



GIG
CYMRU
NHS
WALES | Iechyd Cyhoeddus
Cymru
Public Health
Wales
Research and Evaluation

Emerging Drivers of Vulnerability to Health Inequity in the Context of COVID-19: Perspectives and response from the Voluntary and Community Sector in Wales

Alice Willatt, Daniel P. Jones, Richard G. Kyle and Alisha R. Davies



Suggested Citation

Willatt A., Jones D.P., Kyle, R.G., Davies, A.R. (2021). *Emerging Drivers of Vulnerability to Health Inequity in the Context of COVID-19: Perspectives and response from the Voluntary and Community Sector in Wales*. Cardiff: Public Health Wales.

Authors

Dr Alice Willatt, Dr Daniel P. Jones, Dr Richard G. Kyle, Prof Alisha R. Davies

Affiliations

Research and Evaluation Division, Knowledge Directorate, Public Health Wales

Acknowledgements

We express our gratitude to the two VCS representatives that took part in the research who also dedicated time to review the report, and also to all the participants for their invaluable insights.

We would also like to thank Sue Mably (Consultant in Public Health, Public Health Wales), Deborah Haroon (Head of Evidence and Analysis, What Works Centre for Wellbeing), and Charlotte Grey (Senior Evaluation Lead, Public Health Wales), who peer-reviewed and provided valuable comments on earlier draft of this report, as well as our colleagues in Public Health Wales: Dr Jiao Song (Principal Statistician, Linked Data Programmes), Dr Kate Isherwood (Senior Research and Evaluation Officer), Bethan Carter (Senior Public Health Research Officer), Elizabeth Hughes (Project Manager), and Chiara Tuveri (Senior Administrator and Resource Officer).

Funded by Public Health Wales

Public Health Wales is an NHS organisation providing professionally independent public health advice and services to protect and improve the health and wellbeing of the population of Wales. Production of this report was funded by Public Health Wales.

© 2021 Public Health Wales. Material contained in this document may be reproduced under the terms of the Open Government Licence (OGL) www.nationalarchives.gov.uk/doc/open-government-licence/version/3/ provided it is done so accurately and is not used in a misleading context.

Acknowledgement to Public Health Wales to be stated.

Copyright in the typographical arrangement, design and layout belongs to Public Health Wales.

ISBN 978-1-78986-154-371

Research and Evaluation Division
Knowledge Directorate
Public Health Wales
Number 2 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Tel: +44 (0)29 2022 7744

Email: PHW.Research@wales.nhs.uk

 @PublicHealthW @PHREWales

 /PublicHealthWales

Table of Contents

Executive summary	3
1. Introduction	5
1.1 Understanding vulnerability during the COVID-19 pandemic.....	6
1.2 Understanding the Voluntary and Community Sector.....	10
1.3 Aims and objectives of this research programme	11
2. Methodology	12
2.1 Research context and recruitment.....	12
2.2 Semi-structured Interviews.....	13
2.3 Data and intelligence asset mapping activity	13
2.4 Focus groups	14
2.5 Analysis of data.....	14
3. Perspectives from the VCS on vulnerability	16
3.1 Defining vulnerability: perspectives from the VCS	16
3.2 Changes in vulnerability over time from VCS perspectives	18
3.3 Patterns and distributions of vulnerabilities from VCS perspectives	19
4. Emerging and exacerbated needs within the context of COVID-19, highlighted by the VCS	21
4.1 Mental health and wellbeing.....	21
4.2 Economic insecurity	22
4.3 Digital exclusion.....	22
4.4 Disruption and withdrawal of face-to-face services and support	23
4.5 Limitations of the statutory response.....	24



5. The role of the VCS during the COVID-19 pandemic **26**

5.1 An overview of the VCS response	26
5.2 Tackling poor mental health, social isolation and loneliness	27
5.3 Addressing digital exclusion	27
5.4 Brokering access to statutory services.....	28
5.5 'Picking up the pieces' and filling in the gaps of statutory services	29

6. Challenges and opportunities facing the VCS **30**

6.1 'Fighting for survival' in an uncertain funding landscape	30
6.2 Digital delivery of services	31
6.3 Mental health and wellbeing amongst VCS workers.....	32
6.4 Greater recognition of the VCS and 'parity of esteem'	33

7. VCS assets that enabled the rapid and agile response **34**

7.1 Smaller size	35
7.2 Holistic approach to addressing needs	35
7.3 Embeddedness: connection to people and place	36
7.4 Intelligence sharing, collaboration and partnership working.....	37
7.5 Workforce: volunteers and employees.....	38
7.6 Finger-tip expert knowledge.....	38
7.7 Experiential learning.....	41

8. Summary **42**

8.1 Overview	42
8.2 Strengths and limitations	43
8.3 Implications and future work	44

References **45**



Executive summary

Background

This qualitative research draws on insights from the Voluntary and Community Sector (VCS) in Wales to help understand how the COVID-19 pandemic has affected vulnerability. It specifically uses a capability approach, which relates vulnerability to wellbeing and focuses on what people are able to be and do in their lives. Vulnerability is understood here as developing from **inherent factors** (relating to a person's biology) as well as their **situation and relations**. The latter reflecting the social, economic, political and environmental context in which a person is embedded, including their relationships with people and institutions.

Results

The findings demonstrate how VCS representatives understand vulnerability as reflecting the **unmet needs of a person**. During the pandemic, **vulnerability rapidly arose** and was often exacerbated when individuals were unable to access support from particular resources, services and local infrastructure. Vulnerabilities were typically also **found to cluster together** and were often **patterned along pre-existing lines of social inequality**. The research specifically identifies key emergent needs related to the pandemic, including:

- Worsening mental health due to anxiety and loneliness
- Economic insecurity due to strained household finances and job loss
- Digital exclusion
- Loss of face-to-face services and limitations in the statutory response.

The research also highlights the critical role that the VCS has played in addressing emerging vulnerability throughout the COVID-19 pandemic in Wales. Notably, helping to:

- Tackle isolation and loneliness
- Address the consequences of digital exclusion
- Broker access to statutory services and fill in gaps in statutory provision.

In addition, it helps to pinpoint assets held by VCS organisations, which enabled them to rapidly and effectively respond to emerging vulnerability during the pandemic. These were the:

- Knowledge and expertise held by staff and volunteers that enabled rapid decision-making around operational challenges during times of crisis
- Smaller size of VCS organisations and their flatter hierarchies and quick ratification processes which enabled swift innovation
- Holistic focus on a person's needs

- Understanding and insights gained from being locally embedded in communities and connected to local networks
- Ability to effectively collaborate and share information with other VCS organisations as well as with the statutory sector
- Care, commitment and compassion of the volunteers and employees in the VCS
- Ability of the sector to accumulate experience and learn from it.

The report also highlighted some of the key challenges for the VCS sector, including the:

- Lack of secure funding for VCS organisations
- Impact of digital exclusion on service coverage
- Impacts of the pandemic on the wellbeing of the VCS workforce.

Finally, it highlighted opportunities for the sector, including the time and cost savings from digital working, increased collaboration with statutory services and greater recognition and appreciation for the sector as a whole.

Implications

The report provides several implications for policymakers, public health researchers and future work. In particular, our findings highlight:

- The importance of early identification of those who may be more vulnerable to the direct and indirect impacts of adverse events (be they related to health, environmental or economic crisis); and the importance of preventative approaches to address vulnerabilities and longstanding, underlying health inequalities.
- The importance of recognising, valuing and sustaining the unique assets offered by VCS organisations to identify and support the vulnerable, as we move into recovery.
- The importance of health and social care bodies planning and developing a co-ordinated approach that harnesses and values VCS knowledge, insight and practices – particularly flexibility, adaptability and localised responsiveness.
- The need to continue to strengthen and develop the unique institutional infrastructure for partnership working offered in Wales, critically through the provision of Public Services Boards and Regional Partnership Boards.
- The value of qualitative public health research and person-centred, holistic approaches to vulnerability in complementing existing work and research.

1. Introduction

The COVID-19 pandemic has revealed that we can all be subject to the effects, both positive and negative, of a crisis. For many people, a major impact has been a newfound sense of vulnerability. Indeed, millions of people across the UK were suddenly defined as 'clinically extremely vulnerable' within only the first few weeks of the pandemic¹. The aim of that effort was to identify those who might not be able to cope with or recover well from the impacts of COVID-19 and, given the time constraints, a narrow and clinical understanding of vulnerability was used.



As we recover and plan for future crises, we need to effectively identify those who are vulnerable in order to provide them with appropriate support. An invaluable source of information about people's needs are charities (collectively known as the Voluntary and Community Sector (VCS)) who respond to and support people across Wales on a daily basis. In this research project, our aim was to explore how the VCS identified and responded to emerging vulnerability during the COVID-19 pandemic in order to learn lessons for the future.

In presenting these findings, we use the capability approach to vulnerability^{2,3}. This approach asks whether or not people can live the lives they want and advocates people in vulnerable situations being supported by public institutions. It also argues that social and environmental contributors to vulnerability, for example social and economic inequalities, need to be explored and addressed, not ignored. This is especially crucial given the clear interactions that the COVID-19 pandemic has had with pre-existing inequalities in our society, in what is now being described as a 'syndemic'⁴.

Our report and the findings inform several priorities here in Wales at present:

- The agenda of **"A Healthier Wales"** which sets out a vision for Wales where everyone is living longer, happier and healthier lives and are independent in their communities for as long as possible⁵. Specifically its aim is to set out a whole-systems approach focussed on equity and early prevention.
- The wellbeing goal of **"A More Equal Wales"** which envisages a Wales where everyone can fulfil their potential no matter what their background or circumstances⁶.
- The implementation of the socio-economic duty in Wales under the **"Equality Act 2010"** will charge public bodies with the responsibility to deliver better outcomes for the disadvantaged.
- The principle under the **"Social Care and Wellbeing Act 2014"** that Welsh public services should support those with needs so that they can achieve their wellbeing; to be understood as a person being happy, healthy and comfortable with their life⁷.

- The focus on prevention and wellbeing for those facing inequalities and vulnerability as part of the **“Wales Recovery Plan”** for the COVID-19 pandemic⁸.
- The importance of living conditions, income security and social capital in regards to health and wellbeing, highlighted in the latest **“Welsh Health Equity Status Report”**⁹.
- And finally, the desire to build a healthy, fair and sustainable environment in Wales as set out in the Welsh Government’s **“Prosperity for All”** agenda¹⁰ and Public Health Wales’s **“Investing in sustainable health and wellbeing”** plan¹¹.

In the rest of this section, we discuss the understanding of vulnerability used in this research and provide some background to the VCS in Wales. Following on from this, we present our methods and our findings before concluding in the final section.

1.1 Understanding vulnerability during the COVID-19 pandemic

1.1.1 What is vulnerability?

There are many approaches to understanding vulnerability, broadly speaking it refers to a person’s needs and their susceptibility to crisis. Both of these can affect a person’s health and functioning¹². Different approaches to understanding vulnerability have been used in different studies. These range from demographic assessments that predict population resilience to natural disasters, to sociological approaches that look at vulnerability more broadly.

In this work, building on the Welsh Health Equity Status report and previous work on individual and community resilience by Public Health Wales¹³, we opt to use the ‘capability approach’ originally conceived by Amartya Sen¹⁴ adapted to analyse vulnerability. The capability approach is person-centred, it emphasises respecting people’s needs and preferences. It relates vulnerability to **human wellbeing** and focusses on what people are actually able to be and to do in their daily lives. It also highlights inequalities related to vulnerability with those who have protected characteristics often disproportionately experiencing vulnerability. For public health, the approach advocates for the fair provision of the basic resources and services that are required for everyone in a population to live long, healthy and happy lives.

Sadly, crisis and need are an inevitable and shared feature of our lives¹⁵. As **embodied beings** we are vulnerable to illness, age, disease, social factors and environmental hazards. As **emotional beings** we are vulnerable to mental hardships that may occur across the life course, such as grief, neglect and abuse. As **social beings** we are vulnerable to prevailing social and economic conditions. We are also made vulnerable by **barriers** when accessing the foundational resources and services vital to our capabilities, such as health care, education and housing.

Vulnerability both reflects and effects our capabilities. People with less capability may have less agency and struggle to meet their needs. They will be more likely to experience crisis but less able to cope with it and recover from it. Existing public sector support services from, amongst others, health, housing, schools and social care can help. However, the most vulnerable who may not

be in touch with statutory services, whose needs are “ill defined” and don’t fit one type of service is where **the VCS becomes particularly valuable**. This is in virtue of the person-centred, enabling role it can play, supporting people struggling to access services, acting as an advocate and ensuring basic needs are being met.



1.1.2 How do people become vulnerable?

Throughout our research, we were interested in the process of how people become vulnerable – what conditions and circumstances lead to people becoming vulnerable? Therefore, we used a version of the capabilities approach based on a recent, similar qualitative project conducted in the UK¹⁶. Our approach emphasises capability and features two interconnected and overlapping aspects of vulnerability, inherent and situational, and also explores the role of time in vulnerability.

Table 1 Aspects of Vulnerability

Aspect of Vulnerability	Definition	Examples of contributors	Capability Approach view
Inherent	An individual’s personal need and susceptibility that arises from their inherent biology. An intrinsic feature of humans arising from their bodies and is experienced by everyone to varying degrees.	<ul style="list-style-type: none"> • Nutritional requirements • Susceptibility to infectious disease • Extra needs arising from a pregnancy • Limitations from health conditions • Biological ageing • Poor mental health 	<ul style="list-style-type: none"> • Recognise the importance of people’s own resources and characteristics • Support people so that they can respond to their intrinsic needs • Different people will have different intrinsic needs and require different inputs
Situational (Non-relational)	A person’s needs and susceptibility as determined by their social, economic, political and environmental context (external conditions).	<ul style="list-style-type: none"> • Employment • Clean air • Food security • Community cohesion • Civic participation • Political rights • Supportive environment 	<ul style="list-style-type: none"> • Recognise that context has a large impact on needs, resources and agency • Recognise the interplay between inherent and situational vulnerability
Situational (Relational)	A specific form of situational vulnerability. Need and susceptibility arising from a person’s interactions with others.	<ul style="list-style-type: none"> • Healthcare access • Job markets • Marginalisation, discrimination and exclusion • Loneliness • Emotional support 	<ul style="list-style-type: none"> • Recognise relations are a key part of meeting need • Recognise that abuse and neglect can cause harm and thwart access to services

1.1.3 How does vulnerability change over time?

Many models of vulnerability portray it as a fixed state, either when crisis is experienced or with particular groups being permanently vulnerable. Conversely, our approach recognises that change over time is an important aspect of vulnerability and capability.

Specifically, we propose three key features of this:

- First, needs do not always have to take the form of a fixed state. For example they may be **transient**, such as in pregnancy, or **enduring** such as certain mental health problems.
- Second, vulnerability often **progressively worsens over time** by itself. For example chronic diseases often get worse over time¹⁷, or it can become more difficult to find employment the longer one spends out of work¹⁸.
- Finally, vulnerability interacts with crises over time. This can create a **'downward spiral'** where vulnerability leads to more frequent and worse experience of crisis which then further increases need whilst compromising capability¹⁹. This role of time in vulnerability demonstrates the importance of prevention approaches.



Prevention stops increasing vulnerability taking firm hold. It stops unmet needs and susceptibility increasing and capability worsening unnecessarily. This is a key philosophy of the voluntary and community sector as well as a principle underpinning Welsh policy. An example being the prevention framework set out by the Future Generations Commission²⁰ below:

- To create the conditions so that vulnerability is limited in the first place (primary prevention)
- To target action to areas and people where there is a high risk of vulnerability developing (secondary prevention)
- To intervene where marked vulnerability is being experienced to prevent it getting worse and stop it re-occurring (tertiary prevention).

1.2 Understanding the Voluntary and Community Sector

VCS organisations have a long-standing role in identifying, engaging with and supporting individuals and communities across Wales. This includes through the provision of services targeted at tertiary prevention to address immediate needs. It also encompasses actions targeted at secondary and primary prevention, which aim to enhance people's capabilities and agency, and contribute to the building of a more equitable society.

1.2.1 What is defined within the VCS?

We understand the VCS, often referred to as the 'Third Sector', as encompassing registered charities, community groups, voluntary organisations, and social enterprises, including both voluntary and paid staff. It includes not-for-profit organisations whose mission is to respond to different forms of vulnerability, such as those relating to housing, food insecurity or particular health conditions. During the COVID-19 pandemic, the VCS has grown to include a range of newly established mutual aid groups, formed in response to the surge in needs across communities in Wales. This is illustrated in the COVID-19 Response Map Wales, which maps information on need and levels of citizen-led community support²¹. VCS organisations may be independently funded, through fundraising and philanthropy, and/or commissioned to deliver public services. They carry out a range of functions, including providing support and services to different vulnerable and socially excluded groups, alongside campaigning and advocacy for social justice issues.



The boundaries around what constitutes the 'Public', 'Private' and 'Third' sectors have become blurred as reforms in public service provision have led to a more mixed economy of welfare²². Over time, this has resulted in a diverse range of hybrid organisations, including those that are commissioned by Local Authorities to deliver services, such as mental health support or social care services. Public sector commissioning can be beneficial given VCS organisations often have pre-existing relationships with people seeking support, alongside expertise in service design, and public and patient engagement. However, it also presents various challenges and tensions. The lack of integration across services can produce extra administration and the duplication of efforts and resources. It can also foster competition amongst VCS organisations, and across sectors more broadly, with different organisations in the charity and private sector competing for contracts. While some argue a competitive landscape drives accountability and strengthens organisations delivering the greatest impact, others are concerned it undermines collaboration and the sharing of resources and skills in ways that could hamper pandemic recovery efforts²³.

1.2.2 The role of VCS during the COVID-19 pandemic

The COVID-19 pandemic has underscored the critical role the VCS plays in emergency preparedness, delivering a rapid response to need, and in rising to the complex challenges associated with longer-term recovery²⁴. Throughout the course of the pandemic, the VCS have continued to deliver a range of frontline services targeted at meeting the needs of people facing increased hardship, from those experiencing housing crises and food insecurity, to victims of domestic abuse. In many instances this has involved working collaboratively with statutory service providers, Local Authorities, Health Boards and Regional Partnership Boards, alongside other local stakeholders. Early identification and response to need by VCS organisations has been crucial in bridging gaps in public sector provision at a time when primary health care services have been under monumental strain. VCS organisations have extensive knowledge of the people and needs that arise in this context, and have established relationships with the communities they support. Their awareness of the gaps in health and social care services, and knowledge of individuals not known to statutory services, has enabled them to pinpoint and respond to hard-to-reach groups. The proliferation of joint partnership working, including initiatives supported by Voluntary County Councils across Wales, have also provided individuals with access to a network of community-level support services²⁵.

The sector's response demonstrates their agility in not only adapting to meet immediate needs, but also innovating their services to deliver targeted wellbeing interventions that aim to prevent vulnerability developing. This is evident in the numerous activities, from socially distanced wellbeing walks to telephone befriending services, which aim to mitigate against the sharp rise in social isolation and loneliness, and its associated long-term impacts on mental health²⁶.

The voices and experiences of those working in the VCS offer unique insights on emerging vulnerability in the context of the pandemic. This research harnesses the expertise of the VCS to understand the inherent, situational and relational factors that have created and exacerbated different forms of vulnerabilities in people's lives. These perspectives are key to shaping and strengthening the cross-sectoral approaches at the heart of the Welsh Government's pandemic recovery and reconstruction strategy²⁷.

1.3 Aims and objectives of this research programme

This research focussed on bringing together insights from a diverse range of VCS representatives in recognition of the extensive knowledge they hold on *how* people become vulnerable due to a complex interplay of inherent, situational and relational factors, and to identify key lessons for the future.

The aim of this research programme was to explore how the VCS identified and responded to emerging vulnerability related to the direct and indirect impacts of the COVID-19 pandemic. The research objectives were twofold. Firstly, to explore VCS perspectives on new and emerging vulnerability during the COVID-19 pandemic. Secondly, to explore how the VCS rapidly identified, understood and responded to emerging needs over the course of the pandemic. The findings can help identify lessons to inform future responses to vulnerability, towards addressing underlying determinants of health inequity.

2. Methodology

2.1 Research context and recruitment

This study focused on VCS organisations operating in three Local Authority areas in Wales. It encompassed both urban, semi-urban and rural areas, including places that have higher levels of deprivation, as identified using the Welsh Index of Multiple Deprivation²⁸. Participants were recruited from a range of VCS organisations, predominantly from organisations that would be classified as micro, small and medium in size²⁹. Collectively, the majority of VCS organisations in Wales are micro (income under £10,000) and small (income between £10,000 and £100,000). All organisations were established and operating prior to the COVID-19 pandemic. Some were contracted to deliver public sector services, such as social care and mental health support, and had long standing relationships with the Local Authority and Health Board. Other organisations provided independent services that were resourced through fundraising activities, grants and donations, or had a combination of both forms of funding.

Participants held a mix of strategic (i.e. Director) and operational roles (i.e. Project Worker, Development Officer, Team Manager). There was representation from organisations working in a range of areas across the five health equity conditions outlined in the Welsh Health Equity Status Report: 1) Health Services, 2) Income security and social protection, 3) Living Conditions, 4) Social and human capital, and 5) Employment and working conditions⁹. Recruitment of participants was supported by the Voluntary County Councils, alongside desk-based research on organisations in each area. A ‘snowballing’ approach was also used where participants identified other organisations and representatives who we then invited to take part. We used three qualitative methods: 1) semi-structured interviews (N=31), 2) small focus groups (N=2 with a total of nine participants), and 3) a data and intelligence asset mapping exercise. The data collection was carried out in February and March, 2021.

Health Equity Conditions

				
Health & Health Services	Health & Income Security and Social Protection	Health & Living Conditions	Health & Social and Human Capital	Health & Employment and Working Conditions

2.2 Semi-structured Interviews

The semi-structured interviews were held virtually and lasted approximately one hour. Topics were informed by the literature and input from members of County Voluntary Councils (CVCs). Each county in Wales has a CVC that is responsible for providing advice, guidance and support to local voluntary organisations and community groups, making them well placed to contribute to this study. The interviews focused on three core areas:

- 1) The impact of the pandemic on the people accessing the organisation's services and changes in demand for services across the course of the pandemic.
- 2) Understandings of emerging vulnerability and need.
- 3) The sources of information, intelligence and insight that have enabled organisations to pinpoint and respond to need.

2.3 Data and intelligence asset mapping activity

Before the interview, participants were invited to take part in a short online activity, focused on answering the question:

“What information and data has your organisation used to identify and support vulnerable people during the pandemic?”

The activity was asynchronous (participants completed it in their own time) and 11 participants took part. Each participant received a link to complete the activity, which involved posting their responses on a digital cork board that held the responses of all participants taking part. The activity aimed to create knowledge exchange and learning amongst the VCS and inputs were brought forward into the interviews and focus groups to elicit further reflection.

Local knowledge and expertise. Having been working in this area for many decades we have client data which we measure to identify any gaps in groups coming to us for advice. Our **staff and trustees are also very knowledgeable about the local area.**

Through membership and participation at **local emergency response forum** to respond to community based needs as part of **multi-agency response.**

Local Knowledge - We use “test & learn” and pilot projects to trial and develop new services and to provide evidence of need to support funding bids.

Through personal connections from prior work experience amongst our staff/trustee/volunteer (e.g. we have staff who have recently come from teaching and community development backgrounds who bring **relationships with schools and grassroots community organisations with them).**

The **assessment process undertaken with every new referral helps us to gather information of individual circumstance.** This in turn helps to formulate a much broader scope of needs within a community.

Community needs identified at a national level helped us to better understand what forms of support were needed primarily also helped us to set up the Covid 19 support network in Wales helping to support the most vulnerable both emotionally and financially.

Through **regional forums, networks, Health Board and Third Sector network.** Connecting with other agencies with different specialisms, hearing updates from the health board and others, sharing ideas and responses.

Research - as long as it is of good quality, independent & a large enough sample of the population it can be really useful to guide strategic thinking - I also go & ask staff if they agree/what they think.

2.4 Focus groups

The focus groups (3-5 participants in each) were held virtually with a selection of interviewees, some of whom also took part in the Data and Intelligence Asset Mapping Activity. Interviews lasted approximately 1 hour. They focused on exploring a key theme identified in the interviews during the primary analysis of the data: 'Networks, Collaboration and Partnership Working During the Covid-19 Pandemic'. They enabled collective reflection on how the pandemic impacted relationships with other VCS organisations, statutory services, Local Authorities and other public sector stakeholders, such as Local Health Boards.



2.5 Analysis of data

All data was transcribed, anonymised and analysed. Themes were identified using thematic analysis, which involved the development of a coding framework and iterative cycles of reflective reading and annotating of the data. The framework enabled the research team to identify and cluster conceptual themes, develop broader theme groups, and link these groups to master themes. These are presented in the table below.

The researchers secured the required governance approvals from Public Health Wales's Research and Development Office before carrying out the study. All participants received an information sheet explaining the study, and gave informed consent to take part. Participants used different terms to describe the people they support through their services. In keeping with the person-centred approach adopted by many of the VCS organisations involved in this study, rather than adopting terms like 'client', we used a people-first approach. For example, making reference to 'people who engage with' or 'seek support from' VCS organisations. In order to anonymise the identity of participants involved in this research, the quotes included are not attributed to the names of VCS representatives, but rather make reference to the focus of their organisation, for example 'support for older people' or 'housing support'. However, this is not included in cases where connecting the information identified in the quote to the focus of the organisation's work would risk compromising anonymity. The report features a range of quotes, which appear in text bubbles. Outside of the quotes we draw as closely as possible on the words and terminology used by participants, which are presented in quotation marks.

Table 2 Analytical Framework

Category	Themes	Subthemes
VCS perspectives on vulnerability	Defining vulnerability	Unmet need / Agency / Scope / Stigmatisation
	Changes in vulnerability over time	Changes in demand / Future need / Persistence
	Patterning / distribution of vulnerability	Clustering / Inequalities
Emerging needs	Mental health	Anxiety / Isolation
	Economic insecurity	Household finances / Jobs
	Digital exclusion	
	Disruption to face-to-face services	Participation / Needs assessment / Harms
	Limitations of statutory response	
Role of VCS during pandemic	Tackling isolation and loneliness	
	Addressing digital exclusion	
	Brokering access	
	Gap filling	
Challenges and opportunities for the VCS	Funding	
	Digital delivery	
	Staff mental health and wellbeing	
	Greater recognition	
VCS Assets	Size, scale and governance	
	Holistic focus on needs	
	Embeddedness	
	Intelligence sharing and collaboration	
	Workforce	
	'Finger-tip' knowledge	Situational awareness / Experience / Data and research
	Experiential learning	

3. Perspectives from the VCS on vulnerability

In this first findings section, we present the results of our discussions around vulnerability with the VCS. We focus on three overarching themes: defining vulnerability; changes in vulnerability over time; and the patterning and distribution of vulnerabilities. Within each theme we bring together findings from the interviews into sub-themes which contribute to the overarching theme.

3.1 Defining vulnerability: perspectives from the VCS

Unmet Need

Lack of agency

Variety of forms

Stigma

We discussed the concept of vulnerability itself with all of the participants, prompting a variety of reflections with no consistent definitions given amongst them. Many participants directly spoke of the **multi-faceted nature of vulnerability**, discussing physical health, mental health, social care, finances, community and employment amongst many potential contributors. Vulnerability was most often discussed in a holistic manner that encompassed every aspect of a person's wellbeing. These discussions were not limited to the person either, with many participants also talking about 'vulnerable situations' and the importance of situational factors.

The term vulnerable [...] is somebody who actually can't manage their affairs without help and support.

Older persons support

The term vulnerable [...] is for people who don't have the resources to manage their own wellbeing, as simple as that really, and that could be from both ends of the spectrum.

Mental health support

It [vulnerability] comes in various layers and none of them are good are they, they're all very detrimental to people's physical and mental wellbeing.... People are vulnerable because of all sorts of reasons and as I say the various social or economic exclusions conspire to increase people's vulnerability.

Housing and independent living support

Overall someone who is vulnerable is [...] at risk [...] of moving way out of that thriving space into something that's doing them harm.

Mental health support

The most evident subtheme we identified in defining vulnerability was **unmet need** in its various forms, particularly needs that required support and help from others. These needs varied from person to person with some people requiring more support than others in different circumstances. They included hunger, financial support, housing and medicines as just some examples. At this point, many participants also discussed access to services. Vulnerability could be brought about in some instances by barriers, by exclusion, by poor identification of needs or even by reluctance on the part of the person to ask for help.

Another evident subtheme was **agency of people** (their ability to perform actions) and how a lack of agency could bring about vulnerability. Being vulnerable was clearly identified as something that stops a person from being able to make effective choices and adequately manage their own affairs. It was similarly discussed as putting people into a position characterised by **uncertainty and inability to cope** moving forwards. A position where their capability could deteriorate and aspects of their resilience may become compromised.

Any one of us can be vulnerable for lots of different reasons but for me I think just the sheer uncertainty of what the pandemic was going to bring [made people vulnerable?].

Mental health support

And I would almost put on, that vulnerability almost implies there is somewhere a lack of control over something, or the ability to do something, I would say.

Support for housing and independent living

So, I think there's a kind of personal thing about agency there's something about understanding all of the potential implications and how they interconnect...and there's stuff about social capital, social resources so I think I probably understand vulnerability in those - if there's a Venn diagram you have those three circles in it.

Disabled persons support

Finally, we identified smaller subthemes related to the potential **wide scope of vulnerability** as well as its **potential stigmatisation**. For example, some participants spoke positively about people recognising vulnerabilities regarding their own mental health in the face of the pandemic and then being able to ask for help in response.

However, other participants voiced concern over the use of vulnerability as a label and spoke of witnessing the rejection of this label by those they provided services for. This was particularly the case with blanket use of the term that did not consider the person themselves. For example, the letters issued to those deemed to be extremely clinically vulnerable to COVID-19 were cited multiple times as provoking a defensive, anxious or upsetting reaction in those who did not consider themselves to be vulnerable.



3.2 Changes in vulnerability over time from VCS perspectives

Changes in demand

Future needs

Persistence of vulnerability

In addition to the diverse and person centred definitions of vulnerability, the relationship between time and vulnerability was also an important consideration. One of our subthemes related to a number of participants recalling **dramatic increases in expressed need for their services**. Much of this was attributed, not to the virus itself but to the shielding and social distancing measures in response to the pandemic. For example, many people were suddenly in need of support when they were left without food or medical supplies due to shielding or when they had lost support from family and friends.



So, the demand has gone up massively for our services especially with the lead need being domestic violence.... our clients are, well, were relatively stable before the pandemic and ready to move on and making good life choices. The pandemic hit and it's like set them two years back because of their vulnerabilities.... I mean the government are going to have to do something about looking at how the pandemic, 10 years on, how people have been affected by it.

Support for people experiencing domestic abuse and violence

The first [lockdown] everybody was so scared and worried, and everybody just shut down and it was all – nobody left home and they just shutdown more, but we're finding now that families are struggling more, so we've got more demand... When we opened for the summer there was a big demand for our service and we're expecting high demands again.

Food aid support

If you think of a bowling alley, like people's skittles are all standing maybe at the beginning or maybe they're not all standing some have already been knocked over. Then you've got the pandemic kind of sending balls down, you know, some people, those balls won't hit those skittles but for some people they'll all be knocked over. I think that's kind of knocking over of resources that mean that people head into vulnerability.

Mental health support

However, several participants conversely described an **initial delay** in this process with many people who were in need, though not in immediate crisis, choosing to “hunker down”. After a number of weeks, they then did express need which most often related to deteriorating mental health, loneliness, financial pressures or job loss. This led several organisations to witness a demand surge in the summer of 2020, rather than the spring.

In addition, a number of participants expressed concern for **emerging vulnerability in the near future with a specific focus on underlying issues being revealed**. For example, it was repeatedly predicted that restoring debt collection services would reveal many families as highly indebted or that any sudden loss of the furlough scheme would reveal the true precariousness of many jobs. It was also feared that a significant burden of domestic abuse and child abuse will also be revealed when services and communities move back towards normality. Specifically, we saw several expressions of this in imagery, with terms like “bubbling”, “volcano” and “eruption” frequently used.

Another subtheme related to time and vulnerability that we identified was the **persistence of vulnerability over time and repeated crises sending people into a downward spiral**. Many participants spoke of how vulnerabilities were present in their communities long before the pandemic. Examples given included geographical factors, racial discrimination, deprivation and poverty. Certain people and communities were described as being chronically vulnerable and as being repeatedly buffeted by crises. Many of these had been able to cope beforehand, however the loss of their support networks pushed them into a more vulnerable space where they deteriorated. A key focus of the VCS was to prevent or pre-empt these spirals.

Finally, several participants also expressed concern about **the persistent effects of the pandemic on people’s lives as we move into the future**. In particular, concerns were expressed about the ongoing impact it could have on children and young people with the pandemic potentially turning into a new Adverse Childhood Experience (ACE).

3.3 Patterns and distributions of vulnerabilities from VCS perspectives

Clustering of vulnerabilities

Following on from our discussions on the dramatic changes in vulnerability that could occur over time, the next theme that emerged in our discussions was the patterning and distribution of vulnerabilities across communities. These patterns had considerable breadth and were far from evenly distributed. A key way in which they manifested was the clustering of vulnerabilities in individual people, indeed our discussions rarely featured people who were vulnerable for one reason alone.

Instead, **people were typically facing multiple vulnerabilities and complex needs**, and it was these people who were hit hardest by the pandemic. This was particularly dramatic in the case of people who had been just about coping immediately prior but who then suddenly found the coping strategies that met their needs disrupted. Indeed, several discussions featured cases where people with limiting health conditions fell into crisis and lost their independence only after suddenly losing social contacts and community support.

Vulnerability and inequalities



Our discussions also featured the **compounding of these vulnerabilities by a lack of access to public services**. There were several accounts given of how many people experiencing multiple forms of vulnerability were struggling to get help even before the pandemic, were declining help or were encountering significant barriers. For example, it was highlighted how various migrant groups encountered difficulty in accessing healthcare or social security due to language differences, hostility or concerns of Home Office involvement.

You just take one brick out of the network, and people were just about managing and you take that one thing from them, like economic insecurity or falling into arrears with their rent, all the rest just collapse and the mental health suffers as a consequence, worry, anxiety, shame, guilt.

Mental health support

The inequalities seem to be widened again... linking back to Julian Tudor-Hart...and the inverse care law. I think that's becoming more prevalent because it is affecting people from a BAME (Black, Asian and Minority Ethnic) community more, isn't it? And I know there are lots of different reasons why but poverty, there does seem to be a link to poverty doesn't there and people's backgrounds, disposable income, living conditions and those with disabilities.

VCS Collaborative

WHAT IS THE INVERSE CARE LAW?

The pattern observed in society in which those who need care and support the most are the least likely to receive it. It is often attributed to long-standing socio-economic inequalities.

Finally, we also identified a subtheme in our discussions **connecting vulnerability to pre-existing social inequalities**, which could act as important predictors of vulnerability. Many participants highlighted the role of marginalisation and exclusion in creating and exacerbating vulnerabilities, and how they were already dealing with examples of this, such as violence against women, racial discrimination or exploitation of elderly people. Many also noted that the wider impacts of the pandemic, not just the disease, often interacted with such inequalities. For example, several concerns were expressed over women who were being subjected to domestic abuse prior to the pandemic becoming more vulnerable due to isolation and financial difficulties.

4. Emerging and exacerbated needs within the context of COVID-19, highlighted by the VCS

Our discussions highlighted many potential contributors to vulnerability that the VCS encounter on a daily basis, and reflection on how some pre-existing vulnerabilities have been exacerbated within the content of COVID-19, in addition to the emergence of new vulnerabilities. In this section we focus on the five themes that were most frequently discussed as emerging in the context of the pandemic. This includes: mental health and wellbeing; economic insecurity; digital exclusion; disruption and withdrawal of face-to-face services and support; and limitations of the statutory response.

4.1 Mental health and wellbeing

Anxiety

The first theme was a deterioration in mental health. This was markedly widespread, affecting both people who had never experienced mental health problems and those already experiencing them. It emerged as a rapidly growing need for the VCS as a whole and became a key concern, their response is discussed further on.

Most of our discussions featured **anxiety** as a part of this mental health deterioration. These feelings of anxiety could be generalised; certain people were concerned about the future generally and this translated into a sense of hopelessness for some. However, in most of the cases that were discussed, feelings of anxiety were a reaction to the specific situations people faced. People were worried about the risk of the virus, their employment and debts, about the duration of social distancing measures and so on. Perhaps most of all, people were worried about the uncertainty of the situation. Indeed, a lack of certainty translating into anxiety recurred as a concept in our discussions time and time again.

Our discussions also featured **isolation and loneliness** as another reason for this deterioration. The implementation of social distancing measures immediately and dramatically disrupted communities and social networks as well as the related activities that the VCS provided. This was especially the case for people advised to shield, who were often experiencing loneliness before the pandemic, and effectively became housebound overnight. Much like anxiety, loneliness became widespread as time went on with examples given including schoolchildren missing their friends, pregnant women having to experience antenatal care alone and bereaved persons having to cope without the support of others at home and during funeral arrangements.

Isolation

Originally people I think were fearful for themselves and their family, and I think it is the loneliness and isolation, lots of people are really anxious now. So when the restrictions did ease, there were lots of people who were able to leave the house but were really, really concerned about leaving the house, and then that has a knock-on effect doesn't it?
VCS Collaborative

4.2 Economic insecurity

Poor household finances

The second theme that emerged from our discussions was an insecurity around finances and employment. Many participants spoke about encountering increasing numbers of people who were **struggling with household finances** due to a combination of increased housing costs (due to suspension of work and school) and the loss of income associated with furlough. This particularly affected those who were already struggling with their finances but also had effects on households beyond them. Indeed, several participants spoke about helping people who were applying for Universal Credit for the first time and the shock those people had at the small amounts provided. In addition, financial struggles were clearly identified as pushing certain households into food, digital and heating insecurities.

Another massive concern is finance. Many of our families have experienced financial hardship because if they've got children, they have really struggled with the increase in food costs... When you're at home all day people don't realise how expensive it is to heat houses, especially if you're already receiving a really low income. So, they are the things – we've seen a massive rise in food bank vouchers. Debt poverty is a big thing. Support for housing and independent living

Job insecurity

Further to this, participants also discussed the concerns that many people had around **work and jobs**. These included worries over job loss at the end of the furlough scheme, especially since many of those people were either in precarious work or low-paid service jobs. Participants also spoke of their own concerns that many of the households they were working with appeared to be accumulating debts that would represent a significant problem in the future.

4.3 Digital exclusion

This research demonstrates that digital exclusion operates as a compounding factor of vulnerability. Digital inequalities resulted in individuals struggling to access vital services and resources, which reduced their capabilities on multiple levels. Prior to the pandemic, some VCS organisations involved in this study provided computers, Wi-Fi and skills training and support, which enabled people to complete benefits claims and apply for jobs. However, the disruption and reduction of these services, coupled with the closure of libraries and community centres where people also gain digital access, obstructed access to the labour market and welfare entitlements.

Participants often reported that the sudden reliance on digital connectivity for health care appointments and participation in social activities excluded some of the individuals they supported. Furthermore, families on low incomes that did not have access to Wi-Fi or IT equipment struggled to access education virtually. The impacts of digital inequalities was brought into sharp focus in one interview, where the participant spoke about working with families that had been forced to make “choices between data or food”.

I know some families that we've worked with, [who are] home schooling; they might have only got one mobile phone, one smart phone, three or four kids competing for that, there's been the choices between data or food.

Support with mental health and wellbeing

4.4 Disruption and withdrawal of face-to-face services and support

Participation

Needs assessments

Harms

While recognising the importance of restrictions that prevented the spread of COVID-19, participants spoke extensively about the knock-on effects of the reduction and withdrawal of health and social care services. There were many examples of where this rapidly created and exacerbated both inherent, situational and relational forms of vulnerability, as they were outlined earlier (Table 1). Participants from organisations supporting people with disabilities spoke about providing emotional support to people who had been profoundly impacted due to the withdrawal of social care that enabled them live independently at home. They identified how these changes had limited individuals' capabilities to meet basic needs, diminished their agency and dignity, and impacted their physical and mental health, sending them into a downward spiral.



People that live in supported tenancies, you know, they've got support sort of 24 hours a day... but it's the people that don't have that support all the time that have kind of missed out. Because they've lost their Personal Assistant support, they've lost their floating community support, and it's kind of not been replicated anywhere. So I mean I've got a client and her mum who are, you know, live together, live independently but require a lot of support for certain things and have been left very, very vulnerable.

Support for people with learning disabilities

Organisations that provide advocacy support for older people, and people with disabilities and learning needs, also witnessed how **the remote delivery of services dramatically reduced their participation in decisions that affect their lives**. For example, in the case of organisations that provide face-to-face advocacy support to ensure that individuals participate, where possible, in the review of their care plans. Attempts to provide this support virtually were limited in cases where people were digitally excluded (as identified in the previous section), or struggled to engage virtually or on the phone. This detrimentally impacted their agency and opportunities for self-actualisation in improving their quality of life.

Quite a lot of our assessments go into a lot of detail, we can talk about violence they experience, sexual violence, rape, use of weapons... so even if you've left the relationship, that is not the type of assessment you want to do in front of your children either... even if they couldn't hear you, going through that assessment process can be re-triggering for people and re-traumatising for people, so we felt like to do that to people without that wrap-around support in place, was actually quite dangerous.

Support for people experiencing domestic abuse and violence

Another recurring issue identified was the **challenges of assessing an individual's needs and wellbeing remotely**, either on the phone or virtually via video call. Participants shared concerns about how the absence of visual cues and body language meant it was often harder to get a sense of people's mental health or their drug and alcohol use. Organisations supporting individuals to claim for Personal Independence Payment (PIP) raised concerns about not being able to comprehensively capture all the information required about a person to evidence eligibility for financial support.



There were also contexts where **moving face-to-face services to remote delivery came with particular risks and had the potential to exacerbate harm**. This was spoken about extensively in the case of support for victims of domestic violence. Carrying out a virtual risk assessment posed risks in cases where that person was living with the perpetrator and there was no guarantee of privacy. Even in instances where women no longer lived with the perpetrator, there were significant challenges around remote delivery of support, such as in cases where women were unable to access childcare support. There was also the risk of assessments triggering traumas at a time when organisations were unable to provide face-to-face wrap-around support services.

4.5 Limitations of the statutory response

A number of participants reflected on how **some statutory services were not quick enough to adapt their services to keep up with emerging need**. At times, the statutory response was perceived to be limited in scope and effectiveness, resulting in people “falling through the gaps” and being “left behind”. The inadequacy of the response was often attributed to the “bureaucracy” and “rigidity” that governed the statutory sector, and in some cases larger VCS organisations commissioned to deliver statutory services.

[Discussing the issues affecting local communities prior to the pandemic] ...there was poor transport links, we can't recruit GPs so there's a string of locums, we can't get consultant psychiatrists so we get another string of locum psychiatrists, so there's no continuity of care, and we've got elderly people who are first language Welsh speaking... so they're not getting their needs met in that way either.

Support with mental health and wellbeing

Others pointed towards the condition of the statutory sector going into the pandemic, identifying how cuts in Local Authority budgets already meant some services were “operating on a shoe string”. In areas with high levels of deprivation, the impacts of the pandemic on health and social care services marked a crisis on top of a crisis, compounding longstanding issues around lack of access and continuity of services in primary health care.

I mean we've always seen people in desperate need, but those numbers are going up.... it's much more difficult to get a claim approved for a disability benefit... and particularly for people with mental health or learning disabilities because the system is just rigged against them really... There are people that are falling through the gaps much more because those systems aren't working properly where they put in a claim and it's been turned down.

Support with employment and finances

Participants also spoke about how the barriers to accessing health and social care rose sharply at the beginning of the pandemic, and while they had seen some improvement and stabilisation in services, many people were still struggling to access vital services they needed a year on. Participants made reference to how thresholds for statutory support had dramatically risen and remained high. In some cases this resulted in vulnerable children and families not having sufficient access to support from social workers and Children and Adolescents Mental Health Services (CAMHS), or accessing support at an advanced stage of crisis. Furthermore, many participants also spoke about how increased delays in the assessment and approval process for benefits plunged people into acute financial insecurity. This was often framed as a longstanding injustice, and linked to reforms in welfare services, such as the introduction of Universal Credit.

5. The role of the VCS during the COVID-19 pandemic

Our research highlighted different aspects of the role of the VCS during the COVID-19 pandemic. In this section, we provide a brief overview of the VCS response and then focus on four key roles carried out by the organisations involved in this study, which featured most prominently in discussions with participants. These include: tackling poor mental health, social isolation and loneliness; addressing digital exclusion; brokering access to statutory services, and picking up the pieces; filling in the gaps of statutory services.



5.1 An overview of the VCS response

Many participants reflected on how, in the early stages of the pandemic, their organisation rapidly adapted their services to address and meet emerging needs. Throughout interviews and focus groups, participants spoke about the agility of the VCS in constantly “morphing” and “adapting” their services to address issues such as spikes in food insecurity, increases in domestic violence, and the proliferation of social isolation and loneliness. The response to the first lockdown saw a focus on meeting basic needs, such as food, medicine and housing. VCS organisations mobilised volunteers, employees and trustees, alongside wider community networks, to address the significant logistical challenges they faced around continuing to support people amidst the unfolding crisis and newly introduced COVID-19 restrictions. Many organisations who contributed to this study reflected on the swift adaptation of their services, sometimes “overnight”, to provide remote delivery. However, they also spoke about the challenges around doing this safely and effectively. For example, as identified previously, in the case of domestic abuse charities where carrying out risk assessments virtually could potentially increase risk and exacerbate vulnerability. Where emergency face-to-face provision continued, this required making extensive operational adaptations to comply with social distancing measures. Many organisations contacted people registered with them, especially those considered particularly vulnerable, and took action to reduce the strain on primary health care and other public sector services.

Much of the early VCS response was focused on tertiary prevention, with many VCS organisations engaged in firefighting work, addressing the surge in demand for services. However, as time went on, they rapidly adapted to engage in horizon scanning activities, often through joint partnership working, to systematically identify trends and tailor services to provide secondary prevention. They co-ordinated with other VCS organisations and statutory providers to share learning and develop joined-up operational plans to target actions where vulnerability was developing. Participants in the focus group described this as a drive to be “proactive rather than just reactive”, demonstrating a commitment to move beyond just providing a crisis-driven response.

5.2 Tackling poor mental health, social isolation and loneliness

A key role of the VCS during the pandemic was identifying the new and rapid surge in mental health issues, including anxiety, loneliness, and isolation. The majority of participants spoke extensively about addressing this. Participants spoke about forging new partnerships with mental health charities, implementing telephone support lines and establishing virtual wellbeing workshops and 1-2-1 therapeutic sessions. For many organisations, this meant “going above and beyond” their original charitable remit, securing funding to support new services, such as the remote delivery of Cognitive Behavioural Therapy (CBT) and counselling, and provide mental health training for staff and volunteers.

Many organisations responded in novel and creative ways, particularly when it came to addressing loneliness and social isolation. This included developing a range of online activities, from book groups to virtual theatre productions and quizzes. They also adopted strategies to address loneliness and social isolation amongst digitally excluded groups, such as elderly people and people with disabilities. This ranged from letter writing, to the delivery of care packages and activity packs for children. Delivering welfare packages to people’s doorsteps also provided an opportunity to carry out vital wellbeing checks and identify instances where further mental health support was required.

So, whereas previously we would only be supporting, or we would largely be supporting the one child with learning disabilities now we’re supporting the whole family. So, we’re supporting all the children in the family or we’re doing more emotional support with parents compared to what we would have done if we were just taking the children out... we’ve provided some [virtual] meetings with families to talk together... they have had quizzes, we’ve had virtual treasure hunts... we’ve played virtual bingo.

Support for children and young people with learning disabilities

5.3 Addressing digital exclusion

Another key role of the VCS was to take rapid action to address the digital exclusion that they identified as an emerging need. They recognised how digital connectivity was a vital “lifeline” for individuals experiencing loneliness and social isolation, enabling them to engage with support services and connect with family and friends. In response, some VCS organisations appointed digital support officers to assist with the transition of services online and provide training to ensure people have the skills and confidence to communicate virtually. Emergency COVID-19 funding (such as from trusts, foundations and the Local Authority) and donations helped resource these



additional roles and activities. It also enabled organisations to purchase phones, tablets, laptops, and data top-up cards, for the people they support.

However, there were significant limits to addressing digital exclusion. First, it was contingent on whether the organisation could access the necessary funding and resources. Second, many organisations supported individuals who did not have consistent access to Wi-Fi, including people living in rural areas, those who could not afford Wi-Fi in their homes, and/or were vulnerably housed or homeless. In recognition of these issues, participants pointed towards the need for primary prevention through upstream policy interventions, such as the Welsh Government's digital inclusion strategy. During the focus group one participant reflected on transformations that could be made at the policy level to strengthen digital infrastructure, such as through the introduction of free universal broadband internet.

5.4 Brokering access to statutory services

In addition to the roles above, the VCS also played a key role in helping people who had new difficulties in accessing services. Many participants spoke about how the pandemic had significantly amplified their organisation's role in brokering access to statutory services and welfare support. This brokering role was important prior to the pandemic, and featured in organisations' charitable objectives. However, it grew significantly due to the increased access barriers to statutory support and services.

At the beginning... all the domestic abuse providers were having a weekly meeting to discuss where we could make sure people were housed and make sure people were getting the right services, and really, really pull together which was fab. We've developed quite close relationships with the Health Board and Safeguarding Team, we've all come together to... set up task and finish groups... It's massively affected the way we work with the GPs, we've started looking at how we can try to contact the GPs to make sure that they can recognise signs of domestic abuse.

Support with independent living

The role of organisations brokering access to financial support and advice became particularly important given the sharp increase in people applying for benefits, particularly in the case of people struggling to navigate the Universal Credit system for the first time. Other organisations had an increased role in brokering access to primary health care, such as GP appointments. This was particularly important during times when GP surgeries were over stretched and individuals were reluctant to make appointments because they did not want to be a burden. In some cases, the growth in this brokering role became a catalyst for joint working with statutory services or strengthened existing partnerships. The research uncovered many positive stories of how increased communication with local authorities and statutory providers led to collaborative working to ensure people had access to the support they needed.

5.5 'Picking up the pieces' and filling in the gaps of statutory services

Finally, while there were many positive examples of collaboration, participants also voiced frustration about having to "pick up the pieces" when statutory support was limited or withdrawn. Several spoke about finding themselves in situations where their organisations were filling in the gaps of statutory services despite having limited resources and finances. One participant spoke about receiving referrals to deliver a service to people who had been "pulled off the Health Board's books" without being compensated. Another participant from an organisation supporting people with disabilities expressed anger about how they had "stepped in" to provide support, while an agency was still being paid to deliver that service. This came at the end of the financial year when they were experiencing heightened financial insecurity with emergency COVID-19 funding coming to an end.

[One service that we offer] has had hundreds of new clients that have been pulled off the Health Board's books, from their services because they can't see them and they're not seen as urgent cases. So they've been reviewing all their files and sending them our way, and that's just left us with a real major capacity issue. I've had to... have extra staff delivering this service and in all fairness, if I'd have known how much it was going to be- I mean when we originally agreed to kind of help... but actually there's been no compensation around helping us fund it. So I've had to find funding elsewhere.

Focus group participant

6. Challenges and opportunities facing the VCS

In this section we outline some the key challenges that participants identified relating to their work and the wider role of the VCS during the pandemic.

6.1 'Fighting for survival' in an uncertain funding landscape

However, over the past year many VCS organisations have faced the challenge of meeting increased demand for their services, while also experiencing reductions in their income and/or longer-term financial insecurity. Participants reported loss in revenue from charity shops having to close, face-to-face forms of social enterprise activities and fundraising having to be curtailed, and wider economic shocks impacting funding streams. A range of organisations secured emergency COVID-19 funding offered by trusts and foundations, Local Authorities and/or the Welsh Government. This enabled them to develop and adapt their services to keep up with emerging needs and rising demand, as well as fund new digital forms of delivery. However, participants also spoke about the significant limitations and challenges associated with the funding landscape, many of which long pre-dated the COVID-19 pandemic.



Because we haven't got such a big structure and tight management, we're a very small organisation, and we're basically made bricks without straw because we don't know if we're going to get any more funding- At the moment we're still waiting to know whether our County Council funding will be renewed... and it's a very high likelihood it could be withdrawn.

Support for people with learning disabilities

With rising demand, reduced income and diminished reserves, some participants identified instances where VCS organisations in their local network had been forced to close due to their diminished income. Some participants spoke about facing significant threats to their organisation's very survival, particularly in the case of smaller organisations that had fewer reserves and less financial security. There were also examples of organisations that were forced to significantly reduce or close vital services that local people relied on for support. In many instances this was because emergency COVID-19 funding was coming to an end and/or because the organisation was struggling to secure funding for the next financial year. In the case of emergency funding, much of it needed to be spent in very short time frames (i.e. six months), which meant that organisations more regularly faced "cliff-edge" moments, unable to continue services unless they secured new funds. This was particularly so in February and March when we carried out the data collection, due to the upcoming end of the financial year.

In the focus group, participants reflected on what they saw as a "lack of strategic insight" on the part of funding bodies and also Local Authority commissioners. They identified how financial

instability and insecurity diminished their ability to sustain comprehensive support services that effectively meet the needs of individuals and communities. Short-term funding cycles also meant that a significant proportion of time was used to write funding bids. Participants spoke about how this drained their time and resources, taking attention away from the operational delivery of services at a time when it was needed most by local communities. This precarious funding landscape was particularly punitive for smaller organisations, especially those that found the competitive funding landscape challenging to navigate and did not have the finances to appoint a specialist fundraiser/bid writer.

I think there is a real lack of foresight about funding... They make these pots of money available for a relatively short period of time and it takes a while for these projects to get set up, then the funding is then sort of pulled away. I think it makes us – certainly speaking from our services, is looking at well actually should we be bidding for this because what's the long term or even the short-term impact of this funding? You know, it could be creating more work for us than it actually benefits. There needs to be some sort of strategy around - If we're looking at COVID-19 and it's going to be with us for a while, of how we actually tackle this. Not just going, well, okay, we've got an issue around housing, we'll put some money into that and then that money is taken away and perhaps then put into another pot to do something else with.

Focus group participant

6.2 Digital delivery of services

In the event of a return to face-to-face services in the future, some participants spoke about wanting to offer a blended approach to service delivery, whereby participants would have the choice to attend remotely or face-to-face. They identified benefits for ongoing remote delivery in particular instances, such as how offering wellbeing support sessions or CBT online would remove the burden and cost of traveling to engage in face-to-face services. However, there were many instances in which digital delivery was not suitable and did not benefit the people who relied on them.

Participants often emphasised that many services needed to be delivered face-to-face, particularly when working for digitally excluded groups, and/or meeting practical support needs (i.e. for people with disabilities). Some also emphasised how critical face-to-face delivery was for supporting people's agency, voice and participation. One participant spoke about how, in the case of working with people with autism who participate non-verbally, it was very challenging to find ways for them to participate in the design of their own care plans remotely over the phone or via video conversation. For other participants, operating face-to-face in a community setting was also key to their wider community building work, which aimed to foster social connection and cohesion. Participants highlighted how a longer-term switch to digital delivery was only appropriate "when it is beneficial to the people who need that support". Some raised concerns that the digitalisation of services during the pandemic would be continued going forward, and favoured by commissioners, on the grounds that it offered cost savings rather than benefits to the recipients.

I think moving forward for us, in terms of digitalisation, it's something that we're hearing a lot now isn't it. Digitalisation of services is going to be the new way of doing things. I think our sort of stance on it, moving forward, will be that we will digitalise services, but only where there is benefit to the service user, not where there's benefit to the organisation and not where there's benefit to the commissioner, in terms of efficiencies. We will only use it where it is beneficial to the people who need that support.

Support for people experiencing domestic abuse and violence

6.3 Mental health and wellbeing amongst VCS workers



Participants in interviews and focus groups spoke about how the pandemic has taken a significant toll on employees and volunteers delivering VCS services. Almost all the participants spoke about instances where colleagues, or in some cases themselves, suffered with poor mental health or “burn out”. This was attributed to people having to work longer hours to keep up with the increasing demand on their services, ensure they are reaching the most vulnerable, secure funding, and develop strategies to target emerging need. Participants also spoke about the pressures they

experienced in supporting an increasing number of people in extremely vulnerable situations at a time when statutory services were disrupted and reduced. For example, one participant spoke about struggling to get sufficient guidance from and access to a local GP surgery when supporting a mother experiencing a mental health crisis. Situations like this, which often required balancing competing demands around the clock, were particularly challenging for employees and volunteers with families and caring responsibilities at home.

And obviously we've been out then you know when the services are not open and where do we go? Because I have felt... a lot of pressure is on our shoulders that we aren't medical professionals you know there is a limit to what we can do. But yet we've kind of had all that placed on us with nowhere to go. So, I feel as employees as well that maybe that's had effect on us and our mental health, and obviously we are still at home with our children. We're in exactly the same situation as the people [families] who use our services yet we've also got to do a full time job whilst looking after our children and stuff. So I feel that that needs to be recognised as well.

Support for families and children

The financial instability of the VCS also had a significant impact on employee wellbeing. Participants spoke about their own or other organisations having to furlough staff or reduce their hours. The increasingly short-term nature of funding and commissioning created a precarious working environment, with many employees on short-term contracts with no guarantees they

would be renewed at the end of a funding cycle. This impacted the mental health and economic security of employees. While concerns about the precariousness of VCS workers was a pre-existing issue in some instances, this was exacerbated due to the fragmentation and increasing fragility of income streams made up of multiple small and short-term pots of money.

And that [insecurity in income] has a knock on effect with staff as well, you know, unsecure jobs. We can say you're funded until the end of March but it's that not knowing what's coming after April. We've only just known this last fortnight that we've got our funding to go forward. I had a lot of members of staff looking for other jobs. I didn't want to lose anybody because they're a fantastic team but I understood the situation they were in as well. They all had bills and mortgages to pay, you know, so it's not secure for third sector. You don't have those full times contacts going forward year after year.

Focus group participant

6.4 Greater recognition of the VCS and 'parity of esteem'

Many participants highlighted the need for greater recognition of the VCS and the vital role they play not only in times of crisis but also in the longer-term recovery from the impacts of the COVID-19 pandemic. In many instances, participants felt that the responsiveness and agility they demonstrated during the pandemic, through partnerships and multiagency working, led to their organisation being valued and recognised more by funders, Local Authorities, commissioners and statutory services. However, for many, there was still an urgent need to meet this recognition with further concrete actions. Some participants spoke about wanting "parity of esteem" with the statutory sector. This requires deeper recognition of how VCS knowledge and expertise can contribute to the strategic design of effective, responsive and integrated services. Others identified the need for policy level interventions to create more sustainable and long-term funding for the sector, which would also pave the way for greater job security and increased pay.

Sometimes the statutory mental health services come up, "Oh we've got this idea and we'd like you to do that". And I thought, oh my god are you sending this as a light bulb moment? We've been doing this for the last 15 years. It's really frustrating and again it's that attitude of voluntary equals amateur, and it's such a crying shame because we could work together much more coherently and cohesively, and complement one another much more, and have that parity of esteem as well, but we're not there.

Support with mental health and wellbeing

7. VCS assets that enabled the rapid and agile response

The research identified seven VCS assets that enabled organisations to move in a rapid and agile way to meet emerging need during the COVID-19 pandemic:

- 1) Smaller size
- 2) Holistic approach to addressing needs
- 3) Embeddedness: Connection to people and place
- 4) Intelligence sharing, collaboration and partnership working
- 5) Workforce: Volunteers and employees
- 6) Finger-tip expert knowledge
- 7) Experiential learning

These seven enabling factors allowed organisations to adapt and innovate their services in response to the surge in demand and the changing contexts of need that arose at different junctures of the pandemic.



Smaller size



7.1 Smaller size

Participants spoke about how the **bureaucratic procedures and standardisation of services present in the statutory sector, and in larger VCS organisations, reduced their ability to rapidly respond and adapt services.** The research identified how smaller VCS organisations were particularly adept at adapting and innovating their services. This was because they had flatter organisational hierarchies, small management teams, shorter ratification processes, and services operating within in a smaller geographical area.

One participant, who worked in a larger third sector organisation that delivers services across multiple Local Authorities, spoke about how attempts to adapt their service during the pandemic were hindered by bureaucratic procedures. The risk assessments required to change one service needed to be carried out across all services within the organisation. This included those that would not be subject to the proposed change and where there was a much higher risk of COVID-19 transmission due to nature of the provision. These centralised bureaucratic processes resulted in longer ratification times, with proposed changes potentially curtailed in their scope and impact.

Also our agility as a third sector organisation, so we were able to, you know, get things off the ground really quickly... We didn't do anything unsafe, but we were able to access training for staff really quickly, PPE we were able to access quickly, which was great for us, and you know, we developed, you know, early on in the pandemic, the first few months, the majority of my time really was about developing policies and procedures. But we've got a quick ratification process... so we were able to get those sorts of things in place really quickly, to support the team to get out there and do the work.

Support for people experiencing domestic abuse and violence

Holistic approach to addressing needs



7.2 Holistic approach to addressing needs

The agility and responsiveness of the VCS was often attributed to a holistic approach to addressing need, which attends to different aspects of a person's wellbeing. Many participants spoke about taking an individual's needs as a starting point, and adapting and tailoring their support to meet those needs, rather than identifying how an individual would "fit" into existing services. Organisations that had long adopted a person-centred approach – locating people at the centre of their services – already had a flexible and fluid approach to their service delivery. This became a strength that enabled them to innovate and adapt in the rapidly changing environment the pandemic created.

I think generally the third sector have just adapted to having to change quickly. It's just kind of the way that the momentum keeps going within the third sector, you have to be able to diversify and change to keep up with the need I guess, and statutory services have always got a base of what they provide, whereas the third sector provides such a sort of diverse range of things that it's always had to be adjustable and changeable and flexible. There will always be that need there, so to do it suddenly at the drop of a hat isn't a massive thing.

Support for people with learning disabilities

The holistic focus on need also extended to encompass advocacy and campaigning to address upstream determinants that limit people’s access to the resources and services they require for their wellbeing. VCS organisations engaged with Local Authorities, Health Boards and the Welsh Government to raise awareness on how structural issues were exacerbating vulnerability in marginalised groups, such as people from BAME backgrounds and carers. One participant spoke about campaigning to ensure the Welsh Government and Local Authorities continued to comply with the *Social Services and Wellbeing Act 2014*, which identifies a carer’s right to be offered a needs assessment.



7.3 Embeddedness: connection to people and place

The agility of VCS organisations was often attributed to their connections to people and place. Particularly in the case of smaller organisations, participants spoke about their long standing relationships with local community networks, VCS organisations, the statutory sector, and local businesses. “Pulling on” established relationships and “going

out to community networks” enabled them to rapidly mobilise resources to meet emerging needs. Links with local businesses enabled organisations to source food for people in financial hardship. Knowledge of the local community networks also enabled organisations to collaborate with newly emerged mutual aid groups. Embeddedness in local networks also facilitated the rapid recruitment of volunteers, which was particularly crucial during the initial surge in demand for VCS services early on in the pandemic.

VCS organisations that were embedded in local communities also came into the pandemic with long standing relationships with local people. This was particularly important for organisations in areas with high levels of deprivation, where there was enduring vulnerability and insufficient health and social care provision. Their extensive knowledge of local people and place, enabled them to identify vulnerable individuals, and predict who would need support and how. Furthermore, organisations with roots in their communities went into the pandemic being known and trusted by local people, resulting in them becoming their “first point of call” in many instances. Organisations that were “established by the community, for the community” identified how local people turned to them during the pandemic because they had a long history of working to improve the outcomes of local people.

We are fully integrated into this local community, and whereas previously, in another organisation that I worked at, we would say to funders, we would deliver services Wales wide, but in practice that was really very difficult and that might mean that a member of staff in Cardiff who’s covering a huge area, and there was no integration in terms of the community... we’ve got an investment in our local community, we employ people from the local community, all our supply chains are local as well. We are fully integrated into this community, and that has reaped benefits really, for our support, and our response to the pandemic.

Support for people experiencing domestic abuse and violence



7.4 Intelligence sharing, collaboration and partnership working

The pandemic led to increased information sharing with other VCS organisations, statutory services, and public bodies such as Local Health Boards³⁰ and Regional Partnership Boards³¹. Participants

spoke about their extensive use of established network meetings and forums, but also the formation of new ones, such as COVID-19 related task groups. The increased flows of information was partly enabled by the digital switch in working in many VCS organisations. This was particularly beneficial for employees and volunteers working in rural areas where long travel times had previously been a barrier to attendance. However, balanced against that was the loss of opportunities for informal chats with attendees during meeting breaks where they could check-in, raise concerns, or float ideas for service design.

Virtual intelligence sharing, facilitated through online meetings and forums, provided VCS organisations with a comprehensive birds-eye view of “what was going on on the ground”. It enabled them to work collectively with other service providers to quickly and comprehensively identify which individuals were at greater risk, where progress had been made and challenges encountered.

We increased our relationship with social services, child and family services because also being those extra pair of hands and eyes as well, working with some of the most vulnerable families, so making sure that safety plans are in place in regard to contextual safeguarding. Being able to map then from a substance misuse perspective the progress or the lack of progress, or no progress at all that was happening... The way that all meetings are virtual has definitely increased productivity, so more families can be discussed, debated, looked at... We've increased our relationships with some of the primary healthcare provisions as well.

Support for people affected by drug and alcohol use

Increased contact with other service providers led to the strengthening of existing partnerships and the formation of new ones. Early on in the pandemic, some VCS organisations forged partnerships with Local Authorities to strengthen the communication of public health messages to harder-to-reach and marginalised groups. One organisation working with people from BAME backgrounds connected with the Local Health Board to disseminate important public health messages. This relationship laid the foundations for current joint working around vaccination programmes, including understanding and addressing vaccination hesitancy amongst some ethnic minority groups.

For other organisations, the focus on partnership working came later on in the pandemic, once they had responded to the initial shock, adapted their services and were able to “broaden their gaze outwards again”. In some instances this was six or nine months on from the first “lockdown” in March 2020, and was also contingent on being able to source adequate funding (challenges

I think that the pandemic has accelerated partnership working, and accelerated our understanding that it's very much needed and very much more urgent than we'd appreciated before. So I think initially in the pandemic, perhaps gave an internal focus, but then once we kind of broadened our gaze outwards again, it's led to some new partnerships.

Focus group participant

around funding are addressed in section 6). Partnership working was often strengthened through support from Voluntary County Councils, working in collaboration with Local Health Boards and Regional Partnership Boards.

The strengthening of existing relationships and formation of new ones within and beyond the VCS often led to creative innovations in services that aimed to bridge gaps. In one case, a larger VCS organisation that provides mental health services across a Local Authority collaborated with a smaller organisation working with people from BAME backgrounds. The collaboration was initiated around conversations that people from some BAME communities were struggling because “they didn’t feel that mental health services represented their needs”. This led to joint working around the adaptation of services to reach these groups, and, at the point of the interview the organisations were in the process of submitting a joint funding bid.

The commitment and the level that the staff work. They love working for the third sector... they are the jigsaw piece that makes our organisation.

Focus group participant



7.5 Workforce: volunteers and employees

Many participants spoke about the care, dedication and commitment of the people that work and volunteer in the VCS. Organisations that experienced a surge in volunteer numbers were able to rapidly mobilise emergency food distribution networks in their local areas, or set up community help hubs for people with emergency needs. Many spoke about the value of the skills and experience held by volunteers. For example, in cases where staff on furlough from local restaurants volunteered to cook and distribute meals to older people, or where people signed up to telephone befriending services to support those experiencing loneliness and isolation. Many participants also made reference to the dedication of employees. They identified instances where they had “worked around the clock”, “responded to out-of-hours calls”, and sacrificed their weekends to ensure needs were met. As highlighted earlier (in sSection 6), there is an urgent need for greater investment in this asset through the provision of better pay and job security for VCS workers.



7.6 Finger-tip expert knowledge

When asked about what information sources helped shaped organisational responses to the pandemic, participants spoke extensively about the experience, expertise and collective wisdom held by people in the VCS. This “finger-tip knowledge” was held by staff, volunteers and wider networks. Localised knowledge that was immediately accessible was sometimes brought together with evidence in the form of locally collected population data and research. This enabled rapid decision-making around operational challenges and demands during times of heightened change and crisis.

7.6.1 Situational awareness

The VCS has an in-depth understanding of the situational drivers of vulnerability relating to the environment in which the organisation is embedded. This place-based insight gave organisations a nuanced understanding of how some groups in the local population were going into the pandemic with reduced capabilities. One participant contextualised the surge in demand for mental health support during the pandemic against a wider backdrop of redundancies made by a large local employer over the years, which reduced the resilience of local people to deal with further shocks.

Situational knowledge allowed organisations to identify individuals and groups that would immediately need support and to predict and plan accordingly. For example, awareness of how the inconsistencies in primary care had long impacted the physical and mental health of communities led to an increased awareness of the local VCS's role in brokering access to GPs. As identified previously, smaller VCS organisations embedded in communities also held extensive contextual knowledge of local VCS networks enabling them to signpost and connect with other organisations to provide a holistic package of support for individuals.

...our staff teams have huge knowledge of the areas they work within and the people that they're supporting. It's crucial that we learn from them and I'm a big believer in, and the way that we're commissioned to work, is about learning from the ground up and sort of not from the top down... so the teams on the ground.

Support with housing and independent living

7.6.2 Experience

In responding to the pandemic, the VCS also drew extensively on their historical experience of designing and delivering services to different groups. Participants spoke about how their learning around developing particular services to target need, both prior to and during the pandemic, gave them insight around what would work and what would not. This knowledge was crucial to rapidly develop strategies for engaging hard to reach groups, such as people who are digitally excluded or do not have English as a first language.

*[In describing the information their organisation draws on to support vulnerable people who use their organisations service...]
"Our own knowledge and learning of what has worked/not worked [in service design] in the past – not infallible by any means but has value"*

Comment from participant in Data and Intelligence
Asset Mapping Activity

7.6.3 Data and research

In many cases, finger-tip knowledge was supplemented and brought together with a VCS organisation's own localised data. This included pre-existing data, such as information about the demographics of people engaging with services collected via surveys, needs assessments, interviews, observations, and written or verbal feedback. More formalised types of data were often held by small, medium and large organisations that were commissioned to deliver local services and/or required to report impact to funders.

There were also many examples of rapid-fire data collection, often taking a more informal shape, which aimed to get a sense of who is accessing services and how, what the barriers to access are, and what support needs are/are not being met. This data was often collected by volunteers and employees responsible for service delivery, such as through the use of surveys and questionnaires with the people they support. In many cases it was collected digitally or over the phone. However, participants identified significant barriers to data collection during the pandemic, such as concern that digital surveys providing rapid data did not reach people who are digitally excluded, combined with the limited time and resources they had to collect data. Some organisations collected information during the face-to-face delivery of front-line services, such as in the case of outreach support for people working with drug and alcohol users, and sex workers.

Participants spoke about supplementing finger-tip knowledge with secondary research and data produced by a range of organisations, from think tanks and universities, to the Welsh Government and Public Health Wales. They often emphasised the important role of knowledge brokers in highlighting up to date research and providing concise summaries of take home messages. For example, participants made reference to bulletins, newsletters and online meetings/forums delivered by the Wales Council for Voluntary Action (WCVA) and CVCs.

In the case of larger organisations, this included information disseminated by the national organisation to which they were a part. While there were examples of where research had supported thinking and practice, such as helping to predict trends in need, participants also spoke about its limitations. Some identified that research tended not to be up to date enough given the rapidly changing environment. Others spoke about how they had already identified and responded to emerging trends identified in research by the time it was published.

It's local intelligence networks but on a soft basis that aren't formal sort of, you know, meeting... It's just that informal knowledge and contact, and the relationships that you've built up with individuals. As I say, it's more our common sense and that information, that local sort of information of knowledge of individuals that we've used more than the research because, let's face it, there hasn't been a huge amount of information out or research there that can, you know, say well when you've got this situation this is what you need to do.

Support for people affected by drug and alcohol use

Experiential
learning



7.7 Experiential learning

The experiential learning approach adopted by many VCS organisations involved in this study enabled them to rapidly adapt and respond to changing needs during the pandemic. Immediate responses to need were driven by ‘finger-tip knowledge’ and local insight, often followed by reflection and learning, which informed ongoing adaptation and innovation of their services. The process of identifying what was working and what needed changing was informed by internal reflection on practices but also externally through partnership working and sharing with other VCS organisations and statutory bodies. An iterative approach of enacting change, observing, reflecting and ‘tweaking’ services was particularly valuable when operating in a context of heightened need, rapid change and uncertainty. It fostered an ongoing attentiveness and responsiveness to the changing nature of need, enabling organisations to innovate services in response to what was happening on the ground.

*[In describing the design of their organisation’s services to meet support needs]
Demand – sometimes you just have to try it and see – if it doesn’t work – tweak it – if
it still doesn’t work, give up and learn from it. Usually done small scale and on a hunch.
Surprisingly effective.*

Comment from participant in Data and Intelligence Asset Mapping Activity

8. Summary

8.1 Overview

In this project, we used the capability approach to vulnerability to conduct qualitative research on the role of the VCS in Wales during the COVID-19 pandemic. Views from the VCS on vulnerability varied. The most common was that vulnerability reflected the unmet needs of a person, especially complex need. Another common view was that it was related to a person's ability to do things (agency) with low agency and capability reflecting greater vulnerability. Finally, many also held the view that vulnerability could go beyond the person and also encompass their context, resources, and environment as well as their access to services.

Vulnerabilities were often described as clustering together with certain individuals experiencing multiple, interacting vulnerabilities all at once, such as long-term unemployment and poor mental health. It was also described as often being patterned along lines of pre-existing social inequality with protected characteristics acting as important predictors of vulnerability. In addition, vulnerabilities were described as changing over time, with needs suddenly emerging as well as certain vulnerabilities persisting and worsening over time. On this point, many asserted that it was vital to anticipate and prevent these vulnerabilities from either emerging or being exacerbated to stop a person deteriorating along a downward spiral of increasing vulnerability.



The VCS participants highlighted several specific needs that emerged or worsened over the course of the pandemic. These included worsening mental health due to anxiety and loneliness, economic insecurity due to strained household finances and job loss, digital exclusion, loss of face-to-face services and emerging limitations of the statutory response. This shortfall in statutory service provision was felt to reflect reduced co-production with service users, compromised needs assessments and reduced quality when certain services became digital. The VCS endeavoured to respond to these needs and, indeed, was already responding to existing gaps in statutory support even prior to the pandemic.

The VCS response to COVID-19 in Wales focussed on tackling isolation and loneliness, addressing digital exclusion, brokering access to statutory services and responding to new gaps in statutory service provision. In addition, we identified seven assets within VCS organisations, which enabled agility, a rapid response and innovation of services to meet needs:

- 1) Smaller organisations with flatter hierarchies, smaller teams and shorter ratification processes
- 2) A holistic focus on needs
- 3) Embeddedness in local communities and connection to local people and networks
- 4) Collaboration and information sharing with other VCS organisations, statutory services and business
- 5) The care, dedication and commitment of VCS employees and volunteers
- 6) Finger-tip knowledge of people and places, coupled with experimental knowledge of delivering and designed services
- 7) An experiential learning approach

Finally, the VCS spoke of several challenges it now faces, including the difficulties of obtaining secure and long-term funding, the challenges of digital exclusion and the impacts of the pandemic on staff wellbeing. However, it also spoke of opportunities going forward, including the time and cost savings from digital working, increased collaboration with statutory services and greater recognition and appreciation for the sector as a whole.

8.2 Strengths and limitations

The strengths of this work included its qualitative focus which allowed us to obtain rich, in-depth data from key sources. The variety of methods and participants involved also helped to secure a wide range of views. We also maintained a strong focus on the VCS, vulnerability, Wales and the COVID-19 pandemic helping to improve the validity of our work. This was further helped by the involvement of multiple authors, each from different backgrounds.

The main limitation of our work was that the range of voices we heard from were exclusively those who work in the VCS. This means that we did not hear from people experiencing vulnerability or utilising VCS services, or seek the views of statutory service providers, commissioners or funders. However, the narrow focus of this study enabled deeper exploration of VCS sector perspectives, which are often some of the first responders to supporting individuals who do not engage with statutory services and who may need early support due to a change in circumstances. Furthermore, the findings of this research are currently being further developed within a wider body of ongoing research at Public Health Wales. This includes a project funded by the Health Foundation, which incorporates the voices and perspectives of recipients of community-led support during the COVID-19 pandemic³².

8.3 Implications and future work

This research demonstrates the unique role of the VCS in identifying and responding to emerging needs throughout the course of the COVID-19 pandemic and as Wales continues to navigate its recovery from the wider impacts on our society, health and economy.

The findings demonstrate how VCS representatives understand vulnerability as reflecting the unmet needs of a person. During the pandemic, the VCS described how vulnerability rapidly arose, often along pre-existing lines of social inequality, or was further exacerbated for people who were already vulnerable leading to their deterioration along a downward spiral of increasing vulnerability. Specifically, they described emergent needs related to: worsening mental health due to anxiety and loneliness, economic insecurity due to strained household finances and job loss, digital exclusion, loss of face-to-face services and limitations in the statutory response.

In addition to these needs, the findings also shine a light on the responsiveness and agility of the VCS in times of crisis and in addressing health inequalities through the provision of holistic preventative services. **As Wales looks to the longer term impact of COVID-19 and recovery, these findings highlight the importance of actions to identify vulnerabilities early in crises (be they related to health, environment or economy); the importance of prevention in dealing with vulnerabilities and longstanding health inequalities; and, the importance of recognising and sustaining the unique assets offered by VCS organisations in the recovery that facilitate their flexibility and adaptability.**

This research particularly highlights the value of the knowledge, insight and experience held by VCS organisations in identifying and rapidly responding to emerging needs as well as their role brokering access to statutory services and filling the gaps in statutory provision. Conversely, this research also highlights the longstanding challenges facing the sector, particularly those relating to the insecure funding landscape in which organisations operate and compete for survival.

As the health sector and partners set out their strategy to meet the health and care needs across populations post COVID-19, our research substantiates the importance of developing a co-ordinated approach that harnesses and values VCS knowledge, insight and practices. For example, the potential for VCS organisations to play a key role in supporting the Welsh Government's Digital Inclusion Strategy.

Our findings highlight the need to maintain the momentum of partnership working seen during the pandemic to address ongoing challenges, such as the detrimental impact of unemployment on the health of individuals and communities in the long-term³³. As the Welsh Government sets out its strategy to rebuild health and social care services to meet these challenges³⁴, our research substantiates the need to develop a co-ordinated approach that harnesses VCS knowledge, insight and practices. **This will require strengthening and developing the unique institutional infrastructure offered in Wales, through the provision of Public Services Boards and Regional Partnership Boards.**

Finally, our work illustrates the value of qualitative approaches and the importance of receiving input from the VCS as part of ongoing public health research. It also reveals the value of using a holistic, person-centred concept of vulnerability that takes account of a person's context, a concept already in frequent use by the VCS. Future research and policymaking would benefit from incorporating this understanding of emerging vulnerability to complement more traditional and clinical perspectives that have been used to identify people as vulnerable.

References

- 1 Welsh Government. *Guidance on protecting people defined on medical grounds as extremely vulnerable coronavirus (COVID-19) – previously known as ‘shielding’*. 2020. Available from: <https://gov.wales/guidance-on-shielding-and-protecting-people-defined-on-medical-grounds-as-extremely-vulnerable-from-coronavirus-covid-19-html> [Accessed on 17/5/21]
- 2 Venkatapuram, S. *Health Justice: An argument from the capabilities approach*. Polity Press. 2011.
- 3 Mackenzie C. The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability in *Vulnerability: New essays in ethics and feminist philosophy*. Editors: Mackenzie, Rodgers and Dodd. Oxford University Press. 2014.
- 4 Bamba C, Riordan R, Ford J *et al*. The Covid-19 pandemic and health inequalities. *J Epidemiol Community Health*. 2020. 74: 964-8.
- 5 Welsh Government. *A Healthier Wales*. 2018. Available from: <https://gov.wales/healthier-wales-long-term-plan-health-and-social-care> [Accessed on 17/5/21]
- 6 Future Generations Commission. *Well-being of Future Generations (Wales) Act 2015*. 2021. Available from: <https://www.futuregenerations.wales/about-us/future-generations-act/> [Accessed on 17/5/21]
- 7 Welsh Government. *Social Services and Wellbeing (Wales) Act*. 2014. Available from: <https://gov.wales/sites/default/files/publications/2019-05/social-services-and-well-being-wales-act-2014-the-essentials.pdf> [Accessed on 17/5/21]
- 8 Welsh Government. *Leading Wales out of the Covid-19 pandemic: A framework for recovery*. 2021. Available from: <https://gov.wales/leading-wales-out-coronavirus-pandemic.html> [Accessed on 17/5/21]
- 9 Dyakova M, Couzens L, Allen J, Van Eimeren M, Stielke A, Cotter-Roberts A, Kadel R, Bainham B, Ashton K, Stewart D, Hughes K & Bellis M. *The Welsh Health Equity Status Report Initiative (WHESRI)*. WHO Collaborative Centre on Health and Wellbeing; Public Health Wales. 2021. Available from: <https://phw.nhs.wales/news/placing-health-equity-at-the-heart-of-coronavirus-recovery-for-building-a-sustainable-future-for-wales/placing-health-equity-at-the-heart-of-the-covid-19-sustainable-response-and-recovery-building-prosperous-lives-for-all-in-wales/>
- 10 Welsh Government. *Prosperity for All: The National Strategy*. 2017. Available from: <https://gov.wales/prosperity-all-national-strategy> [Accessed on 17/5/21]
- 11 Public Health Wales. *Making a Difference: Investing in sustainable health and well-being for the people of Wales*. 2017. Available from: <https://phw.nhs.wales/services-and-teams/policy-and-international-health-who-collaborating-centre-on-investment-for-health-well-being/publications-and-resources/bucket/making-a-difference-investing-in-sustainable-health-and-well-being-for-th1/> [Accessed on 17/5/21]
- 12 Chambers, R. Vulnerability, coping and policy. *IDS Bulletin*. 1989. 20: 1–7
- 13 Davies AR, Grey CNB, Homolova L & Bellis MA. Resilience: Understanding the interdependence between individuals and communities. Cardiff: Public Health Wales NHS Trust. 2021.
- 14 Sen, A. Equality of what? *Stanford University Tanner Lectures on Human Values*. 1979.
- 15 Fineman, MA. The vulnerable subject and the responsive state. *Emory Law Journal*. 2010. 60: 251–75
- 16 Emmel, N. Empowerment in the Relational Longitudinal Space of Vulnerability. *Social Policy and Society*. 2017. 16: 457–67
- 17 Murray SA, Kendall M, Boyd K, Sheikh A. Illness trajectories and palliative care. *BMJ*. 2005. 330:1007-11
- 18 Institute of Health Equity. *Reducing the number of young people Not in Employment, Education or Training*. Public Health England. 2014. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/355771/Briefing3_NEETs_health_inequalities.pdf [Accessed on 17/5/21]
- 19 Institute of Health Equity. *Health equity in England: The Marmot Review 10 years on*. 2020. Available from: https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf [Accessed on 17/5/21]
- 20 Future Generations Commission. *Future Generations Report 2020*. 2021. Available from: <https://www.futuregenerations.wales/wp-content/uploads/2020/07/FGC-Eng-Exec-Summary.pdf> [Accessed on 17/5/21]
- 21 Vickers I, Lyon F, Sepulveda L & McMullin C. Public service innovation and multiple institutional logics: The case of hybrid social enterprise providers of health and wellbeing. *Research Policy*. 2017. 46: 1755–68.
- 22 Glasby, J. (ed.) *Commissioning for health and well-being: An introduction*. Bristol: Policy Press. 2012.
- 23 Rees, J. Public sector commissioning and the third sector: Old wine in new bottles? *Public Policy and Administration*. 2014. 29: 45–63.
- 24 Wales Council for Voluntary Action. *Preparing for different futures – Final Report*. 2020. Available from: <https://wcva.cymru/wp-content/uploads/2020/07/Different-Futures-Wales-final-report.pdf> [Accessed on 17/5/21]
- 25 The Welsh NHS Confederation Partnership. *Working across Wales to support the response to COVID-19*. NHS Wales Confederation. 2020. Available from: <https://www.nhsconfed.org/-/media/Confederation/Files/Wales-Confed/How-NHS-organisations-are-working-across-the-public-and-private-sectors-to-tackle-COVID-19-April-2020.pdf> [Accessed on 17/5/21]
- 26 Wales Centre for Public Policy. *Loneliness in the Lockdown*. 2020. Available from: <https://www.wcpp.org.uk/wp-content/uploads/2020/04/Short-Note-Loneliness-in-Lockdown.pdf> [Accessed on 17/5/21]
- 27 Welsh Government. *COVID-19 reconstruction: challenges and priorities*. 2020. Available from: <https://gov.wales/sites/default/files/pdf-versions/2021/1/3/1610565171/coronavirus-reconstruction-challenges-and-priorities.pdf> [Accessed on 17/5/21]
- 28 Welsh Government. *Welsh Index of Multiple Deprivation*. 2020. Available from: <https://gov.wales/welsh-index-multiple-deprivation-full-index-update-ranks-2019> [Accessed on 17/5/21]
- 29 National Council for Voluntary Organisations. *How many voluntary organisations are there?* 2020. Available from: <https://data.ncvo.org.uk/profile/size-and-scope/> [Accessed on 17/5/21]
- 30 Information about the role and responsibilities of Local Health Boards is available here: <https://gov.wales/nhs-wales-health-boards-and-trusts>
- 31 Information about the role and responsibilities of the Regional Partnership Boards is available here: <https://gov.wales/regional-partnership-boards-rpbs>
- 32 Public Health Wales. *Sustaining community led action in recovery: learning lessons from the community response to covid-19 in Wales*. Health Foundation. 2021. Available from: <https://www.health.org.uk/funding-and-partnerships/programmes/sustaining-community-led-action-in-recovery-covid-19> [Accessed on 17/5/21]
- 33 Davies AR, Homolova L, Grey CN, Bellis MA. Health and mass unemployment events—developing a framework for preparedness and response. *Journal of Public Health*. 2019. 41: 665–73.
- 34 Welsh Government. *Health and Social Care in Wales – COVID-19: Looking forward*. March 2021. Available from: https://gov.wales/sites/default/files/publications/2021-03/health-and-social-care-in-wales-covid-19-looking-forward_0.pdf



GIG
CYMRU
NHS
WALES

Iechyd Cyhoeddus
Cymru
Public Health
Wales
Research and Evaluation

Research and Evaluation Division
Knowledge Directorate
Public Health Wales
Number 2 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Tel: +44 (0)29 2022 7744

Email: phw.research@wales.nhs.uk

 @PublicHealthW @PHREWales

 /PublicHealthWales

phw.nhs.wales