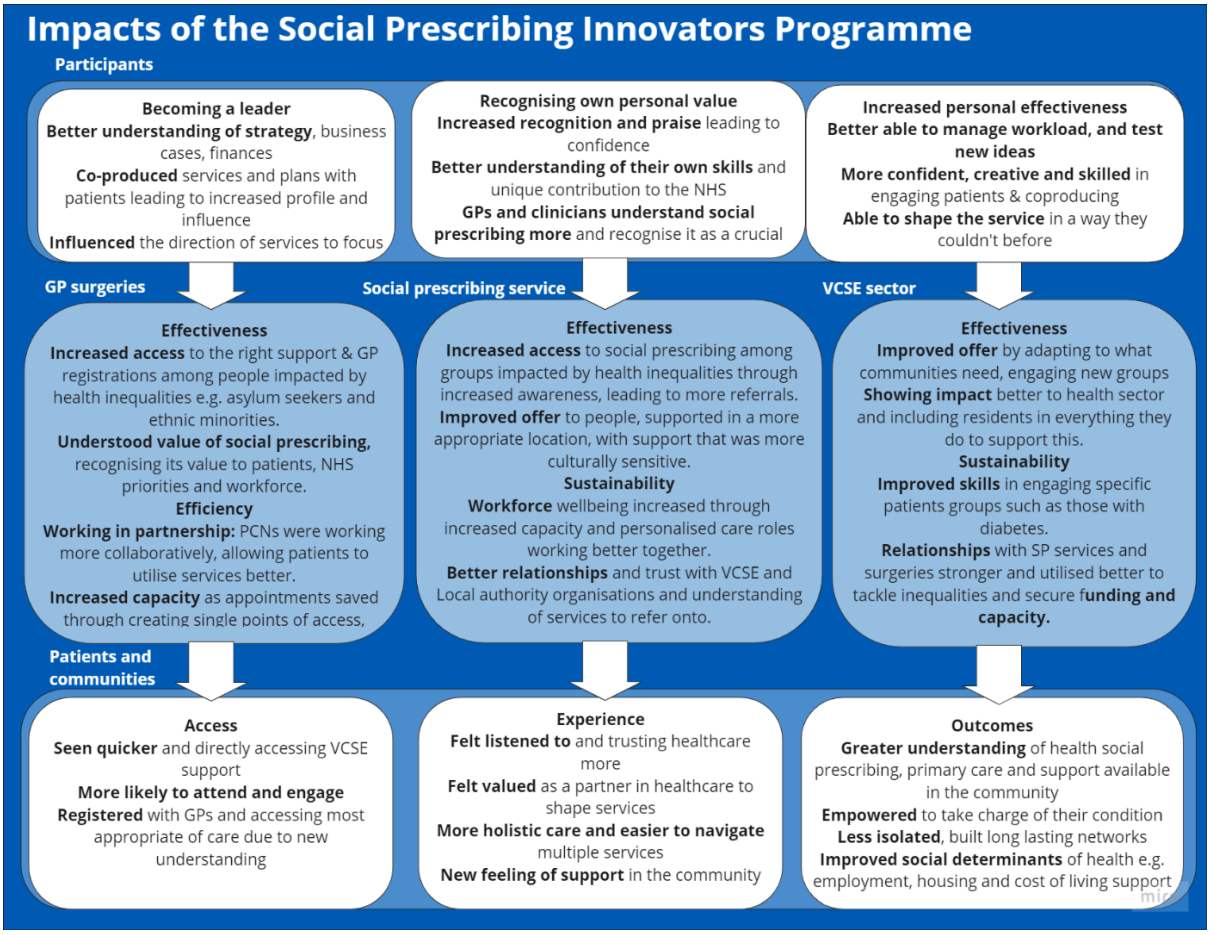
Social prescribing services were more effective and sustainable, providing a better offer leading to increased access. Many services co-produced for the first time.

VCSE organisations improved their support offers and were in a better position to secure more funding due to strengthened relationships strengthened with health.

Eleven subthemes of participant impact were identified under access, outcomes, and experience. The most common impacts were increased engagement with social prescribing, feeling listened to through attending more appropriate community support and participating in co-production. This led to greater ownership of their health and accessing the right support sooner.

The impact on access and experience of patients and communities affected by health inequalities, as well as the ability of participants services in enabling this is expanded below.

Figure C – Summary of Impacts



Impact on access and experience

There were more referrals and people accessing social prescribing who weren't before, particularly groups impacted by health inequalities such as asylum seekers. GPs who weren't referring started referring and awareness of SP increased among communities, VCSE and NHS services.

- “We had a massive surge in the amount of people we've had contact with and engaged.”
- “It’s raised our profile of what we can do... we have GP practices that were still on the fence about social prescribing. And then they've seen what we've done with the residents.... personally, I have more referrals from a practice that didn't want to know us (before).”

People were supported quicker, in more appropriate settings in a single point of access, with more culturally appropriate, accessible support.

- “We had a lot of patients that were Black and South Asian, I had the Urdu and Punjabi language, my colleague had Bengali. It worked quite well with access of services.”
- “They are being supported and just a faster response to their needs”.

However, it wasn’t possible to engage all groups projects wanted to and access varied among areas with demand difficult to predict.

- “There are still some very hard to reach groups that we would have liked to spend more time talking to”

Access increased because participants felt listened to and trusted healthcare more, repairing relationships to GP surgeries.

- “These were people that were quite difficult relationships to healthcare in the past...Having SPLW there to directly respond to the questions they had about social prescribing, I think really supported those participants in feeling empowered to pursue SP in the future.”

Residents registered with GPs and accesses the right support due to new knowledge and a greater understanding of social prescribing, primary care, and support in the community.

- “They don't always need to be like ‘I don't know what to do. I'm just gonna sit here, wait for the GP to tell me what to do’. They know what to do. ‘I've got a plan. I've made this plan now and if I get stuck, I can call VCSE activity provider’”.

They also learnt more about health and the causes of ill health which led to empowerment to take charge of their condition e.g. manage diabetes, access support with social determinants. For some, this changed the direction of their lives.

- “they are really invested in their health now, before they were like ‘I don't care about my health. I've got other problems’.”
- “I know that this opportunity has really made some good change and potentially lifesaving change for some. We’ve had some horrific safeguarding cases that have come out of this.”

However, there was a recognition that social prescribing is only part of the puzzle in addressing social determinants.

- “I think we have achieved half of it. Not all, because their needs in terms of housing is a big issue.”

Services and participants ability to improve access and experience

Because services co-produced for the first time, innovatively engaging patients, and embedding improvements using the newfound insights, the service moved beyond crisis management and targets to meaningful improvement.

- “A key takeaway is it’s important for us to be more confident about what we do and what we've learned from doing this work, we shouldn't be afraid of engaging with patients in different ways.”
- “It's energized our team…. we're a lot more creative and doing more thinking around how we're engaging patients instead of seeing every encounter as a need to engage with some kind of crisis.”

Participants led this through being in a more creative headspace, thinking differently about services. Better understanding strategy, they were equipped to challenge the system to move beyond targets to impact on health inequalities.

- “It's allowing us to kind of look beyond what we've been delivering, what's expected of us and go right... I hear what our targets are. Let's be a little bit more innovative about this.”
- “it's enabled me to do my job better, and think about the activities that we're providing, ensuring they're reaching the (right) people.”

They had the time, tools and structure to shape the service in a way they couldn't before including increased confidence in testing ideas, letting them fail and managing their workload more effectively.

- “It's trained me up for in quality improvement because we talk about it, but looking at how quality improvement is done properly, I'd never done an impact report like the way you taught us. So going forward, that's so impactful.”
- “If something doesn't quite work, it doesn't mean it's failed. It just means you've learnt how it can be improved”.

Participants became leaders, however increased workloads led to stress, especially for lone participants, but they still valued the outcomes achieved.

- “At this stage it created more work, but I'm sure in the long run it is going to balance out”
- “If the stress had never existed. We wouldn't be going into the next financial year with some key themes of how we want to change the service.”

Co-production as a tool to influence, build relationships and make change possible

Through true co-production, participants learnt what communities needed and used this to influence the direction of services across several partners, raising their profile. They were confident to approach PCNs and managers, selling the value of their work.

- “it's giving the evidence to present to the PCNs to say this how we're going to redesign the service”
- “I feel that I can take this to my chief exec and say, look, this is what I need and this will benefit this group.”
- “We’ve learnt how to speak to the GP's and explain to them what we were doing. I think it gave us so much confidence.”

This led to recognition and praise, their role understood and valued more, viewed as less dispensable. They also understood their own skill and unique contribution to the NHS.

- “I feel like our role has become even more important and we are slowly becoming more indispensable, because our patients are telling the GP or telling the pharmacist, the social prescribers really helped me”
- “We've had a lot of good feedback from now from our clinical director, our bosses being really happy with the work we're doing and wanting us to continue it”

However, in a few cases, clinicians were less engaged, especially among lone participants.

- “But whether it then filtered down to the GP level, I’m not 100% sure.”
- “The GP practices weren't engaging with the project at all, they just knew I was doing the project, but no one ever asked me for updates.”

But overall, this helped build partnerships between local authority, NHS, VCSE and communities.

- “We were the middleman as there was no relationship between the hotel managers and the council. We've changed this because we were able to form good relationship with the hotel managers.”

Residents felt valued as an equal partner in their community and healthcare, shaping services, were less isolated and built long lasting networks.

- “I think the main benefits to the community are they felt listened to and they felt cared about.”
- “There’s a real sense of taking more ownership, feeling like they have more choices and feeling less isolated.”

Barriers and enablers

Figure D shows the barriers and enablers of impact, split into organisational, relational, individual. Figures E-G show the sub themes alongside quotes.

Figure D – Summary of barriers and enablers

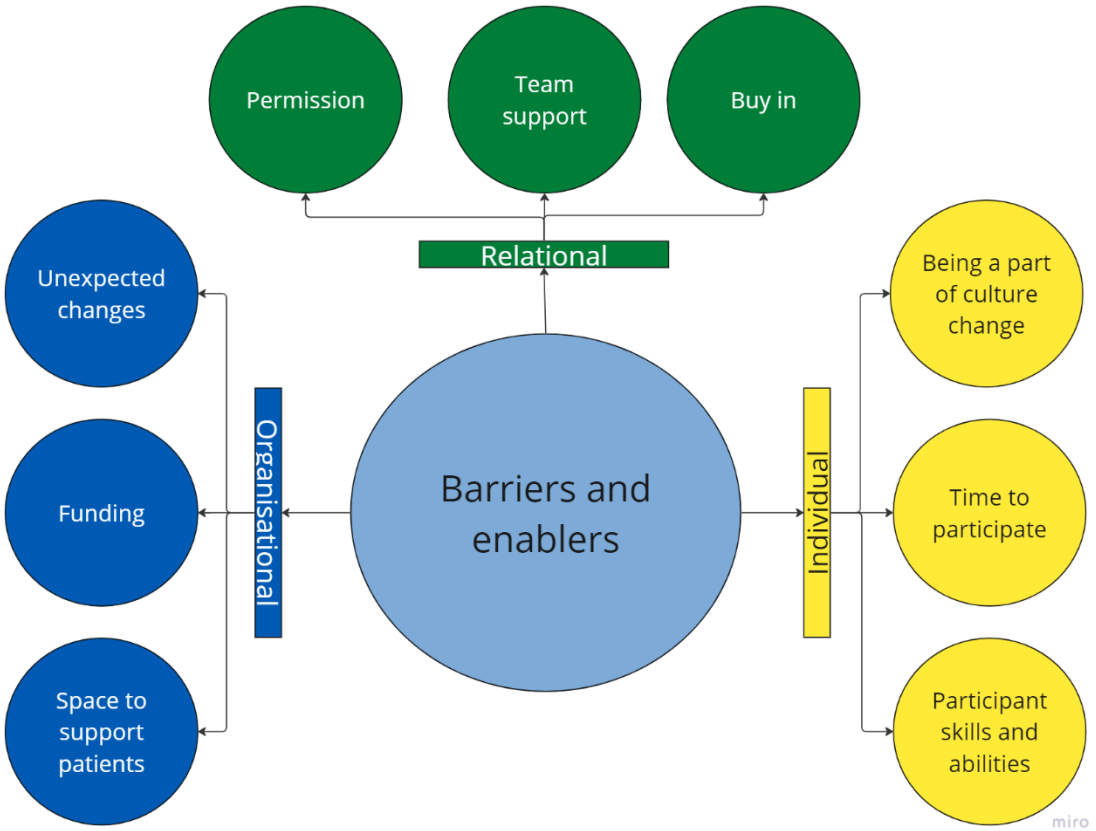


Figure E – organisational barriers and enablers

Unexpected setbacks around staffing were frequently mentioned. Funding was most mentioned as both helping participants have an impact, whilst creating an uncertainty around the sustainability of impacts due to being one-off.

Figure F – individual barriers and enablers

Lack of time to participate was perceived as a major barrier, but it may not have reduced impact. Being a part of a culture change empowered achieving impact. However, it also made it harder to get buy in and permission for service changes.

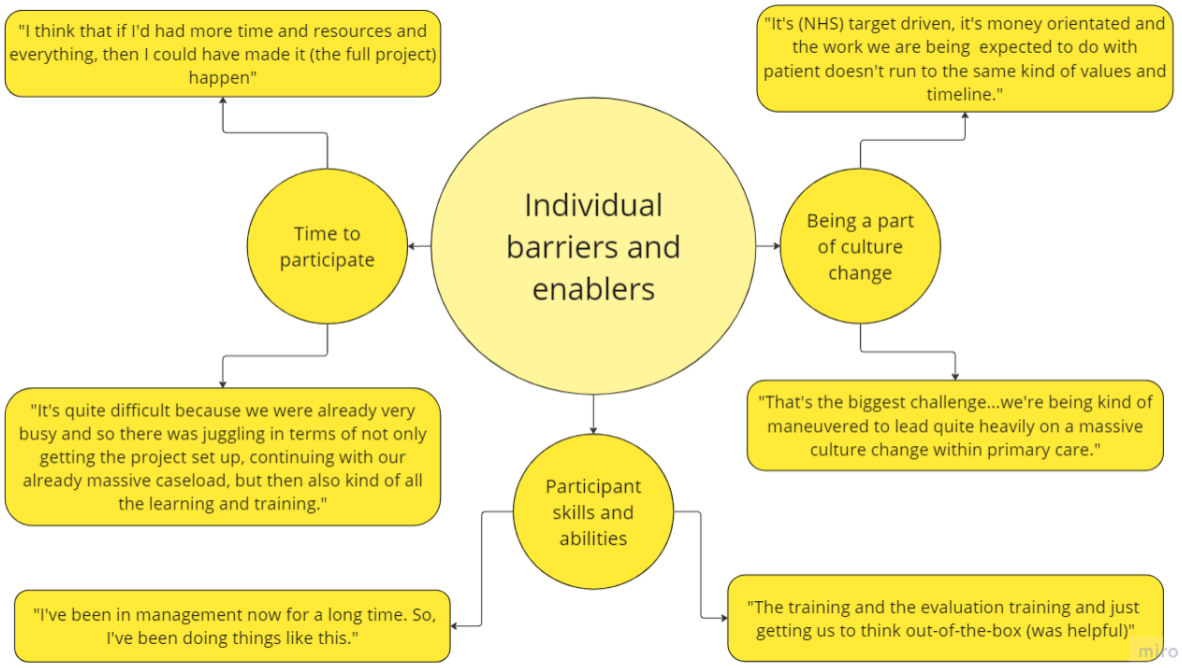
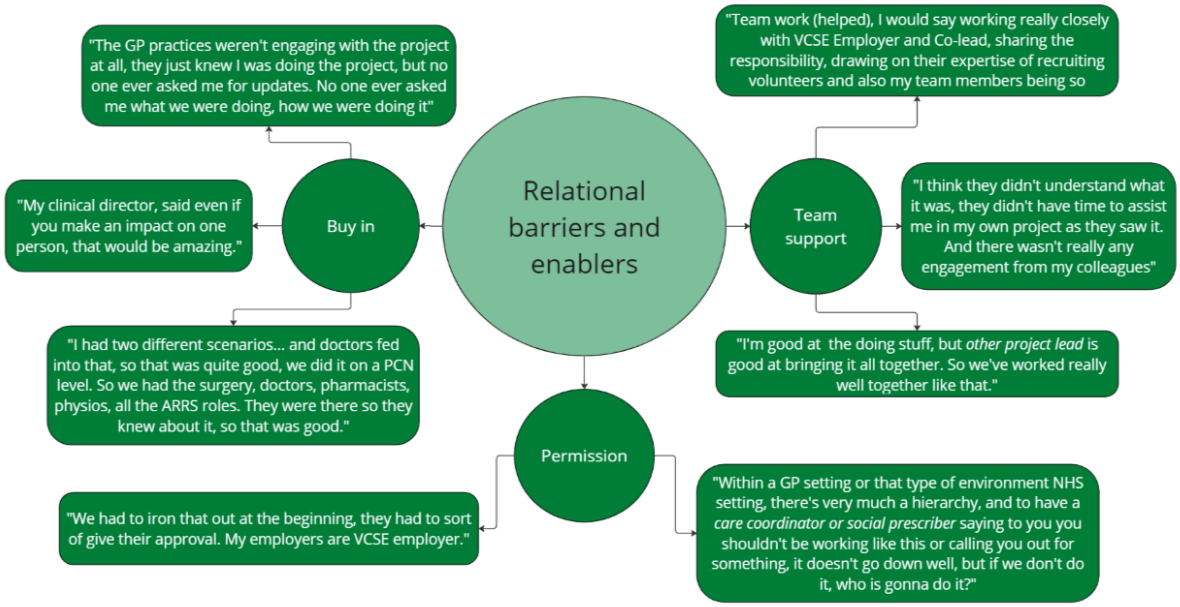


Figure G – Relational barrier and enablers

Buy in, permission and team support when strong had a significant impact on the project's success. Having a strong co-lead was the most valuable enabler. Where little colleague support was present, it was difficult to have a widespread impact.



Discussion

Summary

Combining community development and QI approaches unlocks the full potential of social prescribing tackling health inequalities. Impact on access was not only in terms of increase, but

access to the right support in the right place at the right time for communities impacted by health inequalities. Experience improved, relationships to services transformed, leading residents to engage more. Unexpectedly relationships to their own health changed, feeling empowered to take ownership and proactively access support through new understanding and trust.

Co-production was the tool which developed both people and services to tackle inequalities, whilst repairing relationships with communities. By working more creatively, starting with insights from residents, healthcare and SP services innovated, influencing others to do the same. Project leads facilitated this through greater confidence and strategic understanding, recognising their value in NHS culture change.

With increased time ringfenced for projects, clinical and senior leader buy-in and sustained funding, participants felt they could have had an even bigger impact on health inequalities.

The three-part method gathered rich data exploring impact and mechanisms behind impact. The focus group and logic model enabled greater credibility and rooted the evaluation in practical application, making it more likely to inform ways of working across healthcare. This method is a blueprint for evaluating transformation programmes aiming to tackle inequalities.

Critical discussion

Participants became leaders, more able to influence the direction of healthcare. Leadership is a recognised contributor to success by reviews of QI programmes, emphasising change is 80% human, 20% technical (Backhouse and Ogunlayi, 2020). However, there is less evidence for it being a direct cause or result of successful improvement (Walmsey and Miller, 2007). Perhaps because leadership is considered a barrier/facilitator rather than a cause or outcome of QI (Zamboni et al., 2020; Dixon-Wood, McNicol & Martin, 2012). A key way to achieve healthcare transformation is to “Raise the status and perception of change agents and service improvement programmes” (Bevan, 2010). Investigating causal mechanisms for leadership in achieving change, over appreciating it as a barrier could better inform improvement programme design and allocation of resources in organisations. For NHS managers, reviewing leadership skills in the social prescribing workforce could enable better utilisation and development of change capabilities.

Social prescribing services engaged communities more creatively, coproducing plans to influence services. This led to improved access and more appropriate support for people impacted by health inequalities. By evidencing what is most needed by patients GPs and PCNs were influenced to move beyond targets that don’t fit this. Much of the NHS talks of engagement

or involvement (Mockford et al., 2012), rather than true co-production detailed by community development approaches (Mockford et al., 2012; Fisher and Chanan 2015, Elwyn et al., 2020). However, involvement at any level can influence service improvement but the degree of influence and result is unclear (Mockford et al., 2012). Community development approaches use alternative methods of showing impact, such as case studies (Haldane et al., 2019). For example, a programme combining community development and improvement science to tackle inequalities shared a case study illustrating how connecting project team members with communities and health care professionals, they identified how to reach more people who were not currently engaging (Slater, Knowles and Lyon 2008). This reflects the findings here, by engaging people, access increased. Involvement of communities is not new, however solid evidence around how community insights influence services and decision making is needed. In SPIP, these insights were a powerful tool, equipping social prescribing services to influence healthcare, whilst enabling access through relationships with communities. Identifying to what extent access issues can be overcome by the activity of engagement before subsequent changes to service delivery is critical. Managers and policy makers should consider inclusion of community insights as usual in the entire cycle of decision making around access, services, and improvement (Morales-Garzón et al., 2023).

Communities engaged with felt a greater sense of belonging and inclusion as partners in their own health and healthcare delivery. They felt listened to, trust was rebuilt. They were empowered to take a more active role over their health and lives, which is sometimes referred to as patient activation (Hibbard and Greene 2013), leading to increased access. A review of community participation approaches in primary care in Australia (Bath and Wakerman 2012) found evidence for improved health outcomes but less evidence around intermediate outcomes including access, which was the main impact of SPIP identified. Trust is a recognised barrier to community engagement and reviews identify ‘who’ carries out engagement is critical (Lightbody, 2017; Talò 2018). SPIP rebuilt trust among communities, the NHS and agencies such as the local authority, suggesting there is something special about those leading SPIP projects. Working in SP, they were in a unique position to engage communities and organisations where healthcare had not been successful before. A review from public health emphasises awareness is not the only factor among communities for social change, and reduced inequalities, but the people supporting processes and change play an important function (Morales-Garzón et al., 2023). This further supports the social prescribing workforce as key in evolving services to tackle inequalities. It’s important to understand what specifically about project leads was key and whether this relates to personal factors, role, position or something else. Managers and policy makers should consider the underutilised opportunities to use the social prescribing

workforce in community development to improve healthcare and community relationships to health.

Programme theory logic model

A programme theory has been developed to simplify the key impacts and illustrate recommendations.

Figure H - Programme logic model

If
- The social prescribing workforce recognises their own skill, value and is enabled to lead change
- Project leads learn how to strategically influence PCNs and other organisations
- Social prescribing services co-produce with communities and use this to inform services
Then
- New leaders in health who are skilled in working with communities and all partners are developed
- Organisations are working better in partnership towards the goal of tackling inequalities
- The social prescribing offer, VCSE activities and GP delivered care is tailored to what communities need
- Trust is rebuilt between communities and the NHS
- Communities feel empowered to play an active role in their health and health care services
So that
- Access to social prescribing is improved among people impacted by health inequalities

- Experience and outcomes of social prescribing is improved among people impacted by health inequalities
So that
- Health inequalities are reduced

Conclusion

The social prescribing workforce is a huge asset to the NHS in tackling health inequalities through a multiagency approach. Leadership development among these individuals is crucial, they represent a unique position for tackling inequality. Combining quality improvement and community development approaches has not been widely applied before, but the value of both is clear, particularly for the NHS to consider community involvement. Through co-production, trust and relationships between VCSE, NHS and communities were built, facilitated by project leads. Overall, to tackle inequalities, emphasis on ‘who’ is leading engagement and change is key, and ‘what’ authentic co-production is. What is not explored is how change agents in SPIP influenced the cultural shift towards a biopsychosocial model of health and what else is needed for this. Within current NHS restructures, uncertainty, and a greater need than ever to support the most disadvantaged communities, exploring this further would be useful.

Challenges

There are widespread challenges in measuring health inequalities and quantifying changes in inequality (De Andrade & Angelova 2020). There is consensus that tangible outcomes are likely only to be seen in the long term (Garthwaite et al., 2016). As a short-term evaluation, measurement at a single time point was the only option, potentially limiting the ability to demonstrate impact. By using qualitative methods, a richer picture was created to partially overcome this challenge.

This evaluation focuses on SPIP; however, recommendations span wider, illustrating how healthcare can tackle inequalities. The generalisability of a 12-project programme with self-selected participation may be limited. Leaving the question “Is this achievable for all teams and services?” The rigorous three-part method with two validation processes is proposed to overcome this. Nonetheless, it is important to investigate SPIP across geographies, to ensure generalisability.

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Appendices

Figures guide		
Letter	Name of figure	Description
A	Interview process	Flowchart illustrating process taken to conduct interviews.
B	Coding, theme construction and logic model process	Flowchart illustrating the stages of coding and analysis including theme construction, validation and developing a logic model.
C	Summary of impacts	Chart showing the high-level themes of impacts identified split into five interdependent levels
D	Summary of barriers and enablers	Diagram showing the main barriers and enablers of impact within the three main categories identified.
E	Organisational barriers and enablers	Diagram showing the sub themes under organisational barriers and enablers, alongside quotes.
F	Individual barriers and enablers	Diagram showing the sub themes under individual barriers and enablers, alongside quotes.
G	Relational barriers and enablers	Diagram showing the sub themes under relational barriers and enablers, alongside quotes.
H	Programme logic model	Logic model creating a narrative for the impacts of the programme to clearly articulate the findings and recommendations to readers
Appendices Guide		
Letter	Name of resource	Description

A	Social Prescribing Innovators Programme Brochure	An outline of what activities were involved in the programme, including a detailed breakdown of the support on offer for participants and projects.
B	Social Prescribing Innovators Project Snapshots	A one slide summary of each of the twelve projects on SPIP, outlining their intended goals, impacts and successes.
C	Role of Transformation Partners in Health and Care in the service evaluation and ethical approvals.	Outline of the role of the researcher and support researchers within the programme being evaluated, as well as approvals for ethics.
D	SPIP Stakeholder engagement session September 2022	The results from a stakeholder engagement session in September 2022 to shape the evaluation research questions and focus.
E	SPIP Semi-structured interview guide	The guide developed to carry out semi-structured interviews with project leads and co-leads, including pilot questions.
F	SPIP consent form	Google form collecting responses to gather consent to participate in an interview, including participant Pseudo-ID.
G	SPIP Participant information sheet for interviews	Information sheet with all the detail required for a participant to give informed consent.
H	Programme theory from Stephens et al., 2018	Example programme logic model, which is taken as inspiration in this paper.
I	Overview of SPIP validation panel session	Plan for the session, attendees, example of outcomes of the session and discussion.
J	Board members	List of people and roles who helped shape the programme, supported with ongoing delivery and the evaluation.
K	UCL Ethical approval form	The ethics form submitted for approval from UCL Institute of Informatics.