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Ageing Better: Supporting meaningful connections through social prescribing

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Independent Evaluation for The National Lottery Community Fund

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Contents

This paper has been written by Ecorys, the lead independent national evaluator of the Ageing Better programme. Details on the evaluation **methodology** can be found in a separate note. Unless otherwise stated, evidence is drawn from online interviews and focus groups with Ageing Better programme stakeholders, which took place from September to November 2021.

Acknowledgements

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Executive summary

The Ageing Better programme

Ageing Better was a £87 million, seven-year programme funded by The National Lottery Community Fund (The Fund). It started in 2015 and ran until March 2022. The programme aimed to enhance the lives of people over 50 by addressing social isolation and loneliness, improving social connections, and enabling people over 50 to be more engaged in the design of services for their communities. The programme also aimed to challenge negative narratives around ageing and promote a positive image of later life. The programme funded voluntary sector-led partnerships in 14 areas across England[1].

What is social prescribing?

While there is no universally accepted definition of social prescribing, it is usually understood within a health context as a connector model through which a health professional, such as a General Practitioner (GP), refers a person to a connector or link worker. They then work with the person to produce a personalised plan (or 'prescription') to meet the individual's specific needs[2]. This usually involves connecting people to local, non-clinical services which can provide them with practical, social and emotional support from within their community[3] [4].

Social prescribing, community connectors, and the Ageing Better programme

Both the Ageing Better programme and social prescribing rest on a core belief that people's wellbeing will be improved by connecting with sources of social, emotional and practical support. It therefore makes sense that a majority of Ageing Better partnerships chose to develop social prescribing or community connector activities as part of their delivery plans.

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1 The partnerships are listed in the accompanying Methods Note.

2 The National Lottery Community Fund (2020), *Role of Connectors During Covid-19 – learning from Ageing Better*. Available at: www.tnlcommunityfund.org.uk/media/insights/documents/Role-of-Connectors-in-Covid-19-Final.pdf?mtime=20201218171309&focal=none

3 The King's Fund (2020), *What is Social Prescribing?* Available at: www.kingsfund.org.uk/publications/social-prescribing

4 National Voices (2020), *Rolling Out Social Prescribing. Understanding the experience of the voluntary, community and social enterprise sector*. Available at: https://www.nationalvoices.org.uk/sites/default/files/public/publications/rolling_out_social_prescribing_-_september_2020_final.pdf

Ageing Better partnerships developed a wide range of models across the life of the programme. These included social prescribing services closely aligned to the model now being rolled out across the NHS, as well as other more intensive and/or community-based services. All of these worked in one way or other to identify isolated people and work with them to help them to become less isolated through person-centred structured support[5]. We refer to these as **community connector** models and the staff involved in them as connectors.

These models shared a common set of basic approaches and ways of working, in terms of taking a person-centred approach and working with people to address the breadth of issues affecting their wellbeing and connection. The learning from across these approaches is relevant to the future of social prescribing and all other related models.

What approaches did Ageing Better partnerships use?

In the context of the Ageing Better programme's[6] 'test and learn' approach, partnerships evolved and developed their community connector projects over the course of the delivery period. Ageing Better partnerships adapted their schemes in terms of the duration and intensity of support provided, how formal the services were, and the type of organisations and individuals involved in referral and delivery.

Ageing Better partnerships delivered a range of community connector approaches ranging from:

- Low-intensity activity, such as one-off **outreach or pop-up events** facilitated by staff and volunteers to signpost people over 50 to activities.
- Medium-or higher intensity one-to-one or tailored support allowed connectors to build relationships and people's confidence. This enabled people to identify and access services and activities that met their needs. This support often included **home visits** so that connectors could reach people isolated in their own homes. This gave connectors the flexibility to meet people in a place of their choosing where they felt

[5] Ageing Better (n.d.) *Ageing Better Programme Learning: Community Connector Schemes*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Community-Connectors-Learning.pdf?mtime=20190228153522&focal=none

[6] 'Test and learn' gives partnerships the flexibility to try out different approaches to create practical learning to inform service development.

safe and comfortable. It also involved **specialist support**, such as mental health or debt advice, and additional support to access services, such as **accompanying individuals** to activities and appointments. While some models offered support for a set period of time to provide a focus and prevent dependency, others offered open-ended support to more vulnerable participants. **Follow-up** support was a key part of the offer (for example through regular check-in calls).

- **Asset-based community development** approaches through which community-based staff worked alongside local people and organisations to identify their own strengths and assets and delivered solutions. This approach empowered people over 50 to co-produce community support networks (including informal groups and activities), contributing in tangible and meaningful ways to enhance their communities.

The 'test and learn' approach taken across the Ageing Better programme meant partnerships had the flexibility to try out different referral routes. One of the key learning points was that a **diverse referral pathway** was the best way to ensure high uptake of community connector services.

The evidence shows that a key aspect of many of the schemes delivered within Ageing Better was the **strength-based approaches** adopted. They sought to identify an individual's interests and needs using positive interviewing techniques that enabled people to build their confidence and to decide for themselves what they wanted to do.

Ageing Better partnerships found that it was important for connectors to be **based in their communities**. This allowed them to develop a strong understanding of the range of community-based support available and make personalised and supportive referrals based on the specific needs of the individuals they work with.

As a core feature of the Ageing Better programme as a whole, **co-production**[7] was also evident across Ageing Better's community connector services, with co-design and feedback loops built into these services. Another key lesson from the programme was that community connector schemes can be effective in using people's skills and empowering them to inform the design and development of approaches. Several Ageing Better community connector schemes supported older people to develop informal groups to plug gaps in existing activity provision.

[7] Co-production is an approach that can be applied to a wide range of different contexts. It involves professionals, citizens and other stakeholders sharing power to achieve something together, recognising that both have valuable contributions to make. For example: Ageing Better Programme partners (2021), *Stronger Together: A co-production toolkit from Ageing Better*. Available at: agefriendlysheffield.org.uk/wp-content/uploads/2021/07/Stronger-Together-%E2%80%93-a-co-production-toolkit-Final.pdf

What changed?

Ageing Better's social prescribing and community connector projects were effective at **engaging a diverse range of people** over 50, including groups known to be at particular risk of, or who were already experiencing, loneliness and social isolation. Although there are a number of influences besides their involvement in the programme, after taking part in Ageing Better, people who participated in social prescribing and community connector projects reported, on average, being less socially isolated and lonely and saw improvements in their health and wellbeing. When they joined the programme, 33% of participants reported having low wellbeing, but only 19% had low wellbeing after taking part in a social prescribing and community connector project. A total of 55% of participants reported being lonely at the start of their involvement, but only 45% after taking part in a social prescribing and community connector project.

Learning from Ageing Better shows that it is vital that community connector schemes encompass **community development** alongside the provision of connectors. The experience of Ageing Better was that community connector services were most effective when connectors operated in the context of a **wider ecosystem** with positive relationships between GP surgeries, health services, and voluntary, community and social enterprise (VCSE) organisations or groups. Building these partnerships and relationships supported effective referrals, identified gaps, and strived to ensure there are activities and support services available locally. In many cases the wider work of the Ageing Better partnerships helped to create and nurture this wider ecosystem.

Recommendations for action

The Ageing Better partnerships created effective community connector approaches. These were tailored to meet the complex and varied needs of people over 50 who were experiencing, or at risk of, social isolation and loneliness. These approaches were rooted in a wider **understanding of the causes and consequences of loneliness and isolation**. Through an emphasis on holistic, person-centred and community-based working, Ageing Better connectors have consistently achieved positive outcomes for their clients. The findings of Ageing Better, in relation to both how individual connectors carry out their work and the need to develop the wider ecosystem around community connectors, should be used to enhance and improve social prescribing and other community connector approaches in other communities.

The findings from this study can be used to inform the approaches which commissioners, policymakers and service providers take to social prescribing and community connector models. We recommend they should:

- Adopt an outreach model to support engagement with more disadvantaged groups
- Recognise the need for community development work alongside the provision of connectors to work one-to-one with individuals
- Invest in training for connectors on person-centred approaches
- Enable connectors to link people to the full range of community activities, including informal and unconstituted groups
- Co-produce services with the people who will use them
- Give connectors the flexibility to adapt services to local circumstances and to the needs of the individuals with whom they work, in line with a commitment to co-production
- Establish a pathway for connectors to provide intelligence and feedback within Primary Care Networks

About this report

This report presents independent evaluation evidence and insights from Ageing Better partnerships. Ageing Better invested in a wide variety of community connector approaches which provide relevant learning for those involved in social prescribing. The report explores the projects delivered by Ageing Better partnerships which are relevant to those involved in social prescribing or community connecting. It explores the benefits of these approaches for individuals in supporting social connections, physical and mental health, and wellbeing. It also shares reflections on the process of implementing these projects and sets out how these projects led to changes in practice and whether these are sustainable.

This report builds on earlier research that sought to capture the range and nature of community connector approaches taken by Ageing Better partnerships[8]. It provides an updated assessment of community connector activities within the Ageing Better programme, including how this evolved in response to the COVID-19 pandemic. It also locates the learning from Ageing Better in the new context of the commitment to rolling out social prescribing services across England which was contained within the NHS Long Term Plan[9]. Under this commitment, Primary Care Networks can now access additional resource to appoint social prescribing link workers, and Integrated Care Systems are being asked to consider how to build effective ecosystems to support social prescribing and other community-based approaches to health. This investment in, and development of, social prescribing makes it timely to revisit the learning from across the Ageing Better programme so that it can be used to inform other schemes.

Our recommendations for using the approaches developed through the Ageing Better programme are set out at the end of the report.

8 For example:
Ageing Better (2018), *Ageing Better: Learning Report No. 2 – Community Connectors*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/prog_fulfilling_lives_ageing_better_learning_report_2.pdf?mtime=20181219102827&focal=none
Ageing Better (n.d.) *Ageing Better Programme Learning: Community Connector Schemes*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Community-Connectors-Learning.pdf?mtime=20190228153522&focal=none
The National Lottery Community Fund (2020), *Role of Connectors During Covid-19 – learning from Ageing Better*. Available at: www.tnlcommunityfund.org.uk/media/insights/documents/Role-of-Connectors-in-Covid-19-Final.pdf?mtime=20201218171309&focal=none

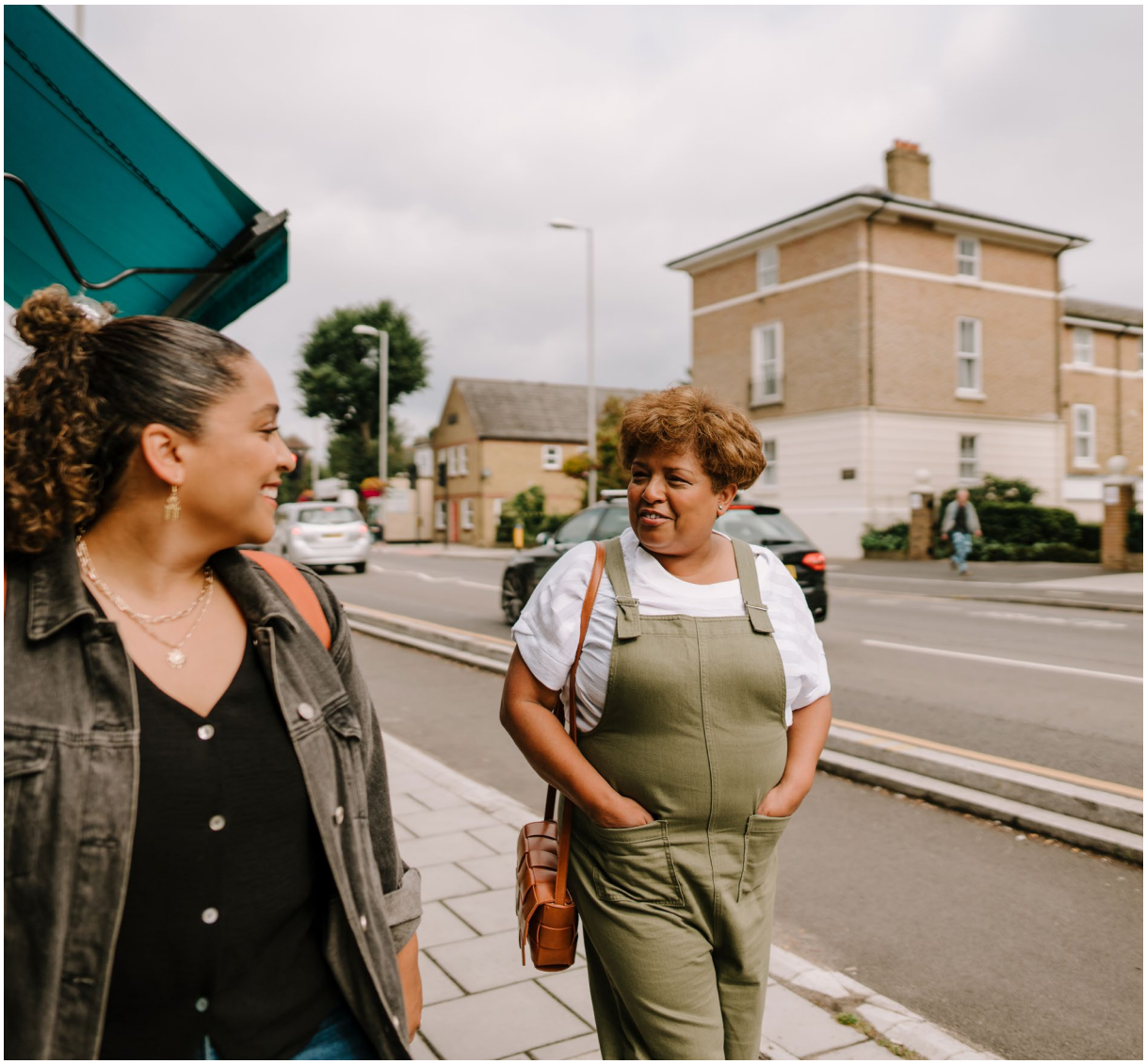
9 www.longtermplan.nhs.uk/

Evidence used in this report

This report draws on evidence collected through qualitative research with Ageing Better stakeholders.

It also draws on data about who took part in Ageing Better's social prescribing and community connector projects and the difference they made. This data from the Ageing Better Common Measurement Framework (CMF) database was reported by participants who completed questionnaires at the start of, and during or after, their involvement in Ageing Better projects. Where we have reported on changes in outcomes for participants (e.g. loneliness), we have not assessed the extent to which these changes were influenced by the projects that people attended or by other factors in their lives.

Further information on the research methods used is provided in the Methods Note.



Context: About Ageing Better and social prescribing

About the Ageing Better programme

Ageing Better was a £87 million, seven-year programme funded by The National Lottery Community Fund (The Fund). The programme started in 2015 and ran until March 2022 and covered 14 areas across England.

The aim of Ageing Better was to improve the lives of people over 50 by addressing social isolation and loneliness, improving social connections, and enabling them to be more engaged in the design of services for their communities.

The programme outcomes were that:

- People over 50 are less isolated and lonely
- People over 50 are actively involved in their communities, with their views and participation valued more highly
- People over 50 are more engaged in the design and delivery of services to help reduce their isolation and improve their social connections
- Services that help to reduce isolation are better planned, co-ordinated, and delivered
- Better evidence is available to influence the services that help reduce isolation for people over 50 in the future

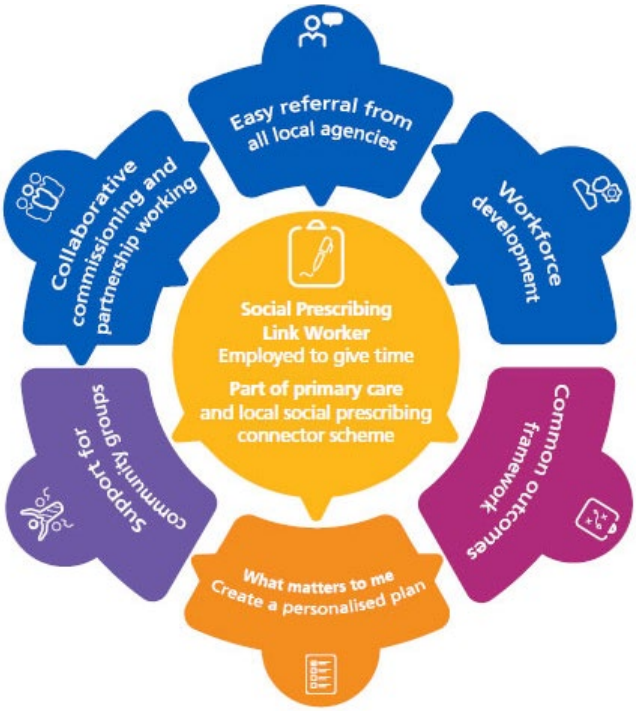
Ageing Better partnerships invested in a range of community connector projects as a means of reducing or preventing social isolation and loneliness by helping people connect to other activities run by the programme or the wider community[10]. The approaches taken were co-designed with local people in response to barriers that they identified.

[10] Ageing Better partnerships designed and delivered a wide range of support and activities for people over 50, including: one-to-one befriending and mental health support, community connecting and social prescribing approaches, and group activities (on topics like arts and crafts, music, exercise, social media and IT, reading and creative writing, healthy eating, gardening and food growing).

What is social prescribing?

While there is no universally accepted definition of social prescribing, it is usually understood within a health context as a connector model through which a health professional, such as a GP, refers a person to a connector or link worker. They then work with the individual to produce a personalised plan (or 'prescription') to meet the individual's specific needs[11]. This usually involves connecting people to local, non-clinical services which can provide them with practical, social and emotional support from within their community[12] [13].

The scope for social prescribing models is broad and the underlying approaches vary across the UK in response to local needs [14]. However, there are certain key features which the majority of social prescribing programmes tend to have in common. These are set out in the NHS model of social prescribing, which was developed with a range of partners across sectors[15]:



[11] The National Lottery Community Fund (2020), *Role of Connectors During Covid-19 – learning from Ageing Better*. Available at: www.tnlcommunityfund.org.uk/media/insights/documents/Role-of-Connectors-in-Covid-19-Final.pdf?mtime=20201218171309&focal=none

[12] The King's Fund (2020), *What is Social Prescribing?* Available at: www.kingsfund.org.uk/publications/social-prescribing

[13] National Voices (2020). *Rolling Out Social Prescribing. Understanding the experience of the voluntary, community and social enterprise sector*. Available at: https://www.nationalvoices.org.uk/sites/default/files/public/publications/rolling_out_social_prescribing_-_september_2020_final.pdf

[14] National Academy for Social Prescribing (n.d.) *What is social prescribing?* Available at: https://socialprescribingacademy.org.uk/about-us/what-is-social-prescribing/

[15] NHS England (2021), *Social Prescribing.* Available at: www.england.nhs.uk/personalisedcare/social-prescribing/

This model of social prescribing[16] was embedded into the fabric of the NHS Long Term Plan building on small-scale social prescribing approaches working alongside the NHS since as early as the 1990s[17]. The Long Term Plan set out commitments for appointing an initial 1,000 social prescribing link workers within Primary Care Networks by 2020/21[18], a target which was exceeded.

The idea that people's wellbeing will be improved by connecting with sources of social, emotional and practical support was central to the Ageing Better programme and to social prescribing, so it made sense that a majority of partnerships chose to develop social prescribing or other community connector activities as part of their delivery.

Ageing Better partnerships developed a wide range of models across the life of the programme. These included social prescribing services closely aligned to the NHS model, as well as other more community-based services. All of these worked in one way or other to identify isolated people and to help them to become less isolated through person-centred structured support[19]. We refer to these as **community connector** models and the staff involved in them as connectors.

These models share a common set of basic approaches and ways of working, in terms of taking a person-centred approach and working with people to address the breadth of issues affecting their wellbeing and connection. The learning from across these projects is relevant to the future of social prescribing and all other related models. The remainder of this report examines these different models and what has worked well.

[16] NHS England (2021), *Social Prescribing.* Available at: www.england.nhs.uk/personalisedcare/social-prescribing/

[17] The King's Fund (2020), *What is Social Prescribing?* Available at: www.kingsfund.org.uk/publications/social-prescribing

[18] NHS England (2021), *Social Prescribing*. Available at: www.england.nhs.uk/personalisedcare/social-prescribing/

[19] Ageing Better (n.d.) *Ageing Better Programme Learning: Community Connector Schemes*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Community-Connectors-Learning.pdf?mtime=20190228153522&focal=none

Reaching people and making connections

Who took part: The reach of Ageing Better's social prescribing and community connector projects

Of the 366 projects that were part of the Ageing Better programme, 42 (11%) were defined as social prescribing or community connector projects[20] (Methods Note, Table 2) and 10,415 (29%) of Ageing Better participants took part in at least one of these projects (Methods Note, Table 1). In total, 4% of social prescribing and community connector project participants volunteered in any of the projects they took part in.

Social prescribing and community connector project participants at a glance

- Two-thirds of participants (69%) were women, one-third of participants (31%) were men.
- Just over half of participants (52%) were aged over 70.
- 89% of participants identified as White, 6% as Asian, 3% as Black, 1% as Mixed ethnicity and 1% as another ethnicity.
- 2% of participants were LGBTQ+.
- 55% of participants were living alone.
- Around two-thirds (69%) of participants had a longstanding illness or disability.
- 19% of participants were carers.
- 56% of participants were lonely (compared with 17% of similar people in England (Methods Note, Table A6).
- A third of participants (32%) had low wellbeing.

[20] Social prescribing projects includes both those health-based social prescribing projects and wider community connector schemes. We identified social prescribing projects by two methods. The starting point was a typology of loneliness interventions that was developed by researchers commissioned by The Fund, which categorised social prescribing related interventions or projects being undertaken by Ageing Better local partnerships. This list was then cross-referenced and extended using wider programme and evaluation information.

Typologies report: Gibson S, Hotham S, Wigfield, A (2020), *Categorisations of Ageing Better Programme interventions designed to reduce loneliness and/or social isolation, A report for the National Lottery Community Fund* (unpublished).

A strength of Ageing Better identified in our Impact Evaluation Report[21] was that the programme engaged a diverse range of people and allowed projects to take different approaches to improving social contact, wellbeing or loneliness, with a huge range of activities and project types being offered through the programme. This meant the programme could support as many people to take part as possible, especially those who did not routinely engage in activities, through providing social prescribing and other types of projects.

Why did Ageing Better partnerships develop community connector models?

Ageing Better partnerships designed and delivered community connector projects as a means of achieving the overall programme aims of reducing social isolation and loneliness and improving wellbeing. These projects were developed in response to an understanding that the reasons that each individual becomes socially isolated and lonely are complex and personal. Those who are most isolated and lonely need one-to-one support to help address their barriers to making connections. Community connector projects were developed as a response to the complexity of needs of those who are lonely and isolated. They also recognise that the barriers to connection may be practical, emotional or social and are often a combination of all of these. Connectors provide person-centred one-to-one support to individuals to overcome these barriers and to identify ways an individual can rebuild their connections.

What approaches did Ageing Better partnerships use?

The 'test and learn' approach taken across the Ageing Better programme saw partnerships evolving and developing their community connector activities over time. Some partnerships delivered pilot or time-limited projects that were subsequently evaluated, others adapted ongoing programmes. Over time, the Ageing Better programme tested and developed a wide range of community connector approaches with different characteristics and key features. Over the course of the programme, partnerships adapted their schemes in terms of the duration and intensity of support provided, how formal the services were, and the type of organisations and individuals involved in referral and delivery.

[21] We have not carried out a study to compare the characteristics of social prescribing participants to participants of other project types. Please see the programme Impact Evaluation Report for further information on which types of projects engaged different participant groups: https://www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Impact-evaluation-report.pdf?mtime=20211014143815&focal=none

Types of community connector approach

In previous research examining community connector models[22], we identified a range of types of community connector schemes delivered by Ageing Better partnerships:

- Low-intensity activity, such as one-off outreach or pop-up events facilitated by staff and volunteers to signpost people over 50 to activities.
- Medium-or higher intensity one-to-one or tailored support allowed connectors to build relationships and people's confidence. This enabled people to identify and access services and activities that met their needs. These schemes often included home visits so that connectors could reach people isolated in their own homes. This gave connectors the flexibility to meet people in a place of their choosing where they felt safe and comfortable. They also involved specialist support, such as mental health or debt advice and additional support to access services, such as accompanying individuals to activities and appointments. While some approaches offered support for a set period of time to provide a focus and prevent dependency, others offered open-ended support to more vulnerable participants. Follow-up support was a key part of the offer (for example through regular check-in calls).
- Asset-based community development approaches through which community-based staff worked alongside local people and organisations to identify their own strengths and assets and delivered solutions. This approach empowered people over 50 to co-produce community support networks (including informal groups and activities), contributing in tangible and meaningful ways to enhance their communities.

[22] Ageing Better (2018), *Ageing Better: Learning Report No. 2 – Community Connectors*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/prog_fulfilling_lives_ageing_better_learning_report_2.pdf?mtime=20181219102827&focal=none

Describing community connector approaches

Ageing Better areas used different language to describe their community connector activities and the roles involved in delivering this support. Some areas implemented social prescribing models with formal links to the health system and following the NHS social prescribing model. For example:

- Ageing Better Middlesbrough delivered a social prescribing project in partnership with a local GP. Through this project, GPs were able to refer patients to a Social Prescribing Link Worker who offered person-centred support with issues like mental health, wellbeing, living with long-term health conditions, bereavement, caring responsibilities, and social isolation[23].
- Ageless Thanet piloted a social prescribing model[24] with social prescribing 'surgeries' within four GP practices taking referrals from GPs. The Social Prescriber referred the patient to the relevant organisation and then followed up with them three weeks later and then another three weeks after that. The pilot was successful and led to the Social Prescriber role being continued alongside a Community Navigator service with support from Kent County Council.
- TED in East Lindsey developed a Social Prescribing project in partnership with Lincolnshire CVS, through which GPs, social workers or job coaches can make a referral to a Link Worker. They worked with individuals to identify activities they could access locally, help identify goals to work towards, and provide practical support to move towards these goals.
- Brightlife Cheshire extended its connector work by establishing a Social Prescribing scheme. The open referral process included collaborating with local Primary Care Networks. GPs and other practice staff referred patients to Brightlife's Social Prescribing Coordinators, who provided tailored support and confidence building. This empowered individuals to make choices, reconnect with their communities, and access services and activities.

[23] Middlesbrough and Stockton Mind (n.d.) *Getting it right: Social prescribing and mental health*. Available at: www.middlesbroughandstocktonmind.org.uk/news-events/blog/2019/9/getting-it-right-social-prescribing-and-mental-health.aspx

[24] Ageless Thanet (n.d.) *Ageless Thanet Social Prescribing Pilot*. Available at: www.agelessthanet.org.uk/wp-content/uploads/2021/01/Social-Prescribing-Report_standard.pdf

Some other Ageing Better partnerships chose other language to describe their connectors' work:

- Ambition for Ageing Greater Manchester, Bristol Ageing Better and Age Friendly Island (Isle of Wight) created teams of Community Navigators as part of their local programmes. Community Navigators worked to inform isolated and lonely older people about community activities and services, providing information, signposting and introductions to a range of local services through one-to-one support and outreach sessions.
- Community Connectors were appointed in Ageing Better in Camden. Following an online referral (which could be made by the individual or another agency), Community Connectors called participants to discuss interests and possible activities, and then offered support to participants to attend/access activities. This support was tailored to the individual and often included attending events/activities with the participant on the first few visits. A similar project was delivered by Connect Hackney, which provided one-to-one coaching to assist people to (re)connect with local activities and services. As part of Leicester Ageing Together, Community Connectors employed asset-based community development approaches. Outreach activities, including listening benches and street gatherings, encouraged people over 50 to access existing services and created new opportunities for skills sharing and interaction.
- Ageing Well Torbay created Wellbeing Coordinators (employed by Age UK Torbay) who took referrals from local GP surgeries, social care and mental health organisations. The Coordinators used guided conversations and took time to build trust and relationships with individuals to help build their confidence and wellbeing before supporting them to get involved in their community or attend activities.
- Ageless Thanet created a Life Planner role to provide intensive one-to-one support to people facing challenging or significant changes in circumstances.

Specialist vs generalist schemes

The focus and reach of the community connector activity and models varied across Ageing Better partnerships.

Across all partnerships, we saw examples of community connector schemes open to the whole population of people aged over 50. For example, the Time to Shine partnership in Leeds delivered the Sunshine in Leeds project, where staff worked one-to-one with individuals to help build confidence and resolve practical issues. They then supported them to access group activities or other social opportunities.

However, some partnerships also developed community connector schemes that were specifically designed for sub-groups of the 50+ population, including people with higher level or more complex needs:

- The SWIFT Service in Leeds supported wellbeing and independence for people aged 50+ living with frailty or who had complex health issues and were at risk of being socially isolated.
- Connect Hackney's Connectors worked collaboratively with people recovering from life-changing health events. Their approach was to foster collaboration between their clients, family, carers and a range of providers. They supported people to prevent and manage long-term physical and mental ill-health. This included people with multiple health conditions, often compounded by social isolation and complex wider support needs.
- The Bee Together[25] project in Leeds supported people with learning disabilities. Another project delivered by Time to Shine in Leeds – Carers Connections – targeted carers with health problems or disabilities or those carers who have lost confidence in socialising.
- Ambition for Ageing in Greater Manchester commissioned three targeted Community Navigator projects: for men over 75, people with recent hearing loss, and people from the Bangladeshi community.

[25] Time to Shine (2020), *Reducing social isolation and loneliness for older adults with a learning disability*. Available at: www.tnlcommunityfund.org.uk/media/insights/documents/Bee-Together-printable-PDF.pdf?mtime=20200214144925&focal=none

Effective community connector approaches

Over time, the Ageing Better partnerships have tested and developed a range of community connector approaches and have generated evidence of what works. This section presents an overview of the learning from Ageing Better partnerships. It looks at the different stages of the work that community connectors do[26]:

- Entry points
- Relationship building/activities/structured support
- Moving on

It highlights evidence and learning that can inform other social prescribing and community connector schemes.

Entry points

Diverse referral routes make it easier to reach lonely and isolated people

Some Ageing Better community connector schemes, which closely followed the NHS model of social prescribing, established primary referral relationships with GP practices. Connectors within these social prescribing schemes typically spent time within GP practices. This was found to be helpful in raising awareness of the services among non-clinical staff who then became more confident in making direct referrals:

> "The better the relationship became between myself and non-clinical staff, they were more aware of what I was doing within their practice, and then they would start booking the appointments directly. So as time went on, I think the whole health community within a GP surgery were referring in."
>
> (Delivery partner)

[26] Ageing Better (n.d) *Ageing Better Programme Learning: Community Connector Schemes*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Community-Connectors-Learning.pdf?mtime=20190228153522&focal=none

However, learning from across the programme found that no matter where connectors were based, a diverse set of referral pathways was best for increasing uptake of community connector support and for reaching the loneliest individuals[27]. Most partnerships took referrals from a mix of public and voluntary sector organisations[28]: These included health and social care services, as well as referrals from:

- **Other services within the same organisation** – for example Thanet's Life Planners and Camden's Community Connectors took referrals from other projects within the organisations in which they were based
- **Organisations using a First Contact Checklist** – for example Bristol's Community Connectors accepted referrals made through the First Contact Checklist, which is used by agencies like Bristol City Council, Avon Fire and Rescue Service, and other advice agencies and charities[29]
- **Other community connector projects in the area** - for example, Care Navigators on the Isle of Wight referred participants to their Community Navigators, and in Torbay Wellbeing Coordinators referred to Community Builders and vice versa

Managing inappropriate referrals

Some community connector schemes received inappropriate referrals. These included people who had higher-level needs, such as physical or mental health issues, or who needed more intensive support than could be provided by a scheme focused on facilitating social connections[30]. Partnerships perceived that inappropriate referrals were the result of health and social care services being overstretched. Another possible reason was a lack of understanding of the capability and capacity of connector services, especially early on in the relationships between referrers and community connector services.

[27] Brightlife Cheshire (2020), *Brightlife Cheshire Legacy Report*. Available At: www.brightlifecheshire.org.uk/wp-content/uploads/Brightlife-end-of-project-report-Low-Res.pdf

[28] Ageing Better (2018), *Ageing Better: Learning Report No. 2 – Community Connectors*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/prog_fulfilling_lives_ageing_better_learning_report_2.pdf?mtime=20181219102827&focal=none

[29] Bristol Ageing Better (2020), *Bristol Ageing Better Community Navigators Service*. Available at: bristolageingbetter.org.uk/userfiles/files/Community%20Navigators%20Report2020%20for%20SCREEN(1).pdf

[30] Ageing Better (2018), *Ageing Better: Learning Report No. 2 – Community Connectors*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/prog_fulfilling_lives_ageing_better_learning_report_2.pdf?mtime=20181219102827&focal=none

Building relationships with referral partners, and articulating to them the boundaries of the model clearly and consistently proved helpful in ensuring that referrals were timely and appropriate[31]. Partnerships also put in place plans to ensure that those who were referred inappropriately were able to access support. For example, Ageing Better Bristol established a clear process for referring people with higher levels of need to more specialist support[32].

Outreach

Other Ageing Better partnerships established outreach models to enable people to access community connector services. Ageless Thanet's connectors visited foodbanks, social supermarkets[33], Age UK offices, community centres, and larger supermarkets to engage people who may not have the confidence to visit a GP or other referring organisation, or who may lack the digital access or skills to see adverts on social media. Similarly, Connect Hackney made links with providers of housing for people over 50 by speaking to housing officers, attending events, and leaving information at the individual housing schemes to support referrals into their schemes.

Case study: Ageing Well Torbay Community Builders

Community Builders were the main connector role developed by Ageing Well Torbay. The team developed a strong outreach model, which supported people to engage with the scheme through a range of mechanisms:

- Clear 'patches' were identified for each of the 14 individuals fulfilling this role, dependent on their existing links and the communities with which they identify and associate.

[31] Connect Hackney (2020), *An in-depth study of the Community Connectors project for older people in Hackney living with or at risk of loneliness and social isolation*. Available at: www.connecthackney.org.uk/wp-content/uploads/2020/11/Connect-Hackney-Community-Connectors.pdf

[32] Bristol Ageing Better (2020), *BAB Learning: Social Prescribing*. Available at: bristolageingbetter.org.uk/userfiles/files/Collective%20learning%20social%20presc(1).pdf

[33] Social supermarkets operate for those on low income, providing access to surplus or donated food from mainstream retail outlets at a discount.

“

Each of [the Community Builders] has been selected as a way of blending into those communities, so they know the communities well, they’re well connected in the communities and they also work to build up connections in the communities.”

(Partnership management team)

- Additional layers of connectors were created to bolster the reach and capacity of Community Builders to identify and engage isolated older people. These additional connectors were people based in the local community, including shopkeepers and taxi drivers who were briefed about how Community Builders could support people and were asked to identify potential participants. Good Neighbour Networks – small and informal groups of individuals willing to support their streets or small areas during the pandemic – also extended the reach of the project by distributing information.
- ‘Bumping places’ were identified. These were locations perceived to be likely to provide opportunities for contact with older people, for example supermarkets or sheltered housing complexes.

“

You can’t expect somebody will come into contact with you through an expected route. You’ve got to be alert and have a range of potential ways of interacting.”

(Partnership management team)

Relationship building and providing support

First engagement

Community connectors placed a strong emphasis on building a relationship with individuals. Most support started with a one-to-one conversation to explore an individual's interests and needs. The evidence from Ageing Better is that investing time in relationship building, finding the right match between connector and the individual being supported, and the personal skills of the person in the connector role were all vital in achieving the trusted relationship necessary.

> "Building trust is a massive part of my role. If they don't trust what you're doing, they won't engage with long-term support."
>
> (Delivery partner)

The value of home visits and face-to-face interaction in building trust and facilitating initial support was strongly evidenced in Ageing Better. This was felt to allow clients to be more comfortable engaging and opening up about the barriers they faced and what they wanted to achieve. It also allowed connectors to directly observe people's living environments, providing insight into wider needs:

> "Conducting a home visit would have allowed us to see other issues that were having a negative impact on quality of life such as hoarding, little-to-no food, and other poor living conditions that a person may not share at a meeting in a community venue or GP Surgery."
>
> (Project management team)[34]

[34] Ageless Thanet (n.d.) *Ageless Thanet Social Prescribing Pilot*. Available at: www.agelessthanet.org.uk/wp-content/uploads/2021/01/Social-Prescribing-Report_standard.pdf

Evidence from across the Ageing Better programme is that unstructured questions and flexibility were typically more effective than a structured, formal approach to initial assessments and that first meetings should focus on relationship building.

However, several Ageing Better schemes also made use of action planning processes to document and guide subsequent support, activity and progress. In the Isle of Wight, for example, Care Navigators produced a Personal Enablement Plan with the individuals they worked with. These tools were helpful in ensuring that connectors were able to establish clear goals for their work with individuals and that they did not slip into dependency.

Person-centred focus

The evidence shows many of the schemes delivered within Ageing Better adopted a strengths-based approach.

Ageing Better community connectors sought to uncover individuals needs through initial conversations and meetings by using approaches which focused on people's existing strengths, building their confidence, and supporting them to decide for themselves what they want. As we found in our earlier report, a common way of framing discussions was 'it's not what's the matter with you, but what matters to you'[35].

> "The essence of the person-centred approach is that the participant themselves defines what they want to get out of it and what their aspirations are. We have support, encouragement, ideas, but it's not a prescription in the sense of we define and write out what's going to happen to them. We help them to write their own prescription and facilitate and find their own way to achieve that."
>
> (Project management team)

[35] Ageing Better (n.d) *Ageing Better Programme Learning: Community Connector Schemes*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Community-Connectors-Learning.pdf?mtime=20190228153522&focal=none

Providing active support to access activities was another successful element of the Ageing Better community connector models. It was seen as something that was different to the approach taken in some other social prescribing schemes. Ageing Better activity demonstrated the benefits of more in-depth support and of managing 'handoffs' where connectors pass responsibility over once a support activity or group has been identified.

> "It needs people to be supported into activity rather than, 'here's a form'."
>
> (Partnership management team)

> "You need to avoid saying 'this person is no longer my problem. I have made a referral into such and such service'. If you develop a culture that you are responsible for supporting them into the activity, that makes a big difference."
>
> (Partnership management team)

Staff delivering the support likewise identified this as an important part of their role:

> "I don't simply signpost people on to other activities, but I am by their side every step of the way, helping to identify goals in an action plan produced with the service user, and then supporting them to making it happen."
>
> (Delivery partner)[36]

[36] Online information on the Leeds SWIFT service: https://www.ageuk.org.uk/leeds/our-services/supporting-wellbeing/

The need for more active and supported onward referrals was seen as particularly important, given that Ageing Better often supported people to access community-based and VCSE-led support. Ageing Better connectors often linked people to support from unconstituted or informal groups, where there were no staff to handle referrals. This required a different approach from connectors, which some Ageing Better staff perceived to be more challenging for staff working in other social prescribing schemes:

> "What that link worker may want is to just send over an email with somebody's details on saying 'please can you pick this person up', but that doesn't work. There isn't a worker on the other end of that, the person essentially has to be responsible or helped to engage. It doesn't function like a referral into secondary care where you send a letter and then that person gets a letter out saying, 'your appointment is at such and such time'."
>
> (Partnership management team)

Across Ageing Better partnerships' work, we also saw evidence of the importance of connectors accompanying people to activities. This was important in helping participants overcome barriers like transport or access, or lack of confidence. Connectors were able to help break the ice for people once they reached a new activity (for example connectors may help to start conversations). However, partnerships recognised a need for care in ensuring connectors could provide support to individuals, while avoiding becoming too embedded within activities[37].

[37] Leicester Ageing Together (2019), *Connecting people to people - places - possibilities – potential*. Available at: www.tnlcommunityfund.org.uk/media/insights/documents/Community-Connectors-initiative.pdf?mtime=20200311152159&focal=none

Awareness of the ecosystem of support

Community connectors working within Ageing Better partnerships benefited from being part of the wider Ageing Better programme across their communities, and from being part of the local VCSE sector ecosystem of support for people over 50. This gave them a good understanding of the support available locally and expertise in working with this particular cohort:

> "I think that if you're working with a more targeted group perhaps you become more specialist in that area and you start to know who to refer on to. That's maybe a better idea than trying to be something for everyone, which is a bit too much perhaps."
>
> (External stakeholder)

- Community-based connectors were more aware of what services and activities are available locally, and this supports better referrals.
- Community-based connectors were able to connect people to more informal provision or unconstituted groups that may not be on the radar of link workers working solely within the NHS.
- Community-based connectors had established relationships to speed up referrals and access to support.

Learning from Ageing Better shows that it is vital that social prescribing and other connector schemes encompass community building and community development alongside connector roles, so that these broad ecosystems can be nurtured and developed. This work is critical to ensuring that there is a vibrant and mixed range of activities and services to which individuals working with connectors can be referred.

> "Without things to refer on to in the voluntary sector or the community, then obviously social prescribing doesn't work."
>
> (External stakeholder)

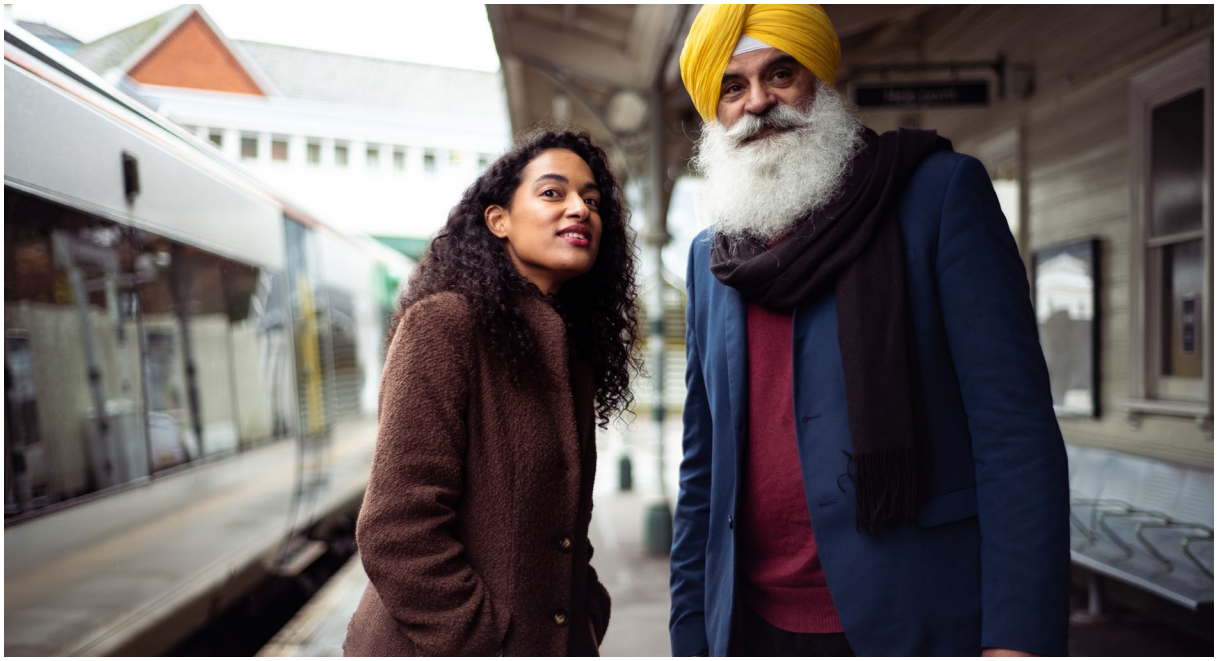
Where Ageing Better's connectors worked as part of an asset-based community development approach, they were often engaged in helping people to create activities, which then formed part of the wider local ecosystem in those communities. This was seen as a key feature of Ageing Better connector schemes.

> "What we do is not provide things for people. Community Builders stimulate the people to identify their interests and to support them to participate in activities which give them a sense of purpose and value."

(Project lead)

> "What I think we've been able to do is make the case for the fact that actually your link worker really should be a case worker, but you need somebody else out there doing the community development in an asset-based way."

(Partnership management team)



Another key way in which Ageing Better partnerships were able to contribute to their wider local ecosystems was by working alongside existing schemes with Ageing Better connectors working in complementary ways to support different members of the community.

> “You still need that community-based social prescribing because we still see that there is a gap, because the link workers are based in the GP practice and not really venturing out into the community. I think it’s really important to have the experience from Ageing Better to make that clear to funders.”
>
> (Partnership management team)

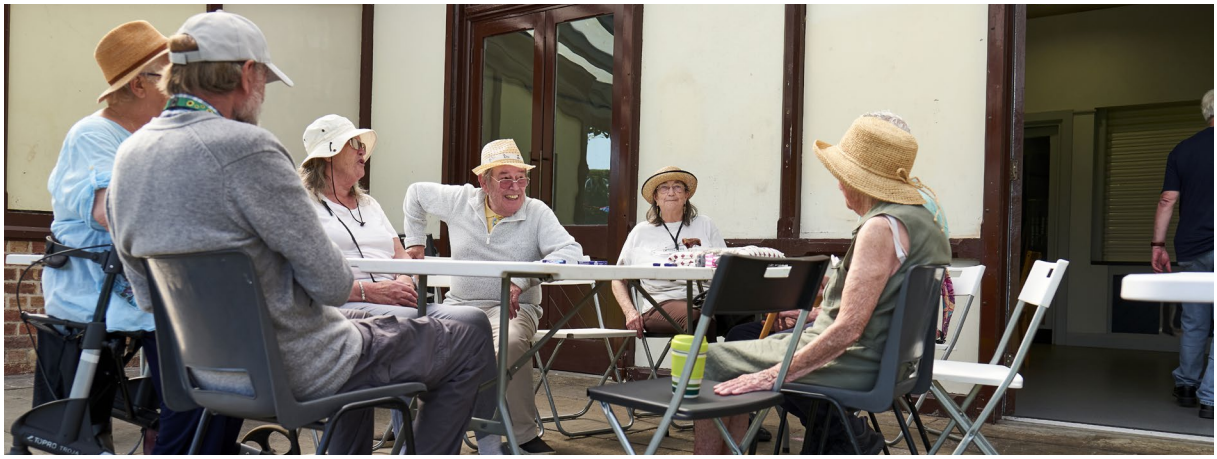
Ageing Better partnerships felt that these additional roles in community development and building were critical. But they also recognised that these approaches were resource intensive and that current NHS funding for social prescribing link workers may not provide sufficient capacity to replicate these approaches, particularly where there are large caseloads to support.

> “If the focus is going to be on throughput and the number of people they see each day, they’re not going to be able to make those relationships and to have the headspace to think about what’s available in their communities. It’s just going to be signposting people to what they think might help, rather than being more sure that it will help them and really understanding that individual.”
>
> (External stakeholder)

Ageing Better partnerships worked with older adults as part of an asset-based community development approach to develop solutions for their communities. This has helped create networks for informal support which could be sustained by the communities themselves.

> We went out to recruit what we called community connectors who would work with social prescribers. [Some] participants have then become those volunteer leads. The participants then form friendships within the group and that can be sustained outside of the group, whether it's by telephone or going to each other's houses. It's a more natural way of making a friend than a formal befriender."
>
> (Partnership management team)

In Cheshire, this was particularly effective in rural areas, where there was a lack of community activities to which people could be referred. For example, a social prescriber initiated a coffee morning at a local café for a group of men who had been referred separately for support around bereavement. The group has evolved and is now self-sustaining.



Responding to COVID-19

The Ageing Better experience clearly showed the need for flexibility in how community connector schemes support people. The flexibility built into the Ageing Better programme as part of its 'test and learn' approach allowed partnerships to continue to reach and support people aged over 50 throughout the COVID-19 pandemic. Ageing Better's connectors' track record in linking with more informal provision was also an asset during the pandemic, as it meant that people could still be supported while some of the more established activity was not available.

Ageing Better community connector models were felt to have been able to adapt in the context of pandemic. Throughout the pandemic, initiatives such as those in Hackney, Thanet, East Lindsey, Torbay and Cheshire moved online with the express intention of providing emotional support to those at risk of experiencing mental health difficulties due to enforced social isolation. Other examples of support delivered through the pandemic:

- Doorstep visits were conducted by connectors in the various schemes delivered by the Time to Shine partnership in Leeds.
- 'Fence time' visits were introduced by Brightlife Cheshire. These visits enabled connectors to maintain or initiate face-to-face contact with vulnerable people at a safe distance by meeting them in their gardens.
- Community Connectors from Leicester Ageing Together established a 'distant socialising' campaign. This included community connectors delivering telephone befriending and establishing a telephone information line and repurposing their website to provide a directory of activities to do online. They also established Zoom groups, which were particularly successful among women from South Asian communities.

> "Throughout lockdown, we connected people to activities that improved their mental wellbeing, reduced social isolation and loneliness, and kept them connected with people. We've now got some people who haven't left the house for years and now they're fitter and stronger because they do yoga every morning. So, the outcomes from that have been absolutely fantastic."
>
> (Project management team)

Ageing Better partnerships were also able to develop other roles, to respond to needs emerging during the pandemic (as identified in earlier research[38]):

- 'Shielding' connectors – connectors were able to provide support during lockdowns and to those who continued to be nervous and anxious once restrictions were lifted. Several Ageing Better partnerships developed ways of helping people to connect back to their local environment, for example offering buddying support for people going to the local shops for the first time.
- Digital connectors – connectors supported people with access to technology and online services.

The pandemic provided an opportunity for some Ageing Better partnerships to evolve and enhance their community connector activity. For example, Ageing Better Middlesbrough found that the constraints of COVID-19 helped them develop a more responsive and effective social prescribing service at speed. For example, the requirement for all appointments to happen within the GP surgery was lifted, meaning the team could develop new ways to engage with people, including garden visits and 'walk and talk' opportunities alongside digital and telephone options[39].

Length of support and moving on

We found there was a wide variation in the length of time connectors engaged with individuals. Some models offered a set number of sessions or provided guidance for connectors on how long to work with individuals. Where this was the case, it was felt to be important to provide a framework for managing caseloads[40], but it also served to avoid dependency or over-reliance on the connector. For example, Brightlife in Cheshire offered an indicative number of appointments based on an initial assessment of need, with those categorised as Level 3 receiving the highest level of support, but with

[38] Ageing Better (n.d) *Role of Connectors during Covid-19 – learning from Ageing Better.* Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing_better_role_connectors_covid19.pdf?mtime=20201211145404&focal=none

[39] Ageing Better (n.d) *Role of Connectors during Covid-19 – learning from Ageing Better.* Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing_better_role_connectors_covid19.pdf?mtime=20201211145404&focal=none

[40] Connect Hackney (2020), *An in-depth study of the Community Connectors project for older people in Hackney living with or at risk of loneliness and social isolation*. Available at: www.connecthackney.org.uk/wp-content/uploads/2020/11/Connect-Hackney-Community-Connectors.pdf

flexibility to add more support if needed. Partnerships recognised that flexibility was needed to be able to extend the support, so that people experiencing health problems or disengaging for other reasons could remain connected to the service[41]. Bristol took a similar approach to Cheshire, where six sessions were initially available, but this was flexed to meet need. The evidence suggests that flexibility to extend support was critical in achieving positive outcomes for individuals[42].

Other models did not have a time limit on support, instead the emphasis was on connectors taking time to support people at their own pace. It was often described as 'needs based rather than time based[43]'. This was noted as particularly important where an individual may have high-level needs, such as mental health, or where needs may fluctuate. Others emphasised the need to take time to establish trust. Another reason for allowing longer for engagement was to take account of the time needed to make referrals to stretched services and to give space to address pressing needs, such as housing or finance first, before moving onto addressing social needs.

All of the community connector models developed by Ageing Better partnerships took proactive approaches to supporting individuals beyond the point of onward referral. This included following-up with people, providing regular check-in calls, and finding out whether people had attended a group or undertaken a specific action and how it had gone. Connect Hackney found that texting people was a good way to share reminders or check in[44].

41 Ageing Better (n.d.) *Social Prescribing (Health Referrals) - Learning from Ageing Better*. Available at: https://www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Social-Prescribing-health-referrals.pdf?mtime=20210201104727&focal=none

42 Bristol Ageing Better (2020), *Bristol Ageing Better Learning: Social Prescribing*. Available at: bristolageingbetter.org.uk/userfiles/files/Collective%20learning%20social%20presc(1).pdf

43 Project Lead Torbay

44 Connect Hackney (2020), *An in-depth study of the Community Connectors project for older people in Hackney living with or at risk of loneliness and social isolation*. Available at: www.connecthackney.org.uk/wp-content/uploads/2020/11/Connect-Hackney-Community-Connectors.pdf

Co-production

As a core feature of the Ageing Better programme as a whole, co-production[45] was also central to its community connector activity. For example, Brightlife Cheshire, Bristol Ageing Better and Ambition for Ageing in Greater Manchester conducted similar co-design and feedback programmes across their connector services[46] [47] [48]. Using people's skills and empowering them to inform the design and development of approaches helped to identify existing services which were not labelled as 'social prescribing' or 'connector activity' but performed a similar function. Recognising these overlaps helped support more efficient use of resources. This allowed activities to be brought together where they were similar, freeing resource to support other activities to fill gaps.

> "At the strategic level, some of our Older People's Alliance volunteers have used life experiences, both as older people, but also as professionals in social work or health care and used their ideas and challenges to help shape the direction - looking at the referral process and asking questions."
>
> (Partnership management team)

[45] Co-production is an approach that can be applied to a wide range of different contexts. It involves professionals, citizens and other stakeholders sharing power to achieve something together, recognising that both have valuable contributions to make.

[46] Bristol Ageing Better (2020), *Bristol Ageing Better Learning: Social Prescribing*. Available at: bristolageingbetter.org.uk/userfiles/files/Collective%20learning%20social%20presc(1).pdf

[47] Ambition for Ageing Greater Manchester (2021), *What works in tackling social isolation of older people in Bangladeshi Communities*. Available at: www.ambitionforageing.org.uk/sites/default/files/What%20works%20in%20tackling%20social%20isolation%20of%20older%20people%20in%20Bangladeshi%20communities.pdf

[48] Brightlife Cheshire (2020), *Brightlife Cheshire Legacy Report*. Available At: www.brightlifecheshire.org.uk/wp-content/uploads/Brightlife-end-of-project-report-Low-Res.pdf

Achieving change

Ageing Better social prescribing and community connector activities generated positive outcomes for people over 50 who participated. The models developed also influenced local services, strategies and approaches in the wider local system.

Change for individuals

Community connectors built trust and rapport with some of the most isolated and lonely people. For some, the relationship with the connector offered an important social connection in itself.

Our outcomes data shows that Ageing Better participants involved in social prescribing and community connector projects saw improvements in their levels of social contact, health, wellbeing, and loneliness during the period of their involvement. We cannot assess that these improvements for people attending social prescribing projects were due to Ageing Better, as we cannot compare their results to a group not receiving this intervention (as we do for all Ageing Better participants in the impact report). However, we can be confident that change happened[49].

When participants joined the programme...	At their latest follow up...
68% said they saw family or friends at least once a week	72% said they saw family or friends at least once a week
62% said they spoke with someone locally at least three times a week	68% said they spoke with someone locally at least three times a week
Participants reported a mean average health score of 55 out of 100[50]	Participants reported a mean average health score of 61 out of 100
33% reported having low wellbeing	19% reported having low wellbeing
55% reported being lonely	45% reported being lonely

[49] The Methods Note provides further information on the methodology. We report anything as a change or improvement/decrease where it is statistically significant at the 95% confidence level. Anything not reaching this threshold is not reported as a change or improvement/decrease. For outcome data, see Methods Note: Social contact Table A6, Health Table A7, Wellbeing Table A8, Loneliness Table A9.

[50] Where a score of 100 is 'best imaginable health state'.

Our Impact Evaluation Report[51] analysed the effect of participating in Ageing Better on key participant outcomes by comparing data for those taking part in the programme with data for similar people not taking part in any activities at all. This work found that taking part in a range of Ageing Better activities had positive impacts on participants' social contact and wellbeing, compared to those who took part in no activities. It did not find any clear links between particular types of activity and more positive changes. Instead, we found that the breadth of activities offered, responsiveness to local needs, and opportunities for people over 50 to get involved seemed to be most important. With that in mind, community connector projects should be part of a wider offer for people over 50, which offers a range of options for people to get involved.

Evidence collected for local partnership evaluations, a separate activity from the Impact Evaluation, demonstrated:

- Reductions in reported loneliness: Loneliness rates dropped by 46% across all the measures used by Ageing Well Torbay to assess the outcomes from Community Builders' support[52]. Similarly, 49% of participants in the Time to Shine's SWIFT service reported feeling less lonely[53].
- Improvement in the wellbeing of participants: Overall, 64.4% of clients engaging with Community Navigators in the scheme delivered by Bristol Ageing Better showed some improvement in their wellbeing scores[54].

There was also some evidence that community connector approaches supported positive behaviour change. Some community connector approaches empowered participants to access local services more appropriately. Independent research by the University of Plymouth on behalf of Ageing Well Torbay showed that self-reported visits to GPs have dropped by 32%. Additionally, it was calculated that people who worked with Community Builders from Ageing Well Torbay, and accessed wider support

[51] We have not carried out a study to isolate the impact of community connector projects on participant outcomes. Please see the programme Impact Evaluation Report for further information about the overall impact of the Ageing Better programme on participant outcomes. https://www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Impact-evaluation-report.pdf?mtime=20211014143815&focal=none

[52] Ageing Well Torbay (2020), *Social prescribing ecosystems*. Available at: ageingwelltorbay.com/wp-content/uploads/2020/11/Social-Prescribing-Ecosystems-FINAL-1.pdf

[53] Time to Shine (2021), *Evaluation of the SWIFt service*. Available at: https://www.opforum.org.uk/resources/evaluation-of-the-supporting-wellbeing-and-independence-for-frailty-swift-service-highlight-report/

[54] Bristol Ageing Better (2020), *Bristol Ageing Better Community Navigators Service*. Available at: bristolageingbetter.org.uk/userfiles/files/Community%20Navigators%20Report2020%20for%20SCREEN(1).pdf

through them, cost statutory health and social care services 17% less (an average saving of £458 per person per year)[55].

Our qualitative evidence highlights some of the ways in which Ageing Better supported participants.

> "[Support from a Community Connector] helps you get some direction when you're a bit lost, it helps you back into the world when you've been unexpected poorly, it cuts down loneliness and isolation."
>
> (Participant)

> "She [Life Planner] provided support, guiding me, she didn't do things for me, I had to do them, she guided me into what needed to be done first and what needed to be done next."
>
> (Participant)

[55] Ageing Well Torbay (2020), *Social prescribing ecosystems*. Available at: ageingwelltorbay.com/wp-content/uploads/2020/11/Social-Prescribing-Ecosystems-FINAL-1.pdf

> The support has built my confidence and I can achieve things that I thought I would never be able to do again."
>
> (Participant)

Supporting the development of ecosystems of support

There is clear evidence that a key factor in the success of Ageing Better's community connector projects was the development of wider ecosystems of support for isolated people over 50. These ecosystems are made up of all of the services, routes, responses, people and touchpoints which enable connection in a local community[56].

Community connector programmes contributed to these ecosystems in two key ways:

- By **encouraging collaborative working** among GP surgeries, health services, and VCSE organisations or groups primarily through their work to build partnerships and relationships for referrals
- By developing activities and sources of support in the wider ecosystem

> We would happily talk endlessly about the work of the Community Connectors and what they've done because I think they've transformed the areas of the city they've been working in."
>
> (Project management team)

[56] The National Lottery Community Fund (n.d) *Ageing Better: Understanding Ecosystem*. Available at: www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-understanding-Ecosystem.pdf?mtime=20211213120327&focal=none

In many cases this wider community building work was a product not just of the specific community connector project, but the wider Ageing Better programme activity. In this way, embedding connectors within a wider programme of activity to build connection was a key success factor.

Responding to the COVID-19 pandemic

In some areas, this partnership working accelerated during the pandemic. For example, in Torbay there were rapid developments in the local ecosystem during the pandemic:

> "The aspects of partnership work have exploded through the helpline throughout the COVID-19 period. We feel that Ageing Better put us in a resilient place with a whole group of partnerships that contain work on dealing with COVID-19 and our community."
>
> (Project lead)

In response to the pandemic, Ageing Well Torbay launched the Torbay Community Helpline. This was initially part of the local Staying Put project but was expanded to reach and support isolated people who were previously unknown to local providers. On calling the helpline, a triage process was conducted, so that the individual could be referred to the most appropriate support service. As such, it became an alternative way for Wellbeing Corodinators, Community Builders and charity sector partners to reach individuals who potentially faced challenges as a result of the pandemic, and for individuals to access a range of support. The helpline also served as a way for individuals to volunteer, with potential volunteers passed to local Community Builders who integrated them into the local ecosystem and supervised their activities. During the first five months of the pandemic, the helpline received 12,000 calls and its rapid response team provided urgent assistance 2,700 times[57].

[57] Ageing Well Torbay (2020), *Reflecting on Torbay Community Helpline, and your responses*. Available at: ageingwelltorbay.com/2020/08/26/reflecting-on-torbay-community-helpline-and-your-responses/

The strength of the existing ecosystem and partnership working as a result of the Ageing Better programme formed a strong basis for the success of the helpline. This worked helped to demonstrate how local connectors working alongside services can create a strong local ecosystem:

> People [in statutory services] up to COVID-19 didn't really understand what we were about. Through the helpline they have seen the strength of the network under an emergency situation. There's a lot more appreciation now of what an asset based approach and the development of an ecosystem locally can do."
>
> (Partnership management team)

A pilot has recently been completed through which the helpline was used as a first point of contact for all people over the age of 50. Those answering calls were able to triage requests for support from adult social care. They were also able to signpost other callers to the existing VCSE ecosystem of support, including the Wellbeing Coordinators and Community Builders. The involvement of statutory services to allow the helpline to act as a front door for adult social care also generated interest from other statutory services. With continued support from these statutory services, the helpline will be sustained beyond the end of the Ageing Better programme.

> The legacy of the social prescribing ecosystem that we created as part of Ageing Better has now turned into a support ecosystem for all ages across Torbay, involving in excess of 100 voluntary sector groups and organisations."
>
> (Project lead)

Reflecting on the experience from Torbay, the following key points of learning were highlighted for developing ecosystems of support around community connector services:

- Making time to build relationships across organisations and regular opportunities to share learning
- Developing a shared database to support information sharing
- Agreeing a shared set of values

Supporting a wider network of social prescribing schemes in the area

Our evidence shows that Ageing Better partnerships were able to embed their community connector schemes into wider ecosystems of support. This includes community connector and social prescribing schemes funded by other organisations or for other groups, for example by sharing their expertise and learning:

- In Birmingham, social prescribing training was delivered to local VCSE organisations as part of the Connect Sparkbrook Local Action Plan project[58]. The training session for organisations interested in becoming involved in social prescribing provided participants with information on what social prescribing is, its function, and provided details of those GPs that were offering social prescribing.
- A Thanet Social Prescribing forum has recently been established to share best practice of social prescribing across Thanet, which the Ageless Thanet Social Prescribers and Community Navigators attended. This has led to good working relationships between the GP-based social prescribing link workers.

[58] Ageing Better in Birmingham (2021), *Evaluation of Connect Sparkbrook local action plan*. Available at: www.ageingbetterinbirmingham.co.uk/media/attachments/2021/04/28/connect-sparkbrook-project---final-evaluation.pdf

Conclusions and recommendations

The Ageing Better programme generated valuable learning about how to reach and support people over 50 though community connector schemes.

Reaching people

- Ageing Better's social prescribing and community connector projects engaged a diverse range of people aged over 50, including groups known to be at particular risk of, or who were already experiencing, loneliness and social isolation.
- Creating diverse referral pathways into community connector schemes and engaging in proactive outreach were effective ways of ensuring that more people could access community connector support.

Effective approaches

- Ageing Better's community connector models were particularly effective because they formed part of a wider response to loneliness (including groups and activities) and because the wider programme invested in the development of these responses.
- Building community development approaches and strength-based approaches into community connector schemes can help to utilise people's skills and empower them to inform the design and development of approaches.
- These approaches can enable communities to develop their own solutions to plug gaps in available activities and support, including through the development of informal groups. Being involved in these groups is empowering and gives people a sense of ownership.
- Flexibility is vital to ensure that community connector schemes can appropriately support more marginalised groups, for example by providing targeted support and enabling connectors to work with people for different lengths of time/levels of intensity. These approaches can increase reach and engagement.
- Offering home visits by community connectors is vital. It enables connectors to reach people who are isolated in their own homes and helps connectors understand people's circumstances and challenges. Meeting people in a place that feels safe to them is also vital.

- Developing a diverse range of partnerships across sectors helps to ensure that people can be referred to appropriate support to meet their practical, social and emotional needs.
- Regular follow-up and check-ins are a key feature of effective community connector schemes.
- Approaches developed through the pandemic have led to improved processes for referral and supporting people (such as combining digital or telephone support with face-to-face) which are now being adopted for the long term.

Achieving change

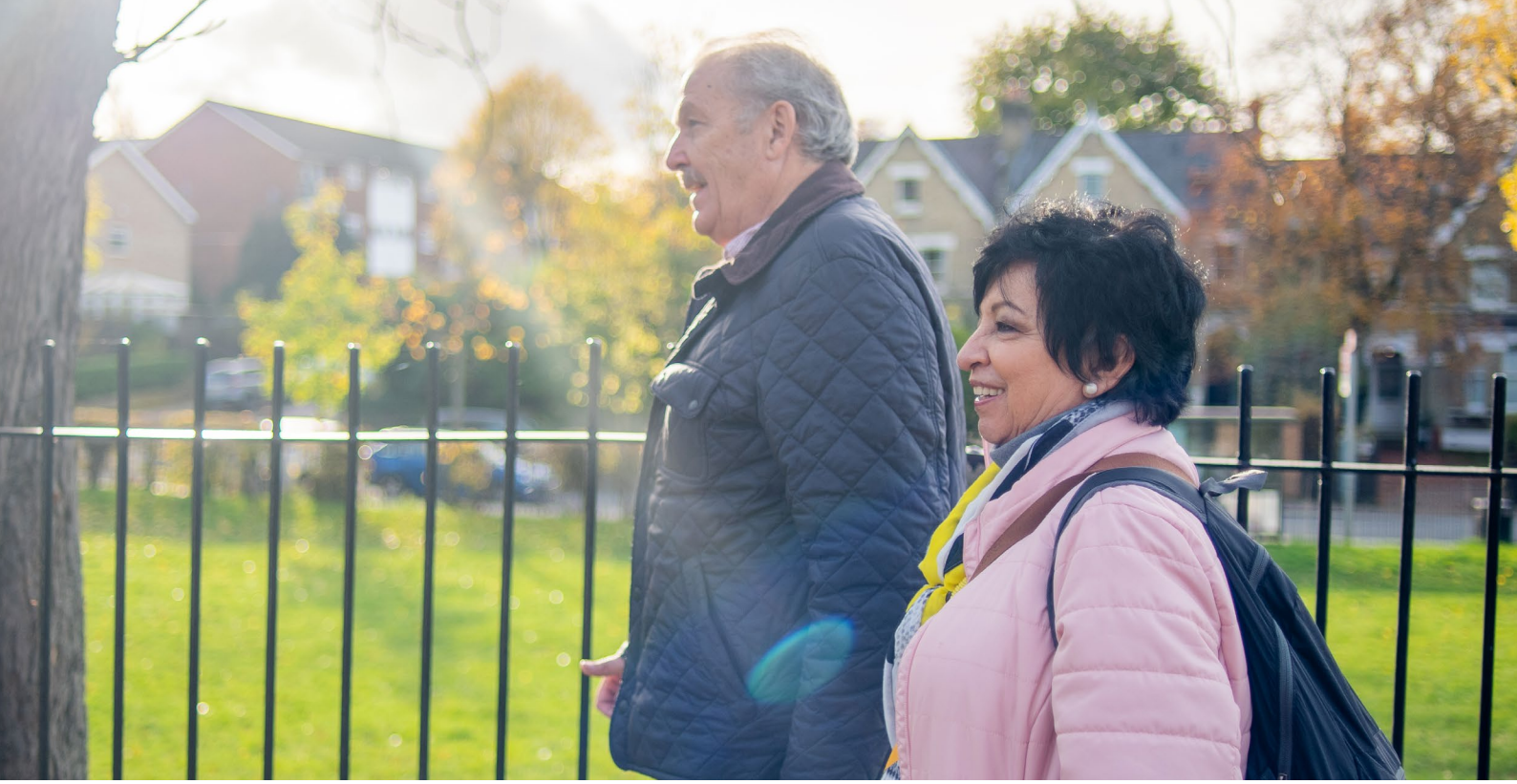
- On average, participants in social prescribing and community connector projects experienced positive changes in social contact, health, wellbeing and loneliness between when they started the programme and their most recent follow up. These findings are supported by our qualitative research that showed involving people over 50 in community connector activities may be an important step in creating tangible change to people's health, wellbeing, and social connection, and may reduce loneliness.
- Community-based community connector models rely on, and can support, effective cross-sector partnership to improve the coordination of services, reduce duplication, and ensure people are able to access timely and appropriate support and activities.

The Ageing Better partnerships created effective community connector approaches. These were tailored to meet the complex and varied needs of people over 50 who were experiencing, or at risk of, isolation and loneliness. These approaches were rooted in a wider understanding of the causes and consequences of loneliness and isolation. Through an emphasis on holistic, person-centred and community-based working, community connectors working in Ageing Better partnerships have consistently achieved positive outcomes for their clients. The findings of Ageing Better, in relation to both how individual connectors carry out their work and the need to develop the wider ecosystems around community connector programmes, should be used to enhance and improve social prescribing and other community connector approaches in other communities.

The findings from this study can be used to inform the approaches which commissioners, policymakers and service providers take to social prescribing and community connector models. We recommend they should:

- Adopt an outreach model to support engagement with more disadvantaged groups
- Recognise the need for community development work alongside the provision of connectors to work one-to-one with individuals
- Invest in training for connectors on person-centred approaches
- Enable connectors to link people to the full range of community activities, including informal and unconstituted groups
- Co-produce services with the people who will use them
- Give connectors the flexibility to adapt services to local circumstances and to the needs of the individuals with whom they work, in line with a commitment to co-production
- Establish a pathway for connectors to provide intelligence and feedback within Primary Care Networks

This report is accompanied by a Methods Note, available online.



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