Bristol Ageing Better Community Navigators Service

Final evaluation report of a social prescribing initiative addressing loneliness and social isolation amongst older people

November 2020

BRISTOL AGEING BETTER

COMMUNITY FUND

UWE Bristol | University of the West of England

ABOUT THIS REPORT

This report is the product of a collaboration between Bristol Ageing Better Community Researchers (Penny Beynon, Ginny Burdis, Jenny Hoadley and Anne Jensen) and researchers at the Centre for Public Health and Wellbeing, University of the West of England (Amy Beardmore, Mat Jones and Richard Kimberlee).

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Bristol Ageing Better http://bristolageingbetter.org.uk/

Centre for Public Health and Wellbeing https://www1.uwe.ac.uk/hls/research/publichealthandwellbeing.aspx

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LIST OF ABBREVIATIONS

BAB	Bristol Ageing Better
BCH	Bristol Community Health
BSC	BS3 Social Club
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CMF	Common Measurement Framework
CN	Community Navigator
CP	Community Practitioner
CR	Community Researcher
DDCMS	Department for Digital, Culture, Media and Sport
EQVAS	EuroQol Visual Analogue Scale
LW	Link Workers
NBAC	North Bristol Advice Centre
NHS	National Health Service
SPN	Social Prescribing Network
UCLA	University of California, Los Angeles
WEMWBS	Warwick Edinburgh Mental Wellbeing Scale

1. Executive Summary

Funded by Bristol Ageing Better from April 2017 – March 2020, the Community Navigators is a city-wide service that works with people aged 50+ to improve confidence, boost wellbeing and tackle loneliness & isolation. It is delivered by two lead delivery agencies (North Bristol Advice Centre and Bristol Community Health), in partnership with 7 other local organisations. Jointly they aimed to reach 5,520 people during the three years.

The Community Navigator service is a type of social prescribing initiative. Trained Community Navigators work one-to-one on a short-term basis visiting people in their homes or via phone appointments. They provide free information, signposting and support for people over 50 who are experiencing isolation and loneliness. This support is tailored around their interests and personal situation. They can also connect the individual to other services, for example related to financial or safety concerns.

Between 1st July 2017 and 31st March 2020 the Community Navigators have supported 1,769 individuals. Analysis of survey data based on validated loneliness and wellbeing scales indicates that the majority of people completing this information are socially isolated and have lower than average health and wellbeing at the point they start receiving support from the Community Navigators. On exit from the service, the cohort show improved health and wellbeing and reduced social isolation scores.

KEY ASPECTS OF SUCCESS

1. Home visiting:

This makes the service accessible to people who have physical or psychological difficulties getting out of the home, or experience hearing difficulties when communicating on the phone. It enables the Community Navigators to gain a better understanding of clients' day-to-day lives and often reveals practical and physical issues such as hoarding, damp, lack of handrails and ability to cope with domestic tasks. Moreover, Community Navigators have found that people can be more willing to reveal other, often sensitive matters, such as debt or benefit problems, when they are in their own home.

In particular referrers to the service, especially from health and social care services, whose remit does not necessarily include home visits, recognise the value of people having face-to-face interaction with the Community Navigator at home.

"Home visits are key… it's massively preventative- it's a really positive intervention, person centred based on supportive interaction rather than telling someone what to do."

Housing Association Tenancy Impact Officer

2. Open to referrals from any source:

The Community Navigators are 'free-standing'; they are open to referrals from anywhere and are not attached to a GP practice. They have received referrals from a wide range of sources in addition to health professionals, including social services, housing workers, voluntary organisations, the individual themselves and family members. While GPs have a good understanding of who is lonely and isolated, they should not be the only referrer.

3. Able to accompany people to groups and events:

Clients, referrers and navigators all felt the accompanying aspect of the service was very beneficial for anxious or under-confident clients, such as those recently bereaved, and believed it could make all the difference in whether someone would carry through and attend a new activity.

"I'd only just come out of hospital and still couldn't drive and I'd lost a lot of confidence, so it was brilliant that my Navigator could come with me. I found that really helpful, that's crucial, especially to start with."

Client aged 81

4. Navigator skills and support:

The role requires a person-centred approach, use of high level communication skills, empathy and patience; people may be reluctant to engage and there are often complex issues to resolve. Navigators need a wide knowledge base and the ability to source up-to-date information about local activities, groups, entitlements and specific agencies. Having appropriate and motivational training is very important, as well as adequate support, reflective practice and debriefing.

5. Combination of staff and volunteers:

The Community Navigator needs to be highly skilled in assessing the appropriateness for the service, the level of support needed and whether a referral to another agency is required in order to resolve a particular barrier first before a home visit occurs. This enables volunteer Community Navigators to take on the less complex cases, leaving paid Community Navigators to manage the more complicated ones. Volunteer Community Navigators have reported benefits for themselves of this type of role.

6. Collaboration:

The two lead delivery agencies and in particular the Community Navigator Coordinators worked well together from the start developing a common brand across the city. Resources were shared and issues relating to geographical boundaries were quickly resolved.

LEARNING AND RECOMMENDATIONS FOR FUTURE FUNDERS

1. More complex issues than originally anticipated:
One Community Navigator estimated this to be the case for 40% of people. There are often practical issues such as: debt, benefits, housing problems, continence management and transport difficulties (e.g. bus pass) that need to be resolved first, before any progress can be made regarding loneliness and isolation. A referral to an appropriate agency may also require advocacy and follow-up.

2. Levels of poor mental health:
Prevalence of poor mental health was higher than expected, particularly regarding more complex forms of anxiety and depression. Sometimes a referral to specialist mental health services is needed first, before any progress can be made on the issues of loneliness and isolation.

"Roughly 10% of referrals have mental health issues more complex than mild depression. They need phone counselling, have memory issues, high level anxiety..."

Community Navigator

3. Transport is a real challenge:
Transport is a significant barrier which Community Navigators and referrers alone are unable to address. Bristol bus services do not cover the whole city and are expensive. Even those who could use local buses find themselves unable to do so if there is no bus shelter where they can sit while waiting. There have been many complaints about the unreliability of community transport, for example failing to arrive at all or arriving too early so that individuals need to leave social events before they finish. Taxis or individual specialist transport for those with mobility problems can be prohibitively expensive.

4. Lack of befriending services in Bristol:
Not everyone wants or is able to go out to social activities and prefer to have someone to visit them regularly. In such cases, Community Navigators refer to one or more of the well-established befriending organisations in the city but are aware that the demand for volunteer befrienders exceeds supply, particularly for face-to-face befrienders or those who can also accompany the individual outside of the home.

5. Adequate and realistic resourcing:
Funders should be realistic about the money needed for travel, telephone calls, management costs and the time taken for this type of work (which often involves a lot of information gathering, liaison and arranging of transport prior to referral to an activity). Budget provision should also be made for confidential non-managerial support in addition to regular work supervision for Community Navigators.

"Effects of cuts really impinges on Community Navigator work, for example lack of sockal work involvement can mean Community Navigators are left holding worrying, vulnerable clients who have no other advocates, this is very frustrating as is not in their remit but no one else is acting for the client."

Community Navigator Coordinator

6. Planning appropriate monitoring and evaluation:
From the outset, appropriate outcome measures need to be planned, agreed, budgeted and incorporated into service delivery. This may require new Community Navigators to be trained in the rationale of collecting outcome data and to assist in devising realistic outcome measures. Similarly, both referrers and 'end organisations' wanted more feedback from the Community Navigators about people's experience of the service. This feedback mechanism should be made available from the outset.

7. Partnership working:
When there are multi-partnership arrangements, there needs to be a single clear management structure with accountabilities for tasks made clear from the beginning. There also needs to be a consistency for Community Navigators across different partner organisations, for example regarding annual leave. Additionally, both referrers and 'end organisations' need feedback from the Community Navigators about people's experience of the service. This feedback mechanism should be made available from the outset.

8. The service is only as good as the 'end organisations' to which they can refer:
There are an impressive range of opportunities available in Bristol but they are not evenly distributed across all areas and there are gaps in what is available. Most are run by voluntary organisations and respondents recorded concerns about funding cuts, a disappearance of organisations and a lack of resource to stimulate further new activities.

"Lack of resources directed to end organisation who are expected to take on extra, unforeseen capacity."

CEO Voluntary Sector Organisation

Consideration needs to be given to the availability of local 'end organisations'. Is there sufficient resource? Is it appropriate? Resources need to be made available to enable community resources to be developed and enhanced in accordance with the need discovered from people accessing Community Navigator services.

2. Background to Community Navigator services in the UK »

This report comes at a key time in the evolution of Community Navigation (CN) services. CN like many other services connected to primary care are sometimes described as social prescribing. Social prescribing initiatives have been growing exponentially around the country. In fact key third sector organizations agree that social prescribing is now poised to go viral (Steadman et al, 2018). The Social Prescribing Network (SPN) has over 3000 registered members and there are several Clinical Commissioning Group (CCG) areas that now offer a universal social prescribing service (i.e. a social prescribing offer in every GP practice) e.g. in Gloucestershire, Rotherham, Bradford, Dorset CCG areas. Enthusiasm for social prescribing has grown because it is seen as offering local partners an opportunity to implement a sustained structural change as to how a person moves between professional sectors and into their community.

Since the commencement of the Bristol Ageing Better (BAB) CN service the national policy context has changed rapidly and it is therefore important to be cognizant of these developments and the changes it will bring especially when thought is given to the commissioning of wellbeing services in the future. There have been two important but inter-related policy announcements in the last two years:

The Government's: *Strategy for Tackling Loneliness* (2018)

The NHS: *Long Term Plan* (2019)

As a result of the Strategy for Tackling Loneliness (DDCMS, 2018) the government is beginning to acknowledge that local partners need to change the way they think about and deliver public services. The expansion of social prescribing across the country is changing the way that people who experience loneliness are treated. Following the activity of the Campaign to End Loneliness it has become recognised that loneliness and social isolation are harmful to our health: research shows that lacking social connections is as damaging to our health as smoking 15 cigarettes a day (Holt-Lunstad, 2015). The government's current strategy has been to give a specific commitment that by 2023, all local health and care systems are to implement social prescribing connector schemes across the whole of the country, supporting their aim to have a universal national offer available in every GP practice. This means that more people will be connected with the care and support they need when they are experiencing loneliness, no matter where they live (DDCMS, 2018:10).

The second key policy document is The NHS (2019) Long Term Plan. This expands and builds on the Strategy for Tackling Loneliness and once again reinforces the government's commitment to social prescribing. In the Long Term Plan the NHS has committed itself to ensuring that within five years over 2.5 million more people will benefit from 'social prescribing', a personal health budget, and be given new support for managing their own health and long term conditions in partnership with patients' groups and the voluntary sector (NHS, 2019:6). As part of this work, through social prescribing the range of support available to people will widen, diversify and become increasingly more accessible to people across the country. It is envisaged that Link Workers (LW) within newly formed local Primary Care Networks will work with people to develop tailored plans and connect them to local groups and support services. Thus, over the next few years 1,000 trained social prescribing LWs will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people will be able to be referred to social prescribing schemes (NHS, 2019:25). The recruitment and engagement of LW are seen as key in helping the NHS to address people's wellbeing needs. Findings suggest that tackling complex and long-term health problems requires an extensive holistic approach not currently available in routine primary care. This model of social prescribing, which takes account of physical and mental health, and social and economic issues, has been demonstrated to be successful for people who engaged with the service (Moffatt et al. 2017).

Against this backdrop, Community Navigators are becoming seen to be a potential part of the offer to reform primary care to help address the increasing demand in primary care services. The origins of Community Navigator schemes can vary. Existing ones are often developed in response to local need by health professionals in primary care; but sometimes in partnership with national organisations like Age UK, as in Brighton (Gilburt et al, 2018). The CN service in Brighton "was developed as part of a local Extended Primary Integrated Care programme, which took a collaborative approach to designing a model to improve access to primary care health services. The programme was led by the Brighton and Hove Integrated Care Service, and delivered in partnership with Age UK Brighton and Hove, and Brighton and Hove Impetus (a local charity with expertise in improving health and wellbeing)" (ibid., p.22).

Community Navigator services have been seen to develop four stages to working with clients (Ageing Better, 2018):

1. Entry Points - how people find out about the service
2. First Engagement – what happens at first point of connection
3. Relationship Building / Activities / Structured Support
4. Engagement with community resources and opportunities

To date there is little research into the impact that CN initiatives may have for people and their communities. However one study has suggested GPs and staff are generally satisfied with CN, feeling it is effective at providing a referral route to non-medical services, useful in improving GP surgeries links to other resources and services in the community and is effective at reducing the amount of time patients attend at their GP surgery with non-medical matters (Farenden, et al 2016). The research conducted here by the BAB Community Researchers (CR) will help to build an evidence base on the impact and challenges faced by health and community professionals to deliver on the 'cultural change' that the Long Term Plan (2019) is anticipated to bring.

3. Overview of the Bristol Ageing Better Community Navigators service ⟩⟩

INVOLVEMENT WITH BRISTOL AGEING BETTER

Bristol Ageing Better (BAB) is a partnership of individuals and organisations working together to reduce isolation and loneliness among older people in Bristol. It is led by Age UK Bristol and is funded by The National Lottery Community Fund. In April 2017 BAB awarded three contracts worth a total of £743k over 3 years to two organisations in Bristol to design, develop and deliver the Community Navigator service.

WHAT IS THE COMMUNITY NAVIGATOR SERVICE?

The Community Navigator service is a type of social prescribing service based on the Community Connector model (Ageing Better, 2018). The service informs isolated and lonely older people, over 50, of community activities and services by providing them with information, signposting and introductions to a range of local services, through one-to-one support as well as outreach sessions. The Community Navigator service provides short-term support, which is completely free and is available by referral, for people in their home or via phone appointments.

WHO PROVIDES THE SERVICE?

The service is run by two different local delivery organisations, each of which works in partnership with other local organisations combining their community expertise. The three contracts were designed to cover the area boundaries used by health and local authorities: North Bristol, Central and East Bristol and South Bristol. See Appendix 1 for map of areas covered by each delivery organisation.

Bristol Community Health (BCH) (https://briscomhealth.org.uk) was awarded two contracts one covered Central and East Bristol, the other covered South Bristol. BCH is a not-for-profit community interest company and the leading provider of NHS community health services in Bristol. Both BCH contracts share the same management team and Community

Navigator Coordinator and are overseen by a Partnership Steering Group of representatives from all partner organisations which include at least 3 people aged over 50 (see Appendix 2)

The contract for North Bristol was awarded to North Bristol Advice Centre (NBAC) (http://www.northbristoladvice.org.uk) which is a long-standing registered charity specialising in provision of free and independent advice and support on welfare rights and money issues. There is no formal Service Steering Group but local partners are expected to attend North Bristol Community Navigator Partners Meetings every four months for communication, feedback and information sharing (see Appendix 3).

STAGES IN SERVICE OPERATION

The following section describes the four stages of the service operation in order to better understand the context of the evaluation.

a) Entry Points – how people find out about the service

Community Navigators are able to receive referrals from anyone, as long as the client has consented to a referral. Main sources of referrals are likely to come from health, housing and social care workers, family, friends and individuals themselves. The service also aims to reach older isolated people, over 50, who are possibly not known to mainstream services, by building more creative referral routes than are found in many 'core' Social Prescribing models. For example through promotion of the First Contact Checklist (see Appendix 6) and via outreach activities in community venues run by The Care Forum, community development workers and Community Navigators.

Referrals are made using the service's online referral form, which can be submitted via a secure online portal, or sent by email, post or via the telephone. The referral mechanism is straightforward and the form clearly details the Exclusion Criteria (see Appendix 4a & 4b).

b) First Engagement – what happens at first point of contact.

On receipt referrals are triaged, checked for compliance with criteria and the client is contacted by phone or letter within 5 working days. If the client is happy to receive support the Coordinator conducts a brief assessment of the person's needs, determines any risk factors and establishes if a home visit is required or whether simple signposting via the phone is appropriate.

Clients are allocated to an employed or volunteer Community Navigator according to needs and complexity and a contact appointment is arranged. Written consent is gained at the first appointment, a full assessment completed and a future contact plan agreed.

c) Relationship Building / Activities / Structured Support

Community Navigators offer a person-centred, holistic service based around what the client wants to achieve to reduce loneliness and isolation. They aim to build a reciprocal relationship of trust and non-judgement, to adopt an enabling approach rather than doing everything 'for' the older person. They use a 'guided conversation' approach to assist clients to identify their own needs and strengths and support them to make their own personal action plan.

Some clients with complex, entrenched issues may require time and a flexible approach, possibly referral to another service for help with practical, financial or emotional issues before ways to connect them with their community can be approached.

The service's initial plan was for 50% of client contacts to be conducted by telephone, with a maximum of 6 sessions per client but these could be spaced out over a number of weeks or months according to the client's situation.

The service has the facility to offer home visits if clients would prefer to discuss their issues face to face. This has an added advantage of seeing the person in their own environment as well as giving an opportunity to assess the home situation which can highlight addition needs.

d) Engagement with community resources and opportunities

Community Navigators are knowledgeable about activities and services on offer in the community and can provide current information and signposting. An accompanying function is offered to people lacking the confidence to connect with community groups or activities alone whereby the Community Navigator can accompany them on a first visit.

4. Evaluation methodology »

RESEARCH AIMS

Essentially, in setting up this research we wanted to ask: Does the Community Navigator service help clients to end loneliness? We were interested in exploring the explicit service aims and perhaps their unintended consequences. This report looks at what the CN services are doing (what works, what is challenging) and unpicks aspects of the service that has changed. To do this we developed further questions to explore:

1. Were the right referrals received?
2. Is the Community Navigator service useful to clients?
3. What sustains the client to reduce loneliness?
4. How useful is the service to the stakeholders?
5. To what extent has partnership building occurred to ensure that future services in Bristol are better planned and more effective in reducing loneliness and isolation?

DATA COLLECTION METHODS

The work of the CRs commenced near the beginning of the CN service delivery using data collected over a two-year period between July 2017 and August 2019. The evaluation team consisted of four volunteer Community Researchers from Bristol Ageing Better (BAB) in partnership with Dr. Richard Kimberlee, Senior Research Fellow from the University of the West of England (UWE Bristol) and the NHS England Social Prescribing Facilitator in the South West. BAB Community Researchers are older volunteers who have been trained and supported by UWE and BAB staff to conduct project evaluations. The aim of the evaluation was to examine the impact of the CN services delivered by Bristol Community Health and North Bristol Advice Centre from the perspective of different players: namely, the recipients, the paid and voluntary staff and their lead officers, the referrers, and the successful recipient organisations themselves. We used a mixed methods approach. Some case studies provided the voice of the individuals who benefitted from the programme. We also looked at data collected as part of BAB's Common Measurement Framework (CMF) which specifically assessed the extent of loneliness and isolation faced by people who were referred to the service.

Running through the evaluation was an emphasis on understanding the lessons learnt, in view of the government promise of funding for social prescribing commencing from July 2019. This evaluation, however, is not a longitudinal study and we were not able to interview individual clients directly about the immediate impact of the service. Nevertheless, the evaluation collected both quantitative and qualitative evidence gathered from a wide variety of sources as detailed in table 1 below:

Table 1: Data sources used in this evaluation

QUANTITATIVE DATA

Source	When	Purpose
Quarterly reports to BAB	Throughout	Activity data about CN staff: number of volunteers, number of participants
CMFs	From 2018	To establish whether CN activities were targeting lonely and isolated people, and improving their lives
First Contact Checklist referral data	Middle of service	To determine the number of clients referred to the CN service, and their satisfaction with the referral
Community Navigator service user satisfaction surveys	Middle of the service	To provide feedback on how the user experienced the service
Partnership minutes - 7 sets	Throughout the service	To understand how the NBAC partnership functioned

QUALITATIVE DATA

Source	When	Purpose
Quarterly reports to BAB	Quarterly reports to BAB	Activity data about work started/completed by the CN service
Interviews: with CN staff under contract (paid staff) n=7	Middle of the service	To establish their perspective of their work, the service and its impact
Interviews: with CN volunteers n=4	Middle of the service	To establish their perspective of their work, the service itself and its impact
Interviews: with coordinators and lead management n=9	Beginning and middle of the service	To establish how they set up the service, and their perspective of what was working well/not so well, and its impact
Interviews: with referral agencies n=9	Middle of the service	To establish the effectiveness of the information provided by the CN service, and the impact of the service on their own working situation
Interviews: with end organisations n=4	Middle of the service	To establish the effectiveness of the information provided by the CN service, and what they needed as an organisation, usually voluntary, to maintain or develop what they were offering lonely and isolated people
“Unstructured” interviews n=2	Beginning of the service	“Shadowing” CN staff including a home visit
Interviews: First Contact Checklist n=2 (one by telephone)	Middle of the service	To establish its impact on the Community Navigator service
Case studies n=9	Throughout the service	To understand the journey and experience of people who received the service
Attendance at CN partnership learning event n=2	March 2018	This was a learning event for professionals in the field reviewing the first year of operation

EXPLANATION OF RESEARCH TOOLS

Quarterly reports to BAB

The BAB staff maintain spreadsheets of the services' activities. These are a mixture of quantitative data about referrals and the numbers of volunteers, as well as text-based information covering:

- Outcomes
- Monitoring, evaluation and learning
- Activities to continue developing the quality of the Community Navigator service
- Activities to develop the range of community navigation support available

Common Measurement Framework Forms

The CMF questionnaire was designed by ECORYS, a private economic and consultancy research company. As part of the National Lottery Community Fund's Ageing Better programme, completion of CMF forms was a delivery condition for service funding, although the client's participation was entirely voluntary. During the initial assessment clients are given information about two CMF questionnaires which they are asked to complete and return at the next visit. One is designed to capture demographic information, the other to provide baseline measurements of loneliness, (including the De-Jong Gierveld Loneliness & UCLA Loneliness Scales) social contact and participation, mental well-being (using the Warwick-Edinburgh Mental Well-Being Scale) and level of health.

A CMF form is also given on completion of the CN intervention and a final one is sent six months after service engagement ended. The aim of the CMF is to ascertain whether there are any long-term changes attributable to engagement with the service.

The CMF forms provided this evaluation with some indication of the participants' characteristics, e.g. how far they matched the target group for the service and how effective the intervention was in terms of reducing loneliness. However, they were not routinely used until at least 3 months after the commencement of the service, as the service providers needed training from BAB which had not been provided at onset. The providers also found it logistically difficult to get the third (final) form returned after the 6-month period, as by then the person had effectively been discharged from the service.

Completed CMF forms were sent to BAB for monitoring and processing using IBM SPSS 25 (statistical software package) to facilitate data analysis and to enable comparison with subsequent data submission from clients through the exit and final stages of their service engagement.

From the 1st July 2017 through to the 30th June 2019, 210 baseline CMFs were received from clients. During this time 903 clients had actually been accepted by the service. So, the baseline data only provided information for 23% of the CN clients.

In all their interviews the CRs encouraged respondents to produce verbal pen pictures of their clients. These pen pictures along with the case studies and observations made during the shadowing visits provided a "soft" picture of the degree of loneliness and isolation the service was trying to address and helped to supplement incomplete CMF data.

First Contact Checklist Bristol

First Contact Checklist was a project set up using BAB funding and it is based at The Care Forum, Bristol.

'The First Contact Checklist project will help older people to get the support they need by ensuring that the first organisation they contact is able to easily refer them on to other services around the city'.

Bristol Ageing Better, 2019

The CN service is one of the 14 registered organisations taking part in this service and it received 37 referrals from the First Contact Checklist project, between June 2017 and 2019. See Appendix 6 for more details.

A telephone interview was used to elicit some facts about how the system worked and the nature of the relationship with the CN service. This was followed up by a more structured interview.

Client satisfaction surveys

Each service designed their own client feedback questions which were sent by post or conducted by telephone after completion of engagement with the CN service. NBAC commenced this system in January 2018 but had limited response rates with incomplete returns making statistical analysis difficult. BCH commenced their feedback system in January 2019 and appear to have had a better response rate which was by their organisation's performance team using Meridian software. It is not possible to make comparisons between the two providers. However, they do make a contribution to our understanding of how the CN service is perceived by the client.

Table 2: Client satisfaction survey numbers

Service Provider	Duration	Responses	% of clients seen
NBAC	January 2018 - August 2019	59	Not known
BCH	January - June 2019	53	83%

Interviews

An interview schedule was prepared for each of the five sets of respondents and sent to the interviewees in advance. This was to keep interview time to a minimum and facilitate considered responses to the questions. However, the interview itself was informal and the schedule was used primarily as a guide to ensure effective interview flow and data capture. Interviews with Community Navigator Coordinators and Managers were conducted by two CRs, while other respondents were either interviewed by one or two CRs depending on availability and context. All interviews were recorded.

Summary reports were written within the questionnaire template, including quotations on issues pertinent to the research questions. Content was checked for accuracy by another researcher. The consistency of form enabled the CRs to share their reports for analysis purposes. All interview reports were subsequently scrutinised by the entire research team to check for common emerging themes and additional insights about service delivery.

The *unstructured* shadowing of CNs was arranged whereby CRs spent a half-day with staff to understand the office-based aspect of their work and to then accompany them on a home visit, where the client had pre-agreed to meet the researcher. This was very informal. The CNs were asked questions about their professional background, what sort of administrative work they had to do and their view on how the service operated. After the home visit, there was an informal discussion about any new issues which had arisen during the visit and what the next steps might be for that client. Everything was written up by the researcher later. No recorder was used.

Case studies

These were written by the organisations themselves as part of the monitoring information required by BAB. One of the three studies in this report was written by a CR following an interview with a client.

In the next section we review the evidence garnered to address the research questions posed.

5. Findings »

QUESTION 1: WERE THE RIGHT REFERRALS RECEIVED?

Who used the service?

Both Delivery Partners were asked to estimate the numbers of people they thought the CNs would be working with over the duration of the service. This is illustrated in the following table:

Table 3: Forecast of estimated referral numbers over 3 years

Bristol Community Health	North Bristol Advice Centre
3,720	1,800

Source: Delivery Partner Contract and Addendums

According to the data provided by both services the total number of referrals received by both providers from 1 July 2017 to 30 June 2019 was 1,279. Of these referrals, 903 (71%) were accepted and 376 (29%) were rejected.

Table 4: Reasons for rejected referrals:

Reason	Percentage of rejected
Out of area	31%
Inappropriate	23%
Declined by client or un-contactable	45%

An 'out of area' rejection may merely indicate that the referral was passed to the CN team working with the other service provider in a different part of the city. An example of an inappropriate referral would be where a person's level or type of support needs were judged to be more appropriate for either the learning disability or dementia navigators or community mental health teams; in which case they were referred accordingly. The mental health teams occasionally referred their service users to the CN service in the hope something additional might be offered; as one CN Coordinator explained:

....we are not mental health workers really; so that can be quite difficult.

Some clients once offered the service then declined to take it up for a variety of reasons, and some clients were un-contactable from the outset. As a CN Coordinator explained:

A client's personal circumstances may have changed or they might be about to be admitted to hospital or had a bereavement, or their physical or mental health was not at the right stage.

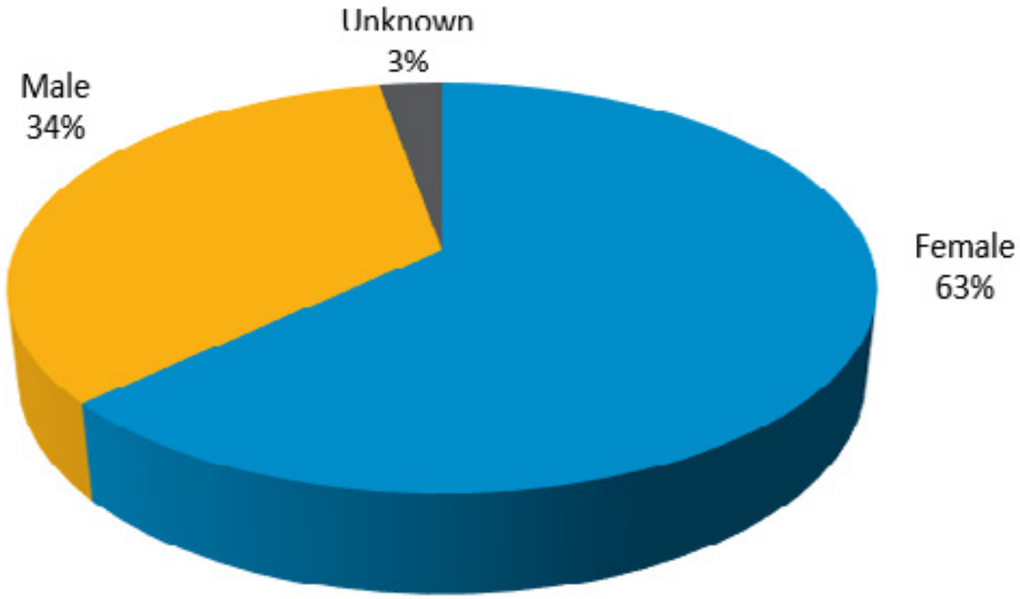
In such cases clients were invited to re-refer themselves when they were ready. Occasionally too long a time gap between referral and contact by the CN resulted in the person losing interest. 3% were rejected because the person was already active as a client.

Gender

Demographic data provided directly by delivery partners showed that those referred were more likely to be female (63%) than male (34%), which is replicated in other BAB projects. However within the Bristol population of people aged 50 years and older, women constitute 52.4% compared to 47.5% men (Bristol City Council, 2019). This indicates that men were under represented in the referrals in comparison to the city demographic. That men would be reluctant to seek assistance was predicted by one of the service providers in their tender when describing factors that were common to those most difficult to reach (Appendix 9).

Community Navigators - BCH and NBAC Referrals by Gender

N=1080



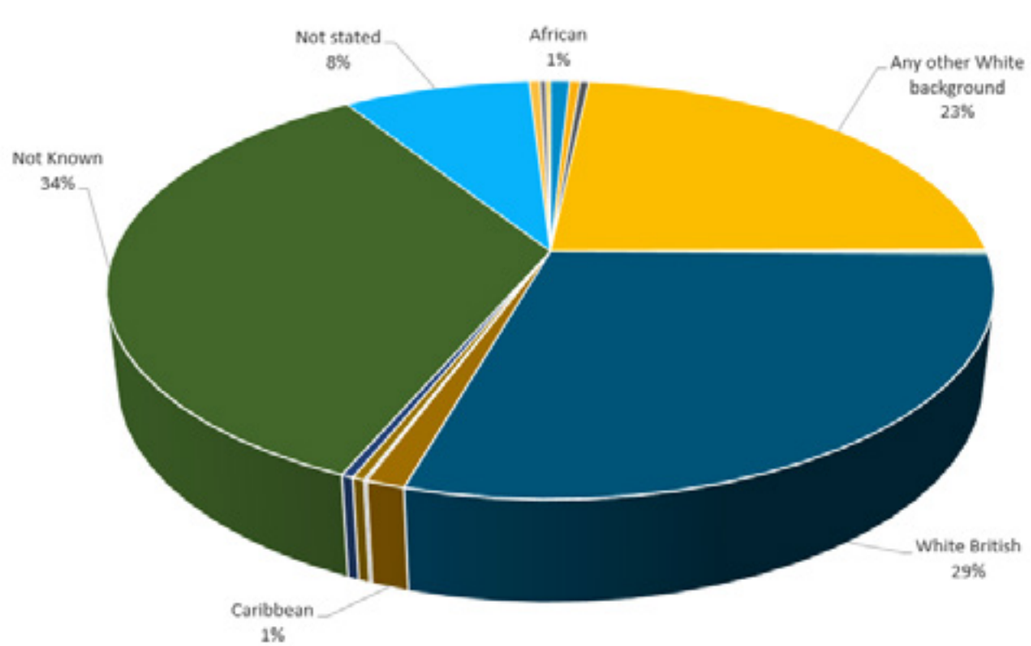
Ethnicity

Demographic data provided directly by delivery partners found that 57% of referred clients had provided their ethnicity information. Of these 52% were White British and 40% had an other white ethnic background. 8% came from BAME groups. There was some variation, with 9.2% BAME referrals to BCH services and 7.7% BAME referrals to NBAC.

In comparison, within the Bristol population (Bristol City Council, 2019) the proportion of older people (aged 65 and over) who belong to a BAME group is just 5%. While this data only relates to people aged 65+ and not 50+, inferences can still be made. So the Community Navigation service appears to have been seen as accessible by many diverse communities. Although this data is sourced from less than half of all clients seen, there is no reason to assume that this is not a representative sample of the total client group.

Community Navigators - BCH and NBAC Referrals by Ethnicity

N=1080



Age

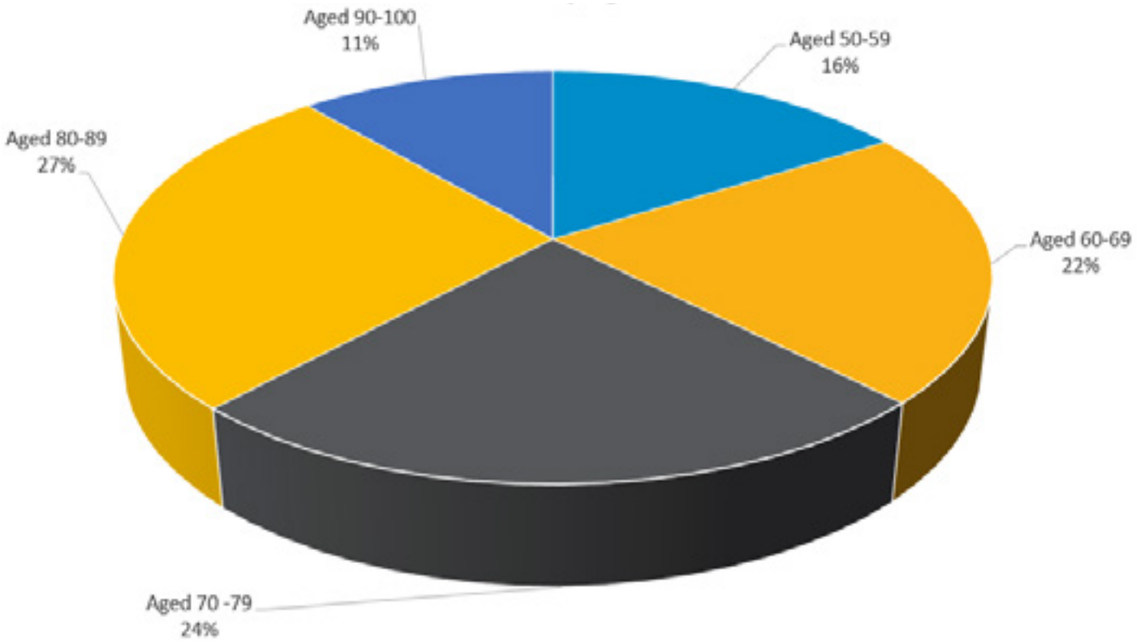
The age profile of referred people was also gained from the service providers' databases.

The largest age group seen by the CN was people aged 80 to 89.

CNs observed that new retirees in the 60 to 69 year range were particularly at risk from becoming socially isolated and lonely. This risk also applied to people taking early retirement on health grounds.

The case study across the page illustrates that loneliness and isolation is not only associated with people over 60.

Community Navigators - BCH and NBAC Referrals by Age
N=1015



CASE STUDY OF A WOMAN IN HER 50'S

Ms M has lived in her local authority flat in Bristol for 20 years. She is a single parent and brought up her two daughters alone. They continue to live with her. Ms M is now in her fifties. Until recently she worked as a play assistant in a company she had helped to establish.

A few years ago her best friend died suddenly of a short illness and her relationship with an abusive former partner ended. In addition to these personal losses she also became unhappy at work due to management changes.

Ms M became increasingly withdrawn and unhappy, she had no family support to turn to and felt isolated. She was signed off sick by her GP in October. On her third GP visit, she was asked to consider a referral to the Community Navigator service, to which she reluctantly agreed.

By January Ms M felt more unwell with additional symptoms of fatigue and she decided to resign from her job. Around this time a Community Navigator came to see her. She says that if the Community Navigator had not come to the flat to see her she would not have managed to go out to an appointment. She described herself at this stage *'at the lowest point in my life'.*

Ms M described her Community Navigator as 'the perfect person at this time, kind, compassionate, knowledgeable, someone I felt I could trust, I felt heard'

The Community Navigator put her in touch with a local coffee club and referred her for counselling. She was again initially reluctant to accept a referral but fortunately the counsellor could see her at home. Some six months later she says:

'Life is better. I feel more settled, more optimistic and confident'
'Learning to look after myself has been a big lesson'

Ms M plans to look for part-time work when she is ready; meanwhile she is a helper at the coffee club and feels more connected to her community.

Were the referrals representative of the most lonely and isolated?

Information gained from CMF data
From the outset both services produced a list of referral criteria (Appendix 4a & 4b) which included social isolation as a valid criterion for making a referral. Referrers were unanimous in describing the referral form and process as 'clear' and 'straightforward'.

From analysis of the CMF entry forms (n=363) it is clear that CN services are reaching clients who are largely living isolated lives. Almost four in five clients reported that they lived alone. They also scored high on the De-Jong Gierveld Loneliness Scale, i.e. 77.4% of clients rated 'high' levels of loneliness (3-6) on the scale. These results are replicated by client scores on the UCLA Loneliness Scale. The clients showed higher levels of loneliness than the UK average for older people.

Client wellbeing was measured using the short version of the Warwick–Edinburgh Mental Well-being Scale (WEMWBS) where clients can score between 7 and 35 on the scale where 7 is the lowest level wellbeing and 35 is the highest level of wellbeing. According to the CMF data the average client WEMWBS score at entry was 20.24. Client scores were generally lower than the national UK average: 25.3 (NHSE, 2010).

In terms of health, the EQVAS (EuroQol Visual Analogue Scale) measures how individuals perceive their own health. This scale ranges from 0 to 100, where 0 is the worst health they can imagine and 100 is the best health they can imagine. At the start of their support from the Community Navigators, the average score was 66.7 which was lower than the UK average for older people. This all suggests that the CN service received appropriate referrals in that they were working with people who were largely socially isolated with lower than average wellbeing scores.

Descriptive observations of the variety of circumstances and needs that can lead clients to become lonely and isolated were gained through interviews with referrers and the CN team. Their observations concur with the statistical information collated on the CMF database and support the claim that those referred were isolated.

Information gained from respondents

We learnt that 2/3rds of referrals came from Local Authority organisations or health organisations with fewer referrals coming from other services or individuals (see Appendix 5). This list indicates that many referred people were already known to another service, which had recognised the person might be isolated and lonely.

In this situation, the professional requires the skill and time to facilitate conversation around loneliness and isolation, as reflected by a physiotherapist working in a rehabilitation centre;

I think in order to deal with the isolation the first thing is to identify that the person is isolated…some people are perfectly happy with that and others aren't, so much of it is getting to know the person and are they lonely and are they depressed or low in mood? Would they benefit from getting out and about, seeing people like talking therapies and that kind of thing?

Some respondents interviewed were concerned that there are likely to be some people who would find the service useful but their needs are unknown to anyone. Reflecting on whether the service reached the most lonely and isolation people who are not in touch with mainstream organisations, one respondent commented:

The main referral routes are social prescribing, social care, GPs, rather than the corner shop. They are people who would be getting support anyway; it's not people who are shut in their homes, really struggling'

A CN respondent said:

I wonder about people who may have slipped under the radar, who we don't know about but who really need the service but haven't got proactive relatives or haven't been hospitalised or picked up by anyone else, I don't know how we deal with that.

Conversely it can be argued that having an existing connection to another service does not necessarily mean that the person is not lonely or isolated. Much may depend on their perception of the issues, their self esteem, relationship with the professional, and ability to communicate their feelings. The professional also requires the skill and time to facilitate conversation around loneliness and isolation and to explore the person's own view and whether they want a CN referral.

A CN Coordinator commented:

I think people will go to their GP if they have an issue or nobody else is supporting them. This is the whole point of the CN service and something to be looked into further.

Summary

There were fewer straightforward signposting referrals than initially predicted and both CN services had received more referrals for people with complex needs than anticipated. The complex nature of many referrals has required more in-depth involvement from the CN team. Most CNs and volunteers work part-time and this, coupled with staff changes, has reduced the services' capacity to see as many clients as initially anticipated.

The shortfall between both services' total estimated referrals (5520) compared to the numbers actually seen (1769 by March 2020), is probably understandable in the light of the factors described above.

In addition, at the time of the data collection for this evaluation, the service had only been delivered for 2 years as it had taken many months to establish and to do the required service promotion. It should be expected that any new community based personal service will take time to become known, embedded and trusted.

QUESTION 2: IS THE COMMUNITY NAVIGATOR SERVICE USEFUL TO CLIENTS?

Findings from CMF data

One of the ways of assessing the usefulness of the service to clients is to look at the CMF data to explore impact. Clients were invited to complete the CMF at the start of their time with the CN service and when they exited the service. A client's completion of CMF questions at both stages is termed 'a pair.'

Between 123 and 162 pairs were analysed for significance on each trait measured in the CMF; the variation in the number of pairs is due to not everyone who completed the CMF form answering all the questions. Table 5 summarises the analysis of the outcomes for CN participants and puts them in the context of the BAB programme as a whole.

Table 5: Outcomes for participants in the BAB Community Navigators service, alongside outcomes for the Bristol Ageing Better programme as a whole. Statistically significant positive change highlighted in red

		Community Navigators service				BAB programme overall			
Area of measurement	Measure	No. of matched pairs	Baseline mean	Follow up mean	Significance (p value)	No. of matched pairs	Baseline mean	Follow up mean	Significance (p value)
Social and emotional isolation	DEJONG	123	4.19	3.71	**0.003**	753	3.37	3.16	**0.001**
Social and emotional isolation	UCLA	136	6.96	6.51	**0.003**	897	5.66	5.35	**0.000**
Social contact with children, family and friends	CONTACT	127	2.45	2.30	0.080	808	3.27	3.30	0.442
Social contact with non-family members	SPEAK-LOCAL	149	6.15	6.27	0.505	1020	6.70	6.82	**0.033**
Social participation in clubs etc.	SOCIAL-SCORE	143	0.63	0.82	**0.013**	966	1.35	1.52	**0.000**
Taking part in social activities	TAKEPART	151	0.71	0.91	0.27	1015	1.40	1.58	**0.000**
Co-design. Activities involved in	INVOLVED	149	0.31	0.36	0.516	843	1.02	1.10	0.082
Ability to influence local decisions	INFLUENCE	162	2.47	2.40	0.597	915	2.85	3.00	**0.004**
Volunteering, unpaid help	HELP	154	0.25	0.35	0.92	981	1.26	1.41	**0.002**
Wellbeing	SWEMWBS	132	19.18	20.84	**0.000**	865	21.10	22.18	**0.000**
Health/Quality of Life	EQ5DIndex	140	0.41	0.49	**0.009**	787	0.65	0.67	**0.042**
Health	EQVAS	143	47.91	53.27	**0.011**	828	62.41	67.31	**0.000**

Table 5 shows that there were significant improvements for:

- Social isolation and loneliness for both the DeJong and UCLA measures
- Health for both the EQ5D and EQVAS measures
- Wellbeing for the SWEMWBS measure
- Social participation in clubs, activity groups etc.

Analysis indicated no significant improvements for:

- social contact with family members
- social contact with non-family members
- participation in social activities
- involvement in co-designing or running social activities
- ability to influence decisions in your local area

Looking at the two loneliness scales there are statistically significant improvements in overall average scores by 0.48 (p=0.003, n=123) on the De-Jong Gierveld Scale and 0.45 (p=0.003, n=136) on the UCLA 4 item scale. Using the UCLA, there were 10% fewer people scoring as 'lonely' at follow-up (81.6% baseline; 71.3% follow-up).

There was also a significant improvement with the follow up WEMWBS scores of 1.66 (p<0.001, n=132), with 64.4% of clients showing some improvement in their well-being scores. Additionally there was significant positive change for the EQVAS scores (p=0.011; n=143), with 52.4% showing an improved score.

It is very positive that the CN intervention clearly improved loneliness, general health and wellbeing. However, it was disappointing that there was no significant increase in social contact with family and non-family members. This is not straightforward to explain, although these types of contacts were not a primary focus of CN practitioners' work with the clients. It was unsurprising that traits connected to involvement in running activities or influencing decisions locally had not improved, as a sizeable minority of people had significant personal and environmental barriers to address to reduce loneliness. This short-term intervention was therefore unlikely to alter these particular traits.

The pattern of scores supports wider evidence that the CN service was working with people with higher levels of social and health needs compared to participants in the BAB programme as a whole. This further reinforces the achievements of the CN service in showing evidence of health improvement for people experiencing higher levels of health need.

Findings from interviews, case studies and feedback forms

The results of our interviews with referrers, CNs, service managers and clients including client quotations in case studies, identified the following key aspects of the service which contribute to its usefulness for clients:

a) Home visits

b) Skills and knowledge of the Community Navigator

c) Person-centred approach

d) Access to information on local resources

e) Accompanying to a new activity

f) Improved wellbeing

a) Home visits
Referrers and CNs consider that home visits are one of the most useful aspects of the service for people over 50. When offered the choice the vast majority of people prefer to be seen at home; it was suggested that they may find a face to face conversation more meaningful than one conducted by telephone.

Home visits are key, massively so – if they are already feeling isolated and anxious about going out, asking them to come out for the first visit, without first building up a bit of a relationship with them, is probably too much, some people need a little bit of reassurance at first.

Housing Officer – Referrer

Home visiting makes the service accessible to people who have physical or psychological difficulties getting out of the home, or who experience hearing difficulties when communicating on the phone. CNs found that a visit at home helped to build a supportive relationship and felt people were more willing to discuss sensitive matters or reveal other issues preventing them from going out, in the privacy of their own home. Additionally the CN was able to gain a better understanding of people's day-to-day lives, which often revealed practical and physical issues, such as poor housing conditions, hoarding, a lack of handrails or difficulty in coping with domestic tasks.

Once you're in someone's home, you can see all those other things that are going on….until you see that, and can ask questions, people aren't going to give you that information on the phone.

Service Manager

CNs estimated that 40% of people referred to the service have initial issues preventing them from getting out. There is a need to unpick and resolve practical issues such as accessible transport, no bus pass and benefit issues before any progress can be made on the issues of loneliness and isolation. In practice this requires more than a referral to an appropriate agency; it also requires advocating on the person's behalf about an issue, such as the urgency of the situation, or help with completing application forms or making phone calls.

What is on offer is very generic, a wrap around service that can offer help with both social and practical issues.

Referrer

b) Skills and knowledge of the Community Navigator
The role of the CN requires excellent communication skills, empathy and patience. They must be flexible and creative in order to find ways to help people who often have complex issues to resolve. They need a wide knowledge base and the ability to source current information about local activities, groups, entitlements and specific agencies for a wide variety of issues.

c) Person-centred approach
Referrers particularly liked the CN's person-centred, holistic approach which focuses on the individual's needs, their likes and dislikes. They saw this as key to building positive, trusting relationships with people.

They can encourage people, they can reach out in the first place, they know how to identify who is at risk of loneliness and have good communication skills to build up rapport with that person, to work out their likes

and dislikes, what they might like to do to move forward.

Referrer

People felt listened to and treated as an individual and were able to decide their own goals.

Brilliant; right time; right person! Navigator very happy to go along with my needs, listened to me, and treated me individually, nothing felt 'off the shelf'.

Client

Comments and analysis from CN client Feedback Questionnaires from respondents show recurring themes around CNs being friendly and very helpful, which illustrates the benefit that people gained from a person-centred approach.

In a BCH CN client feedback survey 94.6% of 37 respondents rated the support they received as either excellent or good.

Table 6: BCH client feedback survey

Response	Cohort	Percentage	Score
Excellent	21	56.76%	100
Good	14	37.84%	75
OK	2	5.41%	50
Poor	0	0.00%	00
Very poor	0	0.00%	00
Not sure	0	0.00%	N/A

In a NBAC CN client feedback survey 82% of 17 respondents said they were extremely likely or likely to recommend the service to others.

Table 7: NBAC client feedback survey

Response	No of responses	Percentage
Extremely likely	11	64.70%
Likely	3	17.64%
Neither likely or unlikely	2	11.76%
Don't know	1	5.88%

The most quoted achievement in both Community Navigator services was an increase in my confidence. In one service feedback survey 66% (n=37) of respondents agreed or strongly agreed that they now felt confident to engage in activities, with mobility issues frequently blamed for lack in confidence.

The Care Forum service which manages the 'First Contact Checklist' multi agency referral form sent 37 referrals to Community Navigators between 2017 – August 2019. Feedback from these people has also been excellent with 100% saying the service had been good.

d) Access to information on local resources

People often struggle to find out what activities are available in their area; especially if they are not connected to the internet. The Community Navigators' wide, up to date knowledge of local groups and resources is appreciated by people who often do not know where to start looking. The Community Navigator's ability to look up on-line information on hand held 'tablets' while doing a home visit is very beneficial. Equally useful is the link that Community Navigators have established with some of the community organisations as they can give credible information to people about what to expect at the activity or group.

Many older people aren't online. There's an assumption that everyone can use email and the internet and if you can't it can be difficult to get phone numbers to make contact with an organisation to help you decide if it is something you want to do, or somewhere you want to go.

Referrer

Having sourced potential activities and groups Community Navigators take practical steps to facilitate the person's attendance at the activity e.g. by writing a timetable to simplify the information, helping to arrange transport to reach the venue and with the person's consent can inform the organiser of their intention to join the activity.

It's alright giving people advice and information but some will struggle to use it.

Community Navigator

e) Accompanying to a new activity

The service is able to 'accompany' people to a new activity or group for the first time if they are nervous and lacking confidence to go alone. Community Navigators found one of the main barriers to getting someone out of the house was that:

Many clients have low confidence and are nervous of trying something new.

Community Navigator

Clients, referrers and Community Navigators all felt the 'accompanying' aspect of the service was very beneficial for anxious or under confident people, such as those who had been recently bereaved, retired or unwell, and believed it could make all the difference in whether someone would carry through and attend a new activity.

I'd lost a lot of confidence so it was brilliant that my Navigator could come with me. I found that really helpful, that's crucial, especially to start with.

Client Case study

It was a relief to have someone to encourage me, who would listen and understand my situation; someone to hold your hand where you've been rejected before.

Client Case study

f) Improved wellbeing

The CMF service exit data indicates that in two of the contract areas there were significant improvements in people's mental wellbeing scores (WEMWBS) and in levels of health at the end of the intervention. There was a significant improvement in people's loneliness demonstrated on both loneliness scales in the contract area in South Bristol, albeit people still had scores well below the national average for their age group. This result is unsurprising given the short length of time over which the intervention has been implemented and measured.

People had been referred to a huge range of activities ranging from traditional tea and natter groups, craft based activities, film clubs, art and reading groups, to boat building and games clubs. Additionally, a few people had gone on to

take up volunteering opportunities and others had opted to attend health and wellbeing enhancing activities such as Staying Steady balance classes to prevent falls or Walking for Health, swimming or exercise classes.

Many people returning feedback questionnaires gave incredibly positive comments about the service, particularly about the qualities of the Community Navigators.

'Very nice navigator – helped me enormously, enabled me to become mobile again.'

'Life is better. I feel more settled, more optimistic and confident.'

Generally people did not volunteer comments about changes in their social isolation or loneliness, which is perhaps unsurprising as these terms may not resonant with them; but there were comments such as:

'I'm getting involved and making new friends'

'I'm getting into the community and finding out about things I wouldn't know about otherwise'

Client feedback forms

Community Navigators acknowledge that not everybody wants or is able to attend activities or join new groups, additionally, that people have to be ready to make changes. This may be reflected in how some people may respond in their Service Feedback Questionnaire.

They will be positive about the Navigator but not necessarily about what's available…. There are a few cases where it's been overwhelmingly positive, but again, working with people, that doesn't happen often, but life gets in the way, or circumstances change which stops them…..there's not something for everyone.'

Manager

QUESTION 3: WHAT SUSTAINS THE CLIENT TO REDUCE LONELINESS?

As evidenced for Research Question 2, the CN service found that a substantial minority of clients needed help to deal with a variety of issues on a personal level: for example, home adaptations, introduction to debt-counselling, home-decluttering service, benefit advice or counselling services before loneliness and isolation could be addressed. Our interviewees, however, told us that the society we live in pushes loneliness and isolation beyond the personal: there were many barriers over which the CN service had no influence which may be inimical to sustaining reduced loneliness.

- the current nature of social infrastructure
- the accessibility of social information, particularly for those who are not tech-savvy or just do not have access to computers or smart phones
- the number and range of end organisations which can provide opportunities for community engagement
- the structure of our communities and how do the more vulnerable re-connect if their support systems fail.

This is a light touch evaluation without the resources to directly answer the question: *'What sustains the client to reduce loneliness'* but our findings indicate what makes it more difficult for people to avoid loneliness and isolation. These are outlined below:

The social infrastructure

The parts of the social infrastructure in Bristol which particularly affect the wellbeing of older people are affected by the national policies and funding of the NHS and the national benefits system, and the Transport Act 1986 which de-regulated bus services (outside London). Local policies and funding influence the range of support services and the shape of the voluntary sector (and this may be the result of austerity cuts to local government since 2010) which have a knock-on effect on older people. Below outlines how our social infrastructure makes tackling loneliness and social isolation more difficult:

a) Lack of transport
This was highlighted by the Community Navigators interviewed as one of biggest issues to resolve and has a direct bearing on isolation. Many neighbourhoods in Bristol have no bus service, bus services and community transport alike are unreliable, and taxis are expensive. Lack of mobility is frequently a factor in loneliness, so transport must be accessible to be useful.

b) Insufficient mental health services
Mental health issues were reported by at least one CN as making up 10% of client referrals. As the local mental health services were unable to meet demand for sessions for things like confidence-building and dealing with debilitating mild depression, the CN was a frequent referrer to talking therapies run by voluntary organisations – but these are only funded by BAB until 2020.

c) Reduced availability of money and benefit advice
Current services for benefit advice, form-filling and taking appeals, are over-stretched, because of increased demand due to austerity, thus resulting in delays. Income can determine what the individual does to deal with loneliness so getting help at the right time is essential.

d) A more restrained community sector
Many of the people interviewed, expressed concerns about funding cuts, support organisations closing down and a lack of resource to stimulate further new activities beyond the CN service.

Lack of ease of access to information

A key to improving the connectedness of lonely people is the provision of information about community activities and how they can access that information. Community activities are largely run by the non-profit making sector, and thus are subject to unreliable funding, reliance on over-stretched volunteers, and a lack of resources to widely advertise their offer, an inability to exploit social media or to be available to respond to enquiries.

These issues have been in part addressed by Bristol City Council funding the Well Aware database (run by The Care Forum) which is free. While the information was accessible by phone, it primarily requires clients to have access to a computer, and knowledge about how to interrogate the internet, which would be difficult for some older people. It is also difficult to keep such databases up to date but this one does undertake a regular three monthly updating process.

However local knowledge is also key. The interviews with CN staff and volunteers demonstrated that they made huge efforts themselves to build up and share a massive reservoir of local up-to-date knowledge, which more than supplemented the Well Aware database. This local knowledge was necessary to keep abreast of the appearance and disappearance of small groups which might be depending on unreliable funding sources, or key personalities who for whatever reason leave the organisation. It is testimony to this knowledge base that referring agencies and even end organisations will actually use CN as a resource of useful knowledge.

Range of activities on offer

Finding out about what is "out there" is one thing. But, as the eligible age for the service (50+) covers such a wide range of interests and needs, (depending on life stage, e.g. pre-retirement, and physical and mental wellbeing) the effectiveness of any service to mitigate loneliness and isolation also depends on the availability of a sustainable and broad-based community sector which can offer a wide range of activities. A CN service is as good as the range of appropriate community organisations available to which people can be referred. As one CN said:

It could be punk aerobics for some and tea dances for others.

Although the CNs were impressed by the range of opportunities available, these are not evenly distributed across all areas. Gaps in service included ones where older people were looking for organised day outings which included transport but there is no service which specifically offers this. However, the gap most frequently mentioned by the CNs was a lack of befriending services. The demand is high, and the few in operation do not cover all areas of the city; for instance, one befriending organisation was cited as an example where matching generations can be successful, but it only worked well in some areas because of the matching difficulties people wanting the service did not necessarily live in the area where sufficient service providers operated.

Remaining connected

As the CN service usually stops after an average of six sessions, there is always the question about what happens to people afterwards, perhaps when an activity they had been introduced to has closed or a change in circumstances has induced another episode of depression or challenged self-confidence. What sustains the individual in these circumstances, especially where the social infrastructure is poor? This may throw up unintended barriers that cannot yet be seen.

The issue of people falling through the net was discussed by some CNs we interviewed. The CN service will accept a re-referral where circumstances have changed, but with no enforced waiting time. Some community organisations may signpost users on to another activity but many are staffed mainly or entirely with volunteers and not set up to offer that as an after service. A local community centre or "social hub" may be able to signpost, if there is one which is accessible to the individual.

Interviewees were asked how they might visualise a future where loneliness becomes uncommon. Wanting to see more neighbourliness was frequently said. This difficult–to-pin-down concept was echoed by most in various ways, for example:

(There is) a need for people who are less confident to meet more confident people in close proximity to where they live. There needs to be space to make lasting relationships but not to over complicate how those circumstances come about.

Senior manager of a CN service

or as a wish that local streets, blocks of flats and communities could be more friendly, so people remain connected.

QUESTION 4: HOW USEFUL IS THE SERVICE TO STAKEHOLDERS?

The BAB Community Navigators Research & Evaluation Plan defines the term 'stakeholders' as including

- Providers
- Referrers of scale
- Volunteers and
- End organisations i.e. those groups/ organisations to which users of the service are referred or introduced by CNs.

The following findings were obtained largely from our interviews with stakeholders, some case studies and service reports. While it is impossible to quantify 'how' beneficial the CN service might be to any particular stakeholder, it seems clear that in many cases those involved recognise and welcome the benefits they perceive, whether as an organisation or an individual. At the same time experiences of the service have resulted in useful learning and positive suggestions for design and provision of future services.

Providers (lead organisations)

Although there was no formal requirement to do so, both lead organisations (NBAC and BCH) found the development of their close working partnership on the ground and at managerial level very positive and mutually valuable, both in creating a single 'brand' as well as practically.

Partnership working with Bristol Community Health to create a city-wide brand for Community Navigators has been hugely effective

Source: Service Report NBAC CEO and CN Coordinator

We found evidence for:

a) Internal partnership working:
Significant beneficial learning for both lead organisations – though for different reasons – resulted from the need to resolve issues which arose where staff were based in separate partner organisations (see Q5 below, Staff engagement).

b) Steering group peer representation:
Members of the public aged 50+ make up 50% of the BCH CN steering group. This was described by BCH as having a 'transformative effect' in influencing the direction of the service to what is important and relevant for the public by making practical use of the reps' own specific skills, interests and contacts, for example in improving accessibility of promotional material, promotion to BAME communities or making use of local knowledge.

It's been a fantastic example of public involvement… It changes the tone of the conversation … we can have a different conversation about the quality of the service …what did that case study show? What can we learn from it?

BCH Patient & Public Empowerment Lead

c) Use of Volunteers:
The decision by the two lead organisations to recruit, train and embed volunteers as CN proved invaluable to both. Once trained it enabled the volunteer CNs to take on the more

straightforward referrals thus freeing up time for paid CNs to concentrate on more complex cases of which there were many more than predicted.

Referrers of scale[1]

In both BCH and NBAC services by far the majority of referrals come from those working in the health or social services sectors. The main benefits relate to important aspects affecting the client's well-being which the referrer recognises as needing attention and support, but which are outside their own professional remit, knowledge or ability in terms of workload.

We found evidence for:

a) Person-centred approach

You can't expect patients to self-manage their health conditions if they are sad or lonely.

Respiratory Assistant in Community Respiratory Team

For most referrers, whose own role concerns only specific aspects of a client/patient's well-being, the person-centred in-depth approach at the heart of the CN service was really valuable and reassuring. The referrer feels that the client is not left 'abandoned' after discharge with issues that still need to be resolved if they are to feel less isolated and lonely and become more socially active.

It gives me reassurance that after the person is discharged …. Someone will be visiting and doing their best to ensure the person does not become isolated

Physiotherapist at Rehabilitation Centre

b) Home visits

The work remits of most professional referrers to the CN service do not permit home visits. They highlight the use of home visits as 'key' to the person-centred approach used by CNs. In addition to issues like anxiety and lack of confidence CNs often find that there may be serious practical barriers to be dealt with before a client is ready to think about any social engagement.

c) Potential for reduction in demand for NHS services

Several referrers felt that the CNs concern for the whole person, not just their physical or mental health, and supportive interaction had:

the potential to reduce hospital admissions – good for the patient and the whole system.

Physiotherapist at a rehabilitation centre

It potentially sustains the tenant's physical and mental health and decreases use of the NHS …..I think it's massively preventative

Tenancy Impact Officer with a housing association

d) Personal benefits to referrers

Health and social work professionals valued the ability to reduce their own increasingly heavy caseloads by referring clients to CNs and to reduce their personal concerns about limits of time/help for existing clients and potential clients they are unable to see e.g. if they are unable to attend surgery. They also feel less isolated in their own role.

It makes you feel a bit of hope when you leave somebody. You realise you haven't just left that person sitting with nothing.

OT Aide

Footnote: **1** Defined as those organizations from which the majority of referrals are received.

Volunteers

Volunteer CNs we interviewed were unanimous in finding their CN activity fulfilling. For various reasons, including retirement (the majority are over 50); they are not in paid work. They value the flexibility and being able to choose the amount of time to commit but more than anything they want to 'feel useful'.

Being involved with the Community Navigators has given me new momentum. …. I have new purpose and I find the challenge of the task invigorating.

Volunteer CN, BCH

In particular the sense of fulfilment comes from seeing the positive change they can help bring about as a result of the relationship they build up with the client.

You can really see that you do make a difference to somebody, having that contact, that chance for them to share and talk to somebody who is not a family member or a professional…….I had a card from a client who said 'you've made me realise that I've still got a life to live'.

Volunteer CN, NBAC

However, the role can be challenging at times. The client's psychological issues of anxiety, lack of confidence, fear of the unknown can mean

…getting out of the front door is the main thing, even if it's just into the garden

Volunteer CN, BCH

But the challenge or the unknown, "not knowing what each client is going to present with" is part of the satisfaction volunteers experience when things go well.

I enjoy seeing people's lives improving, even marginally, that's a big plus.

Volunteer CN, NBAC

End organisations

There is no formal requirement for end organisations to give feedback to either CN service regarding the person the CN has accompanied, signposted or referred. End organisations are not necessarily set up specifically for those who feel lonely or isolated. It can be a one-off referral to a special interest group e.g. linking someone with an interest in carpentry to a friendly wood-working group, or more frequent links with informal 'Tea and Talk' or 'Coffee and Chat' groups meeting regularly in cafés, to well established voluntary community centres or hubs offering a variety of activities for all ages. But for some clients who, for varying reasons, prefer to engage on a one-to-one basis and find it difficult to leave the home, referral to a befriending scheme can be a better fit than group activity.

Befriending schemes, involving regular one-to-one home visits from a volunteer to someone who feels lonely or isolated for any reason, welcome referrals from CNs although demand for such schemes in Bristol exceeds the supply of volunteers. Both the St Monica Trust befriending scheme and Good Gym recognise the CN service as valuable in sustaining and promoting their own services by raising awareness of loneliness and isolation.

CN referrals were welcomed by end organisations. Regardless of the type of end organisation, they help to sustain their

existence and justify their purpose. They can also, as a side effect, expand awareness of the group within the voluntary and community sector.

CNs have referred about half a dozen people to an informal self-funding BS3 Social Club (BSC), which meets twice a week in a local café. BSC describes itself as 'the prevention end' not providing a 'rescue' however:

We try to be welcoming. If you come along we'd introduce each other, people go out of their way to be welcoming....

Link person for BSC

They "don't tend to be intrusive" in terms of asking why anyone has come along – the raison d'être of the group is that anyone can just come along without the need to explain why. They don't keep a register, but add basic contact details to a member list used to send a regular newsletter notifying of other self-funded activities such as: cinema trips, walks, outings. There have been spin-offs in getting members of BSC to be involved in other local activities. They suggest it would be useful for them to have follow up from CNs to find out why those referred choose not to continue to come.

In contrast 'Natterbox', a similar, but smaller, 'Coffee and Cake' group in North Bristol, pre-dating the CN service, was specifically set up to break down social isolation and loneliness in the 55+ age group. When they know someone new is attending a volunteer is assigned to welcome and look after them, take contact details, offer a lift if required etc. Following an initial referral from a CN in the North around 6 people have been referred by CNs. This has had a positive effect and, similarly to BSC, attending can lead informally to involvement in other activities, thus expanding social engagement.

What's great about this group is that they've remained very welcoming, it's never got too big to become cliquey..... remained an open group.....It happens naturally that people are asked to come along to something else by other people in the group.

Coordinator, Natterbox

The Beehive Community Centre in East Bristol welcomes people of all ages, but has a particular emphasis on meeting the needs and interests of older people. The benefits of working closely with the CN service for both the Beehive Centre and their older attendees, is illustrated in the following case study written by the CNs and the Beehive Centre.

CASE STUDY: THE BEEHIVE COMMUNITY CENTRE

Tucked in a side street behind St George's Park, the Beehive Community Centre is a thriving meeting place for the communities of East Bristol. The centre offers a wide range of activities for all ages – from parent and toddler yoga and line dancing, to arts and crafts, and a gardening club – with a particular emphasis on meeting the needs and interests of older people.

Run by the Bristol & Anchor Almshouse Charity, the centre also helps to provide lifetime accommodation to older people in Bristol through a number of one and two-bedroom almshouses nearby.

"I think we've created a really dynamic community here, with older people at the core" reflects Amber Williams, the centre's community development worker. "And it's lovely to see how it's grown – their children, grandchildren coming too. Local people of all types, with everyone getting involved."

A sense of belonging

Part of Amber's role is to support the people who attend the centre: building their confidence, encouraging them to get involved and, in time, helping them to become ambassadors for the service too.

"Most of all, I want to help them feel a sense of belonging here, which I think we are achieving," she explains. "It doesn't matter what age you are – loneliness is something anyone can experience... We make a point of getting to know everybody who comes here."

As well as clubs and classes, the centre also offers a range of volunteering opportunities. "We have loads of volunteers, including lots of older people," Amber says. The volunteers get involved with all sorts of things – from taking part in the 'Beehive buddy' scheme to help new members settle in, to serving refreshments, baking cakes, and running the centre's lunch club.

"Our volunteers might have lots of issues in their personal lives – bereavement, health problems, financial difficulties – but being able to come to a place like this, meet their friends, and give something back really helps them to manage all that difficult stuff," she reflects.

Transforming lives

The Community Navigator scheme has been really positive for the Beehive. "Our service has definitely grown since Community Navigators began."

Amber estimates that around 20 people have attended since the start of the programme – 7 or 8 of whom now come on a regular basis.

"They just wouldn't have those social connections if it wasn't for the Community Navigators bringing them. It's only with their support that they have the confidence to come and get involved."

Amber tells us about one older person, Philip*, who discovered the centre through Community Navigators and now attends three or four days a week.

"It has transformed his social life. Even the activities he can't join in with, he'll still watch and have a cup of tea and a chat. It shows that he feels so welcome here – that he can just come and hang out if he wants to."

For Amber, the role of a Community Navigator is invaluable. "A 'what's on' guide or a leaflet is never going to be enough for a very isolated person. They need a physical presence – a

someone – to tell them about it," she says.

The service's work to identify these people, introduce them to the Beehive and attend with them – making sure they have the right transport or accessibility arrangements in place – has been a huge support.

Working together

"We can't do everything ourselves. Our big challenge is getting the word out about the service – letting people know we're here, that we're accessible, that everyone is welcome, and having the support to break down the barriers that prevent access... These are all things the Community Navigators service has helped us overcome."

She explains that Philip is a great example of how well this collaborative approach can work. As someone with limited mobility, the centre worked closely with his Community Navigator and other local agencies to ensure he can travel to and from the centre safely, and make sure he's safe while he's here. "We've worked together really well," she concludes.

To help build this relationship further, Amber suggests introducing a single point of contact for the service.

"With different navigators working for different services around the city, it can sometimes be difficult for us to know who to update about new services or opportunities at the centre."

She also explains that different navigators work in different ways, so having more standardisation in how they approach and refer into services would help too. But overall, the relationship has been a big success.

"Some of the navigators we work with are just fantastic," she enthuses. "They bring a really wide range of people here, and they've all enjoyed coming and attending the activities. I love how we're open to a wider audience now."

QUESTION 5: TO WHAT EXTENT HAS PARTNERSHIP BUILDING OCCURRED?

- to ensure that future services in Bristol are better planned and more effective in reducing loneliness and isolation?

Both the government's Strategy to End Loneliness (Bellis, 2019) and the NHS Long Term Plan (NHS England, 2019) emphasises the importance of developing a network of social prescribing services in the future to combat loneliness. This raises questions about partnership and collaborative working, and the significance of the development of trust. This section identifies the six key themes identified through data analysis that underlie what the BAB Community Navigator Service said about their experiences and reflections on their partnership working, across the duration of the service.

Collaboration not competition

BAB commissioned three contracts for the CN service, one for each geographical area (see Overview). Bristol Community Health (BCH) applied for all three and won two, indicating that it would co-operate with any other successful bidder. North Bristol Advice Centre (NBAC) only applied for the Bristol North area and was successful. Within the first nine months of the contract the relationship between both service providers had become collaborative:

"... (The) North locality went from a rival in the commissioning process, to North provider being a major asset – strong relationship, (the two coordinators) work closely together."

"(There is) always a risk that it creates competition where none exists."

Lead Manager

"We have had a really good relationship with BCH, both working on the ground and at managerial level, which is very positive, and they've done a lot of excellent publicity and joint publications and the teams have cross referred clients according to catchment address."

Lead Manager

A common *brand* across the city quickly developed: the same referral process, similar referral form, common website, same client-centred approach to the client, similar use of volunteers working alongside paid staff, shared training, and a sharing of knowledge about community resources. There were also joint annual reviews to review the service. For most of the duration of the contract a seamless service across the city was presented by the CN staff to potential referrers.

Partnership working is time-consuming

Staff said that there was also some indication of duplication of effort especially at the beginning around the initial asset mapping exercises. However, we suggest that this is perhaps a symptom of the fact that collaboration is a lengthy and a time-consuming business. The staff illustrated this in several ways:

"Everybody has got too much work to do. (It is) harder working in partnership than you think."

One service found that partnership meetings of those organisations which had signed up to the contract were not always well attended:

My vision of the partnership has not been as dynamic as I would have liked but everybody is very, very busy. We have wider partnership meetings but that has probably not developed as much as I would have liked.

So we wanted to meet quarterly, so we've had 2 meetings so far, the main issue for us has been Partner engagement, I know everyone is really busy, but, I feel like we're almost a 2nd thought, and they know that we're already working hard and it feels like they don't need to get involved.

Involvement improved later, though, partly when one of the Navigators became more embedded in the community locally and communication and feedback increased from the CN service itself.

Their attendance at Partnership meeting is much better so I think that was a two-way thing.

Engagement with voluntary sector end organisations

Without end organisations the CN service would not work. Most of these are within the non-profit-making sector. One of the providers allocated 30% of its budget to community development work which had been assumed at the beginning to include, in part, identifying gaps in provision and to pro-actively help to close those gaps. The other provider did not allocate anything in its budget to this work From the outset the first provider told us:

A unique part of our model is to develop strong relationships with end organisations.

However, from the discussion below the community development work had not unfolded as the initial bid writers had hoped, and it was admitted that was partly due to not unpicking in sufficient detail at the beginning what the initial bid writers meant by the concept to the CN service. Staff turnover did not help.

In the analysis outlined in response to Section 5, Question 3 (above) it was found that although there were many organisations with much to offer lonely and isolated people, coverage was not universal, and one provider commented on the withdrawal of funding from their particular area. Significantly the CN budgets did not include any money for starting new initiatives or supporting current ones to expand to manage Community Navigation referrals. We did discover that there were one or two examples of CN setting up schemes to meet need, but it was indicated to us that this was not the role of the CN.

It was also not clear whether there had been any assessment at the beginning of how the service might impact on the not-for profit making sector. As one of the lead providers pointed out:

"(mainstream professionals) when making strategic plans which include patient referral pathways to Voluntary Sector organisations don't always understand the voluntary sector issues and fail to make the connection about how increasing referrals, without a commensurate financial contribution, will have a significant effect on a voluntary sector organisation's capacity to cope with demand, which is already over stretched."

From another provider partner, who had had more experience relating to the statutory sector:

It has been beneficial to get to know them (voluntary sector organisations) personally and to find out more about how it is for them on the ground rather than from a strategic viewpoint.

This suggests that when setting up services the perceptions of the different sectors should be heard and understood, and assumptions made, are open to re-definition.

We were given lots of examples of CN staff and volunteers getting to know local end organisations and the relationships they built were co-produced. These relationships tended to be with organisations which had reliable funding or were based in their own building. One befriending organisation said that they found the CN service was always very honest about the issues the client might bring with them, and on one occasion offered to help to do the introductory visit. Again, it is about developing a sense of mutual trust about referrals. As the organiser pointed out, the organisation needed the referrals to justify continuation of charitable funding, but also the CN service really needed the befriending organisations.

The contract from one of the service providers included dedicated staff to explore possible end organisations and develop ways of communicating that information in a usable form, but it did not however meet the full potential of a developmental role for reasons outlined above. Nonetheless, across both services all the partner managers, staff and volunteers made a contribution to engaging with the non-profit making sector to obtain the best outcomes for their clients.

Lack of operational clarity

Although a shared vision was developed and sustained by both providers, operational clarity was impacted by a range of issues. There were tensions particularly between the partners of each contract over misunderstandings within the contract:

During the first year perhaps we were not all singing from the same hymn sheet

and with hindsight:

To spend more time at the beginning with key partners and staff about expectations.

Lead Manager

The researchers also could see that over the three year contract period there was some staff turnover, including managers, which might have contributed to some misunderstandings.

One of the providers devolved the community development function to staff who were based in, employed, and managed by a separate partner organisation. The community development workers' view was that there were unclear, and possibly unattainable, expectations in the bid about what they could achieve, leading to disappointment and frustration amongst staff tasked to carry it out.

We do not have the time here to do the detailed engagement with the hard to reach groups, individuals, members of the public that we need..... (This sort of work) takes time and needs people to be fully embedded and engaged in those communities.

In addition, they felt that there were communication issues due to the handover between the bid writers and the staff on the ground as well as changes in managers, although they felt that their organisation was potentially well-placed within the voluntary sector to carry out the work. Not sharing office space with the CNs added to the communication problems, but eventually tighter supervision arrangements were put into place, and regular email newsletters provided by the community development workers provided a reliable flow of up-to-date information about community resources underpinning the Community Navigator service.

Within the other provider, problems arose where two partners had employment responsibilities for CNs but the terms and conditions were different for both. With hindsight, both saw they had different expectations of the service and so staff were getting different instruction about the mode of work. A compromise was negotiated that the lead partner would take over day-to-day supervision of the work of one of the CNs but the employment responsibility would remain with the original partner. Having a different geographical location of the work base is not necessarily an issue. In the other provider service there was one CN whose work base was elsewhere and whose employer was a partner organisation but day-to-day supervision of the CN role was by the Coordinator - this relationship appeared to work well with no conflicts of interest felt by any of the parties. Nonetheless, complex employment and supervision arrangements have the potential of misunderstanding developing leading to a lack of operational clarity.

Staff engagement

The two community development workers were at a separate base employed by a partner organisation. Although they were satisfied with the training made available by their organisation, their local managers during the contract period were not working in the same field. Nevertheless, this was the person who represented them at higher management meetings, which left the staff feeling they had no voice. In addition, they felt that their job descriptions were vague and they were seen more as an add-on rather than an integrated part of the CN service. However, this was eventually addressed. In the latter part of the contract this post was required to work with the second CN provider. Relationships here were easier and less formal.

Unfortunately, we were unable to interview the managers of the community development workers due to time restrictions and the turnover of managers. We wanted to understand why the potential of such an innovative part of the CN service had not met the providers' or the staff's expectations. Our interviews showed that by the third year compromises in supervision and meeting opportunities were made which mitigated to some extent the concerns of the staff. This management style evolved during the course of the contract period rather than being in place from the beginning.

As for Community Navigator staff, both paid and unpaid, we found that they felt they were well supported with training and supervision.

The importance of service promotion for referrer and potential user

Both through our interviews and the activity reports provided to BAB it was clear that all staff, to a greater or lesser extent, spent a lot of time developing referral pathways. Meeting organisations in their local areas was important because they could either be potential referrers to the service or could provide a service as an end organisation. The community development workers spent most of their time attending

local network meetings as well promoting the service to health professionals at GP surgeries, local libraries, housing associations and pharmacies:

Their promotional / publicity work has been useful to the community navigation service because community navigators themselves don't have time to do this work e.g. street pop ups etc.

CN Coordinator

Although one of the service providers also provided health services, the face-to-face contact at GP surgeries and with other health professionals still appeared to pay off. The community workers also leafleted housing blocks in areas where there were low referral rates and designed leaflets to go into dosset boxes prepared by pharmacies for those who faced barriers leaving the house.

Both providers had persuaded local voluntary sector anchor organisations to be signatories to the contracts and these were seen generally to be fruitful ways of tapping into local networks. BAB had also funded the First Contact Checklist (see Appendix 6), a network of organisations including the fire service, police and the CN service to develop an easy direct referral process to each other. In the end the CN service received a steady stream of referrals from this source.

Promotion is not just about providing information about a service. It is also about developing a sense of trust that the service can deliver and therefore be of benefit to all stakeholders (see below). Although often intangible, we felt that this sense of trust came across in many of the interviews, in all sectors, and seemed to be the essence of good partnership working. Referrers all said that they trusted the CN service would provide a good outcome for their clients, and that they rated the CN community knowledge so highly that they themselves would often contact the service for information they could pass on to clients on their own caseload, particularly when a full referral to CNs was not required.

We work together really closely, sharing knowledge…it's really valuable, we support each other's service for signposting for their own caseload.

Referrer

What felt apparent to us was that promotion especially through face-to face contact played a large part in the success of the service. The promotion led to a building up of trust when referrers saw what the service could achieve, and so enabled partnerships based on mutuality to grow.

Promotion is a time-consuming process. CNs did some of this work and at the beginning of the contract only one Full Time Equivalent post was costed for community development activities to cover two thirds of the city. The other provider thought it could be done without any dedicated staff; but in fact additional money was successfully sought half way through to provide some additional community development support. However, as described above, the staffing levels did not support the work required to engage with very isolated people, who by definition, are and remain very hard to reach.

6. Discussion »

LIMITATIONS OF THE EVALUATION

As volunteer researchers we came to the evaluation project with virtually no research experience, a limited amount of personal time but with a background of professional experience of social work, nursing, social care commissioning and local government and the voluntary sector. There were two major limitations of the evaluation over which we had no control:

a) It was not a longitudinal study so it was not possible to show the long-term effectiveness of a CN intervention. The CMF forms were supposed to have measured whether loneliness and isolation had changed six months after an intervention but the forms were completed by only a minority of users - see Section 4 Evaluation Methodology (above) & Section 6 Discussion on CMFs (below)

b) Despite many efforts no social worker who had made at least one referral to the CN service was available for interview, despite Social Services being the second largest referral agency and considered key in identifying isolated and lonely people.

As an outside evaluation team we found it difficult to capture the client's voice and these are the potential issues:

- how to avoid selection bias so that not only people with success stories are recruited to be interviewed;
- how to approach people from a cross section of the areas and social strata;
- how to overcome possible reluctance on the part of recipients to being interviewed by an unknown researcher.
- if the person is interviewed by a member of the CN team how likely is the person to raise any negative issues about the service
- how can anonymity be guaranteed?

Other methodological issues may pose difficulties e.g. gaining informed consent and the appropriateness of interview venue. We were only able to interview three clients on their own and these were selected for us by the CN manager. Apart from these three case studies, to gain the "client's voice", we could only rely on secondary sources like "pen pictures" within interviews with CN staff, referrers or "end" organisations, or find written case studies completed by CN staff.

There were two things we would have done more thoroughly if time had not been an issue:

- More rigorous analysis of the available CN records: quarterly activity sheets, the minutes of the CN Coordinators meetings and the BCH steering group minutes. The latter might have enabled us to understand more fully what the service had achieved and why the steering group appeared to work, in comparison with the other provider which had not had previous success in setting up steering groups including local people although they consulted in other ways.
- More visits to "end organisations" to understand the limitations of what they can achieve, what they do best, what sort of future relationship they would envisage with service deliverers and to debate the issue of quality assurance.

CMFs

As mentioned in the Methodology section, there were difficulties in obtaining comprehensive CMF data through self-completion of forms by the service recipients at all of the intended three stages of the intervention and this limited the amount of robust quantitative data available to test service outcomes. A CN service manager explained that if the importance of the outcome evaluation process had been fully explained and CMF forms had been introduced to the prospective service providers at the service tender stage, their service model could have been designed to take account of the full CMF process requirements.

In practice the length of the form - intended for self-completion - was intimidating for some people, with 37 questions to be answered on the wellbeing form. Some questions were felt to be insensitive and a few people refused to complete it, others became visibly upset by the questions; CN's also felt the sensitivity of some questions interfered with building their relationship with the person. It is possible this sentiment affected the way CNs promoted completion of the CMF's.

Return rates of the registration (46%; n=412/903) and follow-up forms (18%;n=162/903) were problematic despite great efforts by the CN service to remind and incentivise people to return the forms (one service provider employed extra, un-budgeted for, administrative support to do this work).

Nevertheless Community Navigators were cognizant of the need for some data collection and said their clients also appreciated that there should be some indication whether the service makes a difference. The CNs made suggestions for improvements:

- to use a much shorter form by rationalising loneliness and isolation scales to improve uptake and return
- to ask what had helped to bring about any change
- to measure changes in confidence and feelings
- to use numerical scales rather than descriptive scales
- the time frame for gauging any sustained change needed to be much longer e.g. after a year
- planners of future CN services factor in sufficient resources to collect and analyse appropriate quantitative data from the beginning of both delivery and end organisations.

In future we would argue that CN training should include how to positively introduce evaluation tools which will ask sensitive questions at the outset of their relationship with the person. We note that the Common Outcomes Framework for Social Prescribing developed by NHSE and Social Prescribing Network (SPN) recommend the new link workers use just one wellbeing scale.

Despite all of the problems there were enough completed matching questions on entry and exit forms of the service to indicate some

statistically significant improvements in loneliness and in well-being scores attributable to the CN service. The service participants were offered a maximum of 6 sessions over a relatively short period, generally of no longer than six months, and the CMF exit forms were administered shortly after discharge from the Community Navigator's intervention.

This is a very short time frame in which to gauge long term changes, particularly if the person has experienced long term isolation and loneliness and possibly additional problems. Nonetheless these early results are encouraging in that they do indicate some positive change in loneliness and wellbeing for some participants.

IN SERVICE EVALUATION

As described in Section 4 Evaluation Methodology, both Community Navigator services designed and used their own client feedback questionnaires in addition to the CMF exit form. Various methods of administering the feedback questionnaires were tried following a poor return rate by post. The two CN providers had different approaches:

- NBAC acknowledged that feedback was important but felt the best method had not yet been found. It was time consuming to collect, difficult to analyse and needed more resources than available to their organisation.

- BCH's CN service had the advantage of being able to utilise their organisation's Performance and Administration team to analyse and graphically display their results. The service also kept an electronic referral database with easily extractable information and could use the BCH organisation's EMIS medical record system to retrieve some further outcome data.

Eventually both services decided to contact the person by phone and use a volunteer to ask the questions if no response was received by post. This rendered more responses but was not anonymous which could have influenced responders' answers.

How both organisations tackled this issue illustrates the advantages afforded to larger provider organisations which have IT systems linked to medical notes and trained personnel to assist with evaluation. It poses the question as to how smaller organisations without this technology, expertise and resources can provide robust evidence for their own in-house client feedback exercises and this should be considered at service planning stage. Case studies done by CNs provided invaluable vignettes which illustrated their work and successes, and these were used in our evaluation; however selection bias cannot therefore be discounted.

BENEFITS OF HOME VISITING

A major theme in our findings was that the barriers to dealing with loneliness and isolation are far more complex than had been anticipated when the service was first commissioned (see Question 2). This issue has been identified in other learning[1] from Community Connector services. The statutory services no longer provide those preventative services, which would have enhanced quality of life and reduced those barriers. The CNs became involved in work which might have previously been done by social and health care staff; e.g. arranging for ramps and handrails, de-cluttering, low key talking therapies benefit advice, re-housing etc.

Footnote: **1** https://www.redcross.org.uk › connecting-communities-learning-report

The curtailing of statutory intervention, except at the point of crisis, has four impacts on how a CN service needs to be designed with:

a) targets for the number of people supported should be realistic and based on maximum intervention periods (6 sessions or more for the CN service) rather than quick-fix signposting. [Note: at one point referrals were closed to avoid unreasonable waiting times].

b) high quality recruitment processes to find the skills required by paid and unpaid CNs i.e. very sophisticated skills to engage with the psychosocial problems often presented within a context of complex systems in housing, care and health services.

c) investment in training to cover the broad range of knowledge required to communicate effectively with local statutory and voluntary services to resolve practical issues impeding social engagement.

d) supervision and support which are not optional extras but the mainstay of a service which looks after its staff and minimises stress levels.

The offer of a home visit gives the CN the benefit of picking up on additional issues, such as described above, giving the opportunity to get these issues addressed before other actions to ameliorate loneliness and isolation can take place.

In this respect the service differs from Bristol's similar social prescribing services, which are delivered to people aged 18 years and over, as their link worker appointments are mainly offered at health care premises and rarely at home.

In Bristol there are other similar services to the Community Navigators which also provide home visits. One is called First Call Support at Home, provided by the British Red Cross and funded by the Clinical Commissioning Group. First Call Support at Home is for people over 18, is provided free of charge and has paid and volunteer support workers who can offer short term support (up to 12 weeks), signposting, practical assistance and accompanying to activities. However the service is mostly offered to people recently discharged from hospital, or to people following a period of illness or crisis which has caused a change in circumstances; people with long standing issues are likely to require referring to specialist agencies, including to CN teams.

Given that existing social prescribing services in Bristol rarely do home visits, usually only in exceptional circumstances, and First Call Support at Home has no additional funding to expand, there is no alternative equivalent to the current CN Service for older people.

ACCOMPANYING TO ACTIVITIES

The CN's help not only includes introducing people to activities but also provides an element of 'hand holding' in order to overcome any barriers to attendance [see Section 5 Findings Question 2 (above)]. The fear of the unknown and anxiety about fitting in with others is often a barrier to older people taking the first step to socially engage. It has been a reoccurring issue in the BAB Community Development for Older People projects too (see BAB Community Development for Older People Evaluation Report). A more nuanced approach might also include paying attention to people's perceived deep-rooted fears and more importantly their social identity (see Goll et al, 2018). This article recognised that fears about perceived safety in social situations may be so profound that people develop behaviours over time to *maintain* isolation and convince themselves that this is a normal protective

response. In these cases sometimes a referral to talking therapies can enable people to socially re-engage.

NATIONAL AND LOCAL SERVICE PROVISION – A STRATEGIC APPROACH

The findings in Section 5 Question 3 (above) illustrate the aspects of the social environment which impinge on the success of the CN service. There are two issues which require a strategic approach and leadership by national and local commissioning bodies and major charitable funders, as the issues lay outside the scope of a CN service itself.

Firstly, we want to emphasise again the importance of transport. CNs and some of the service user feedback suggested that one reason for not attending activities was either the lack of availability of transport which met the physical and psychological needs of the user, or its price. It is suggested until there are national changes in the current deregulation of bus services, outside London, that pro-active steps are needed to ensure that there is affordable community or commercial transport available, either as a one-to-one service or based on adapted minibus services.

Secondly, the local spend of statutory and charitable funds should be co-ordinated so there is an equitable spread of resources throughout the city. For example there is an uneven spread of "end organisations", including befriending organisations which do not cover the whole city area. BAB, in the setting up of its micro-grant scheme (Community Kick-Start Fund), was exemplary in deliberately promoting the scheme so every area received some funding, albeit that most went to inner city areas. However statutory and charitable funding sources are not just about supporting "end organisations", but also about the distribution and accessibility of other support services which challenge the barriers to overcoming isolation and loneliness: benefit advice centres and surgeries, de-cluttering services, talking therapies for low level but enduring psychological conditions, etc. Ten years of austerity has had a negative impact on these support services, a dearth of which make a CN service harder to deliver.

We would suggest that the availability of such support services would be resourced according to the principle of "proportionate universalism" i.e. in scale and intensity proportionate to the scale of need (NHS Scotland, 2019)

Making these services accessible and available to all parts of the city, taking into account the current transport resources as well, would benefit all citizens. The principle of a universal service would also remove the stigma which might be associated with using it.

VOLUNTEERS IN SERVICE DELIVERY AND DEVELOPMENT

Case Study: Kathy

Kathy joined the Community Navigators Bristol steering group (for services in Central, South and East Bristol) because "it hit home with me," she says. "I have been in that situation, lonely and isolated, so I understand completely how people might be feeling. I felt I could offer a lot of insight and support to the navigators and people they work with."

In her role on the steering group Kathy, who is visually impaired, helped the CN service make improvements to the accessibility and inclusiveness of the new Community Navigators Bristol website: for example, now the colour scheme is a more accessible colour palette. This better awareness of colour contrast has also helped to improve the readability of printed leaflets.

Other changes to the website include:

- An 'Accessibility' page has been added which gives users the option to get in touch for information in another format
- Information about how to change font size and display appearance etc.
- the appearance of links has been changed so it's more obvious that they are clickable.
- making sure that all the images have appropriate 'alt text' behind them. This makes sure sight-impaired screen readers can provide a meaningful description of the images.

From: http://bristolageingbetter.org.uk/case-studies/

As with many voluntary organisations where "coaching" is an element of the service, the addition of volunteer CNs enabled the service to reach more people by taking on more straightforward cases, leaving the more complex for paid CNs. The positive spin-off, of course, is that it also offered people with spare time an opportunity to make a contribution to local community life. Our findings would support the view that volunteers can play a big role in any future CN/social prescribing service, but with one important caveat: that there is adequate training and support.

Both service providers had a track record of consulting with relevant communities about their services, and had done so prior to the CN application. After their successful bid, BCH set up a steering group, with 50% of its members over 50; it was seen by the Lead Manager and the CN Coordinator as a valuable body. We did not investigate how and why it was seen as successful but the case study above provides an insight into the potential of untapped knowledge and skills in the community. In

these contemporary times when it is seen as good practice to involve non-professional perspectives in service management, we felt it would only have a positive effect. We would hope that future CN services would aspire to volunteer involvement being partnership-based rather than at the level of "Tokenism" as described in Arnstein's model *'A ladder of Citizen Participation'* 1969.

CHALLENGES OF QUALITY ASSURING "END" ORGANISATIONS

The "end" organisations are a crucial part of the success of any CN service [See Section 5 Findings Question 5 (above)]. Given that the referral process to an "end" organisation is part of the service there is a question about whether the CN providers have a responsibility to quality assure these organisations prior to referral. A Lead Manager expressed regret that no monitoring or quality assurance systems had been put in place in respect of "end" organisations. The people who use CN services are certainly entitled to believe that the service they may be referred to is at least safe and benign.

This was not an area we evaluated. Some of the relevant issues a quality assurance system might want to address include:

- a DBS (Disclosure and Barring Service) checks of paid staff and volunteers, including casual drivers
- health and safety of the building and its access
- vulnerable adult protection procedures,
- risk assessment of the activities
- the stability of the underpinning finances and management so that the activity would not immediately stop functioning.

However monitoring and quality assurance systems should be considered within the context in which "end" organisations operate: very many of the most successful organisations helping people to "re-connect" into a social life again are small, many with minimal insecure financial backing, and frequently run by volunteers who would be put off by large amounts of monitoring and form-filling. Yet usually these small groups are well run and deliver high standard services, but often without the record keeping required by quality assurance systems. Most people in the voluntary sector are altruistic and passionate about what they do – this enthusiasm could easily be killed off by over-bureaucratic processes which frequently may reveal little.

The issue might be addressed in part by the statutory and national funding sources ensuring that community development organisations in Bristol have the resources to provide:

- support, training and knowledge about safety aspects of delivering any service to vulnerable people
- make that available to both large and small groups at affordable costs.

As part of partnership working with the voluntary sector, it is incumbent on the commissioners and providers of CN services to work with "end organisations" to find a way of setting standards which are in the interest of everyone, and easy to monitor – and passing that knowledge on to new "end" organisations as they emerge.

"END" ORGANISATIONS' APPROACH TO DELIVERING ACTIVITIES TO THE SOCIALLY ISOLATED

We were struck by the way many end organisations took care to ensure that people who were lonely and isolated were welcomed to the group - see Section 5 Findings, Question 4 (above) and also BAB Community Kick-Start Fund Evaluation Report (2020).

The article *Barriers to Social Participation among Lonely Older Adults: The Influence of Social Fears and Identity* (see Goll et. al., 2018) prompted more thought about the concept of "social isolation" (as opposed to "loneliness") and the implications for the development of relevant "end" organisations.

The article recognised the role of social identity as a barrier to social interaction, in particular where the individual does not want to be seen as "old" or "dependent". So any activity which hinted at old people being present or the neediness of the participants would be a turn-off. For some their identity might be aligned instead with a religious faith, a professional identity or education levels. A skilled CN would recognise these identities, but the implications are for the "end" organisations. They need to understand how to challenge the inherent ageism in our society and promote activities that remove the stigma of ageing. For example, activities which might be participant-led and based on shared values of interdependency as well as independency. Activities could also be focused on different identities e.g. faith groups, artistic creativity, being invited to offer help or where seeking support is validating rather than challenging the person's view of personal independence.

We felt that this was an issue which commissioning bodies might want to explore with organisations who wish to provide opportunities for lonely people to re-engage.

AFTERCARE

Case closure on completion of the Navigator intervention will not necessarily resolve all the issues which brought about referral in the first place. To avoid dependency and to keep capacity within the service to deal with new referrals in a manageable way, the services recognise that they have to have a limit of a maximum of 6 face to face meetings, although some flexibility is agreed in a few cases.

The services reported that although in practice very few clients re-refer once they have been discharged, some may request or need further support. In such cases these will usually be dealt with by phone rather than re-opening the case with further face to face meetings. In very rare cases (single figures) e.g. changes in health conditions, clients were given further visits over an extended period of time.

Clients' social re-engagement may not go to plan for a variety of practical reasons. They may be unable to continue to participate because of illness, transport or financial issues. They may simply find the chosen activity is not, after all, 'for them'. The activity itself may have ended or closed down.

Or the client continues to lack the confidence and capacity to engage in social contact which may alleviate their loneliness. The report[2] 'Hidden Citizens - How can we identify the most lonely older adults?' by the Campaign to End Loneliness and the University of Kent, finds that:

Footnote: **2** https://www.campaigntoend-loneliness.org/wp-content/uploads/CEL-Hidden-People-report-final.pdf

Lonely adults are more likely to have poorer social skills and express anxiety when anticipating social interaction.

Both services recognised that very complex cases need longer term support to develop the resilience to re-engage socially. In such cases the key to continued engagement may lie with an end organisation to which the client is referred. An important factor will be whether the group is willing to provide a link person to ensure the client is supported psychologically - and sometimes practically - to continue to attend independently after the initial visit when they are accompanied by the CN. There needs to be agreement with the client about how much they want revealed to the end organisation about themselves before they are introduced. Alternatively referral for one to one befriending may be more appropriate as a gentler lead into more social activity and where the client has more control.

With a view to reducing the likelihood of future reliance on the CN service, each service developed a closing session proforma to work through with the client in order to put on record personal aspects of their CN experience:

- Completed activities or actions
- Goals to take forward
- Useful contacts details - Who? Where? Why?

This is practical - a reminder of what the client has achieved, an underlining of what they would like to do to move forward and the information they may need to get help from sources other than Navigators in future.

One of the volunteer CNs suggested that long term closer integration with other services might enable smoother transition for service users. This idea is also reflected in one of the recommendations in the report from British Red Cross and Co-op 'Connecting Communities to tackle Loneliness and Social Isolation'[3] with reference to both to the complex needs of the lonely but also to gaps in the community infrastructure.

Connector services should be planned and developed in the context of a wider web of services and support for people experiencing loneliness and social isolation in the community, and mindful of what other services and support exists for people with complex needs.

Footnote: **3** https://www.redcross.org.uk › connecting-communities-learning-report

7. Recommendations »

1) Staff training and support

To manage the complexity of the barriers which contribute to loneliness and social isolation. For both paid and unpaid staff, sufficient training and support is not an option – it is a necessity.

2) Use of volunteers in service delivery and service development

Trained and supported volunteers can play a useful role in supporting the paid workers and thus extend the reach of the service as well as enhancing service management.

3) Common conditions of service

Where there is more than one service provider, common conditions of service and job descriptions lay a foundation for co-operation and a common branding of the service.

4) Investment in the social infrastructure

There two aspects of the social infrastructure which require funding and resources from outside the CN service itself:

a) Ensure that there is a sufficient number of client support services like de-cluttering, installation of aids and adaptations and “talking therapies” for mild depression and issues of self-esteem, to enable timely access.

b) Develop a pro-active environment for “end” organisations to flourish:

- There is a clear access to finance and non-financial resources to develop and expand activities, including access to training and support for services working with vulnerable adults
- Commissioners and providers of community navigator services should work with the voluntary sector to consider developing an effective quality assurance system which is not burdensome or stifling to local initiative.
- Set up a dialogue with potential ‘end’ organisations’ about the basic requirements to make activities relevant to the socially isolated.

5) Transport

Although part of the social infrastructure this is such an important issue - invariably top of the list of major reasons why people can find it difficult to re-engage in social activities. Investment and a more efficient design needs to be put into place to ensure that there is reliable and affordable community and personal transport available for those who cannot use a bus service nor have access to a car.

6) Partnership working

Relationship with partner organisations must be established from the start. Clear accountability structures and mutual expectations need to be recognised and documented and sufficient time built in for review meetings and collaborative exchanges.

7) Home visits

Any new Community Navigator service designed for people over 50 should include the option of home visiting as this element allows for a more tailored assessment of needs, which may include referrals to other agencies to tackle additional issues impeding the person from addressing isolation and loneliness. Lack of home visits risks exclusion of some of the most lonely isolated people, including those with hearing, sight or mobility impairments or people suffering serious anxiety and lack of confidence.

8) Accompanying to activities

The facility to accompany anxious, isolated people to activities and groups is an invaluable element in the success of the CN service and should be available in future provision of the CN service for this client group.

9) CMFs and evaluation methods

Appropriate measurement tools for evaluating Community Navigator services need to be shorter in length, more comprehensible to participants and measure levels of confidence and wellbeing through user-friendly language.

New Community Navigators should receive training on the importance of evaluation methods including discussion on ways to positively engage people in the evaluation process, which will require having to ask sensitive questions at the outset of their relationship with the person.

10) Service user evaluation

To maximise learning, service providers should agree a common evaluation framework which is effectively resourced.

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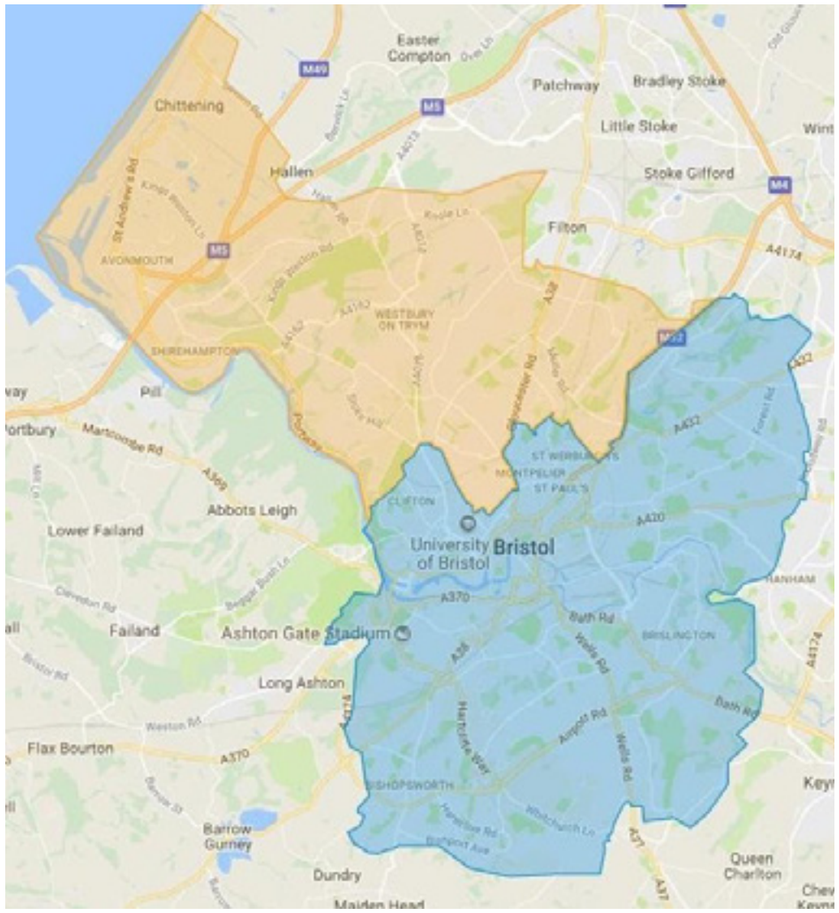
9. Appendices »

APPENDIX 1

Map of areas covered by Community Navigator Service in Bristol

Key: Blue area = Provided by Bristol Community Health

Beige area = Provided by North Bristol Advice Centre



APPENDIX 2

a) Role of Partners in Central & East Bristol Community Navigator Service

Name of Organisation	Role in Service Delivery	Number of CN Service Employees
Bristol Community Health	Lead Delivery Partner Volunteers will be recruited, inducted and trained by BCH;	1 x FT Service Coordinator (covering Central, East & South) 1 x 0.6 Navigator (Inner Central & East) 1 x 0.2 Admin Support
The Care Forum	Will identify resources and groups within each of the neighbourhood partnerships, which may be formal, informal or peer led, to find out how they currently support older people, any issues or problems they face, how they would like to work more effectively with older people, and what support they need to be sustainable. TCF will advise groups on how they can access additional support through BAB or other services, will find out where the gaps in service provision lie and work with other providers across the city to identify ways to meet these unmet needs.	2 x P/T Community Development post [Note: subsequently reduced to 1 x 0.5 post following underspend due to staff changes at The Care Forum]
Barton Hill Settlement	Barton Hill Settlement will bring significant expertise to the partnership on mapping community assets, capacity building and working with partners to develop new services. Employ 1 expert Navigator.	1 x 0.8 paid Navigator [East]

b) Role of Partners in South Bristol Community Navigator Service

Name of Organisation	Role in Service Delivery	Number of CN Service employees
Bristol Community Health	Lead Delivery Partner	1 x 0.7 paid Navigator based 1 day/week at SCDA
The Care Forum	Will identify resources and groups within each of the neighbourhood partnerships, which may be formal, informal or peer led, to find out how they currently support older people, any issues or problems they face, how they would like to work more effectively with older people, and what support they need to be sustainable. TCF will advise groups on how they can access additional support through BAB or other services, will find out where the gaps in service provision lie and work with other providers across the city to identify ways to meet these unmet needs.	See Appendix 2 a) above
Southville Community Development Association	Community Base of 'Expert' community navigation for older people with complex needs. The Southville Centre is a modern community centre run by the SCDA, which provides support to local groups and the community in wide and diverse ways, including a range of community services for older people	

APPENDIX 3

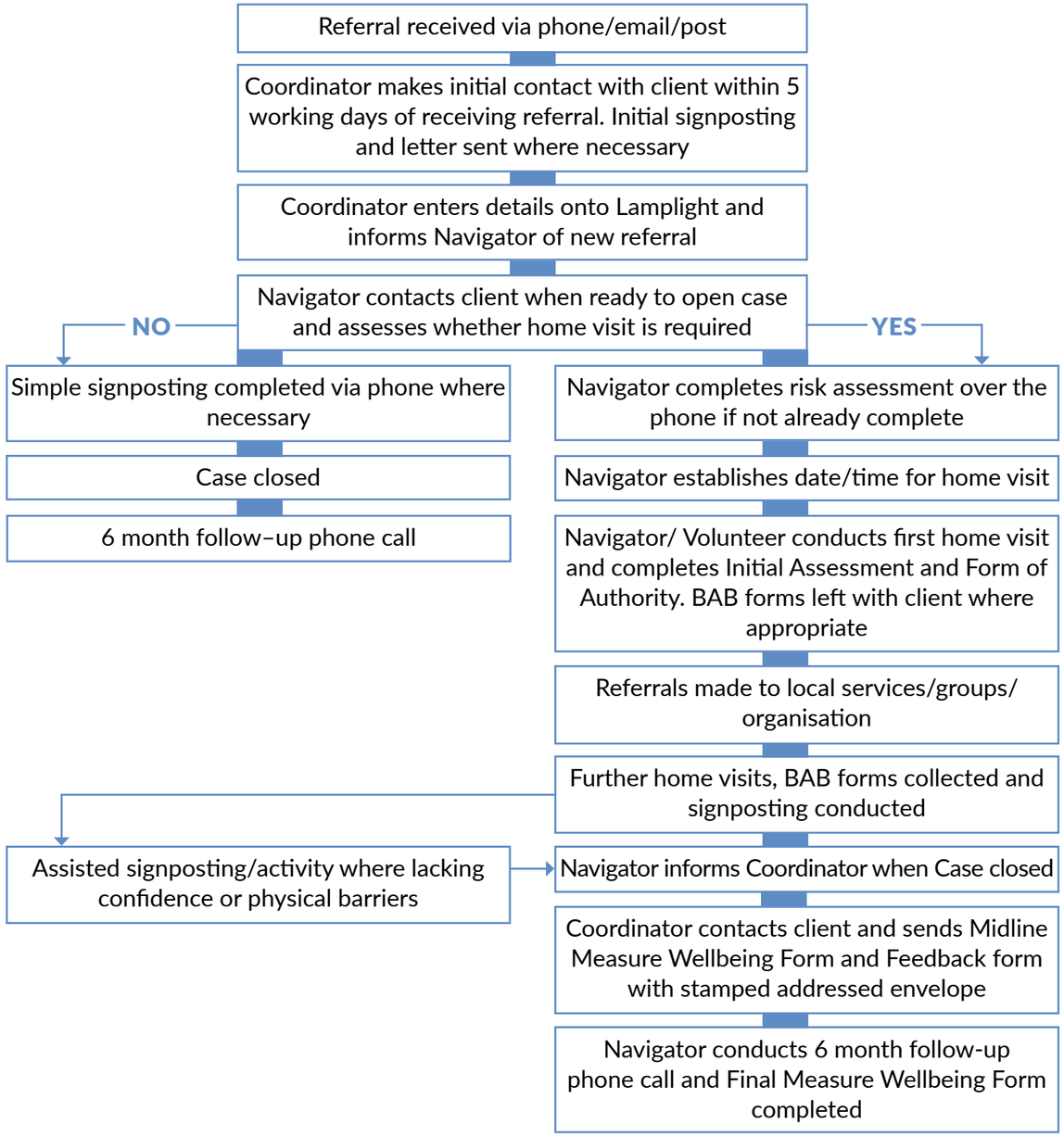
Role of Partners in North Bristol Community Navigator Service

Name of Organisation	Organisation's Role in Service Delivery	Number of CN Service employees
North Bristol Advice Centre	Lead delivery partner. Design, develop and deliver all aspects of CN service. CEO to supervise Service Coordinator who manages the service.	1 Community Navigators (P/T) + 1 Community Navigator who is also the Service Coordinator and manager of all Community Navigators.
Southmead Development Trust	To employ and co- supervise 2 CN's. Provide meeting room and desk space, IT & phone facilities for CN's Assist in service development through wealth of experience of working with older isolated people; Facilitate access & introduction to local networks, partner organisations, community & residents' groups and other stakeholders.	2 Community Navigators
Ambition Lawrence Weston	Host organisation for CN's offering desk space, meeting rooms, IT facilities, informal supervision, access and introductions to local organisations, older people's groups, community and residents' groups and stakeholders.	0
Shirehampton Community Action Forum (SCAF)	Host organisation for CN's offering desk space, meeting rooms, access and introductions to local organisations, older people's groups, community and residents' groups and stakeholders.	0
Avonmouth Community Centre	Host organisation for CN's offering desk space, meeting rooms, access and introductions to local organisations, older people's groups, community and residents' groups and stakeholders.	0

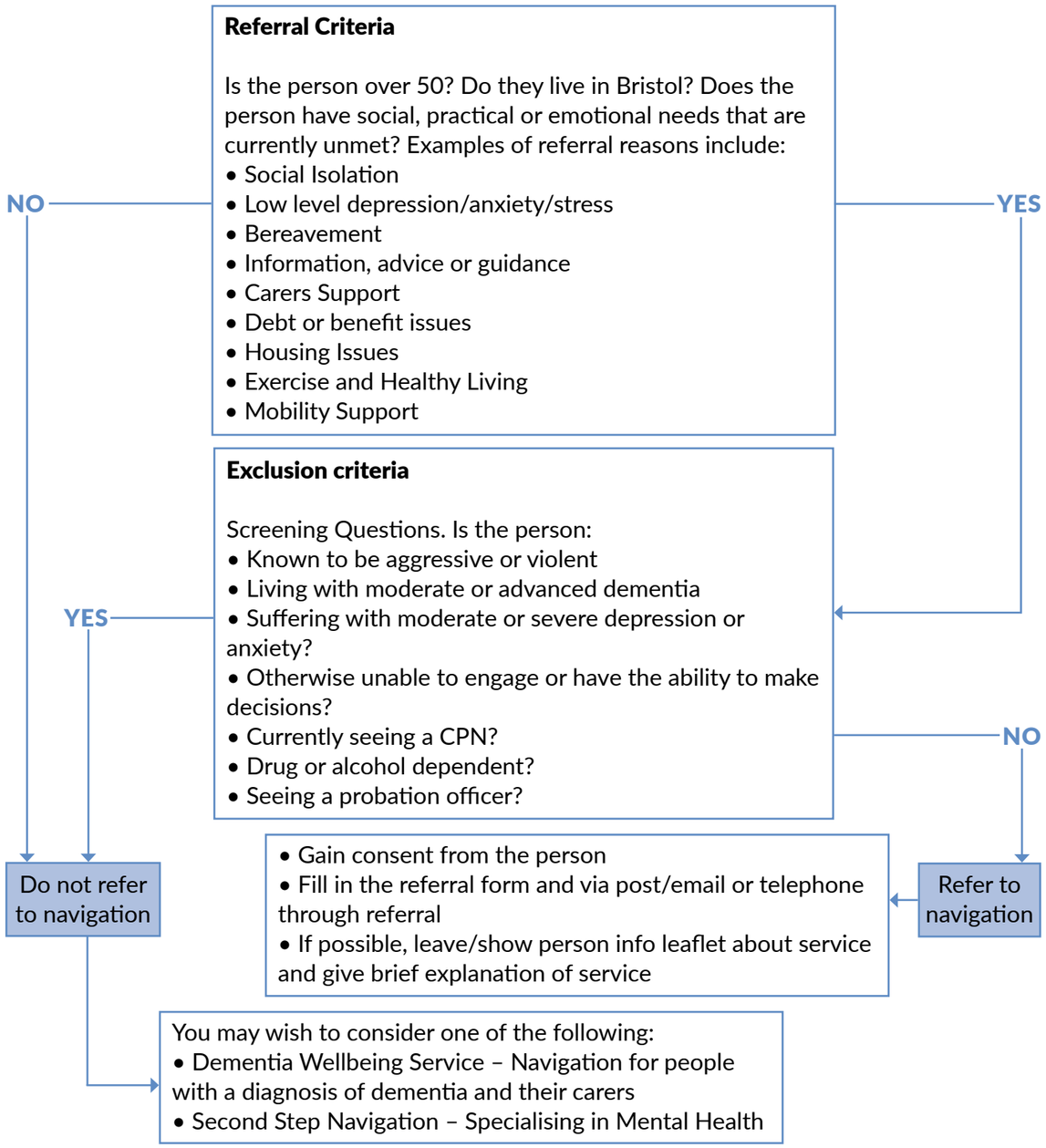
APPENDIX 4a

Community Navigator Referral Process

Simple signposting = information given with no support required
Assisted Signposting = Navigator/Volunteer support required to access services or activities



APPENDIX 4b



APPENDIX 5

List of referrals by category

Total number of referrals received 01 July 2017 – 30 June 2019

	Number of referrals	Percentage
Community health	225	18%
Self, family and friends	231	18%
Social prescribing	177	14%
Social services	173	14%
Miscellaneous	116	9%
GP / NHS	77	6%
Care coordinators / CRL	67	5%
Mental health	62	5%
Unknown	63	5%
Housing support	43	3%
First Contact Checklist	35	3%
Advice services	4	0%
Re-referral	6	0%
TOTAL	1,279	

APPENDIX 6

First Contact Checklist Project

The Bristol Ageing Better First Contact Checklist scheme is a partnership of agencies in Bristol including: Bristol City Council, Avon Fire and Rescue Service, and other advice agencies and charities. The project is administered by The Care Forum.

- 14 organisations are signed up to provide relevant help and advice to people over 50 in the following areas: Home safety; Health & Wellbeing: Advice & Financial Advice.

- Referral is via a First Contact Checklist form which includes a list of different services which may be referred to, and a box for the person referred to sign to say they give consent to the referral. Other details e.g. disability, access to the dwelling can be included so as to make the referral more useful.

- Referrals can be made by other agencies to First Contact Checklist either online to: https://www.wellaware.org.first-contact or via a secure email to: firstcontact@thecareforum.org.uk. Individuals can refer themselves online or via a 1st Contact leaflet, available in community places, e.g. libraries and GP surgeries. Referrals are received from a variety of agencies, particularly the Carer's Support Centre and BCH (COPD teams and nurses for older people).

- Referral forms are sent to First Contact Checklist at The Care Forum which then sends them by secure email to the requested organisation(s) or agency.

- The First Contact Checklist project makes phone contacts with the referred person after 2 – 3 months to enquire if the requested service(s) have been in contact and gather feedback.

- On average the First Contact Checklist project gets about 15 referrals /month, 37 were forwarded to the CN service from July 2017 up to 31.07.19.

- Both CN Coordinators and the CN staff based at The Care Forum attend First Contact Checklist Steering Group meetings and so have a say in how the scheme is working.

APPENDIX 7

Quotes from referrers, CN's, end organisations and volunteers illustrating the degree and variety of support needs of clients

From Community Navigators:

- 'I try to involve clients in making arrangements so as to build their confidence to do that in future but rarely does it work as many people have too many problems and they need someone organising them or it can all fall down'.

- 'I have been surprised at the levels of anxiety and depression in the older people I'm seeing'.

- 'People from 50 – 70 years assume that retirement will be fine but often become depressed with a lack of purpose and isolated from friends who perhaps are still working. These people still have an active life and could do volunteering or mentoring or learning new skills. For 70 plus some people would never have been 'joiners' so going to a new activity could be quite difficult. There are also practical barriers, e.g. mobility, incontinence'.

- 'Social prescribing has limitations and is a top-down medical model – do they case manage and provide support and follow up? Need to ask people what they want which is the main principle of the Community Navigators. Need to encourage people to self-refer and encourage the use of Twitter to get the message out'.

From Referrers:

- A GP Care Coordinator: 'Yes, it's a very useful service especially for people who are reluctant or lack confidence to undertake or join activities'.

- 'The CNs have been better at unpicking the complicated referrals.'

- A NHS Counsellor said that she referred mainly people of retirement age or people she had seen with complex grief following bereavement. The counsellor observed 'that a talking service is not necessarily the right thing; there is a need for a befriending service'.

- A tenancy impact officer said that she felt 'the service most appropriate for people 75+ who have lost their mobility, confidence, live on their own and have fewer visitors'.

- A mobile warden commented that 'the CN service was good if no family are visiting'.

From end organisations:

1. ‘many attendees live on their own and/or are bereaved’.

2. said they were not specifically set up for the lonely and isolated. ‘Their role is prevention, not rescue’.

From volunteers:

1. ‘getting people outside, even nowhere in particular e.g. Leigh Woods, can help them begin to remember what they want to do’.

2. Another volunteer said that many clients have low confidence, low self-esteem and are nervous of trying something new. He estimated that out of the 13 clients he had worked with up to his CR interview; ‘about a third don’t go out because of their state of mind – they’re anxious and nervous about the unknown, about seeing new people’.

APPENDIX 8

Tender Submission Q5 from NBAC

Q5: Please describe how your proposed project will identify isolated and lonely older people and how you will develop referral pathways with other organisations.

Weighting: 5% Word limit: 300 Words.

Will identify isolated and lonely older people through a combination of referrals, outreach activities and using test and learn methodology to find innovative ways of identifying the most hard to reach. Challenges include:

- Reluctance to seek assistance (particularly men)
- Lack of knowledge of local services
- Lack of money
- Lack of confidence to try new things
- Poor physical and/or mental health and/or impairment
- Transport and access issues
- Not engaged with existing services so “invisible” to providers.

In year 1 we will work with partners to develop new referral pathways across all areas. All partners have existing strong links with key agencies and organisations in their communities. For example CSaH currently receives referrals from GPs, community nurses, advice workers, health centres, BCC and community groups while SDT and ALW have strong links with local GPs and community groups. The project manager will oversee asset mapping of all areas and development of referral processes and protocols. All referrals will be recorded and monitored on our database. Clients with complex needs will be referred to paid CNs. Pathways will include:

- Sheltered housing
- Churches/Faith groups
- GPs
- Home Care
- Community Nurses

- Social Care
- Housing associations
- Community/VCS groups (e.g. Bereavement).

In years 2 and 3 will utilise test and learn methodology to identify and engage most isolated and hard to reach. Methods to be decided based on learning in year 1, using information gathered at mapping stage to identify previously unexplored referral routes and through co-production with older people and volunteers. Examples: Hair salons; Supermarkets; Public transport/buses; Charity shops; Bingo Halls; Meals on Wheels; Dosett box deliveries; Betting shops.

We will work with other regions to maximise learning and avoid duplication and will ensure services link in with other initiatives (e.g. BAB's Community Webs and Community Development; Building Better Opportunities) to maximise effective working.