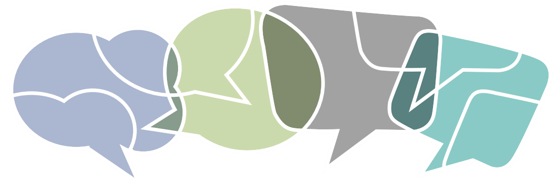


How successful has the Connect Hackney 'Connector' model been?

An in-depth study of the Community Connectors project for older people in Hackney living with or at risk of loneliness and social isolation

INTERIM REPORT

Report prepared by: Angela Harden and Darren Sharpe, Institute for Health and Human Development, University of East London (UEL)

(May 2020)

Contents

Report summary	3
1.0 Background	5
2.0 Research Questions	6
3.0 Method	7
4.0 Findings	10
5.0 Discussion	20
Appendix A: Further background evidence, policy, and learning relevant to Community Connectors projects	23
Appendix B: Further details on the Connect Hackney Community Connector model	25
Appendix C: Indicative operational research questions and lines of inquiry for fieldwork topic guides	26
Appendix D: Summary of methods and findings of an online survey of Community Connector participants and external stakeholders	28
Appendix E: Interview guide for providers and participants	31
Appendix F: Interview guide for participants	36
Appendix G: Interview guide for external stakeholders	38
Appendix H: Socio-demographic and baseline outcome profile of participants	39

Report summary

Background

'Connect Hackney' is one of 14 'Ageing Better' programmes across England aiming to tackle social isolation and loneliness amongst people aged 50 and over.

Connect Hackney has commissioned a Community Connectors project as part of its programme to support already socially isolated and lonely older people to (re)connect with the people, activities and services within their local community.

The Community Connector model has much in common with social prescribing. Models of social prescribing vary, ranging from a 'light touch' signposting of participants to community activities through to a coaching type of intervention delivered by a 'link worker' (or 'navigator'/'social prescriber').

The Community Connector model in Connect Hackney is a one-to-one coaching intervention delivered by link workers called community co-ordinators. Unlike many social prescribing schemes, the Community Connector model is located within the community rather than in primary care. Statutory, third sector and private sector organisations can refer participants to the project or participants can self-refer. Although research on the effectiveness of social prescribing has shown mixed results to date, this social intervention is currently being rolled out within the UK National Health Service.

Aims

The research described in this report is part of a broader local evaluation[1] of the Connect Hackney programme. The evaluation is guided by a set of eight test-and-learn questions. One of these questions is focused on whether the community connector model has been able to support older people living with or at risk of social isolation and loneliness to take part in community activities and projects:

> *"How successful has the Connect Hackney connector model been to recruit and retain older people living with or at risk of social isolation and loneliness in sustained activities?"*

1 A national evaluation of the whole Ageing Better programme across the 14 areas in which it is implemented is being conducted. The local evaluation will complement the national evaluation by providing more in-depth contextual data and understanding.

To contribute to answering this question, a small-scale, in-depth study of how the Community Connector model is working in Hackney is being undertaken. Key areas of inquiry are: the reach and referral process, engagement and retention of participants, project, implementation and adaptation, the impact of the project on participants, and the wider local context in which the Community Connectors project is operating.

This report presents the findings from the data collected so far. As of December 2019, qualitative data has been collected from seven out of a planned ten participants, three out of a planned five providers, and three out of a planned four external stakeholders. We had also planned to interview up to five volunteers working within the project, but these were not undertaken due to the low numbers of volunteers active within the fieldwork period. Available quantitative data from 67 participants has been analysed. Follow-up interviews to qualitatively assess participants journeys and project impact over a longer period are planned for 2020. The findings presented in this report should therefore be regarded as tentative, and this report will be updated once the outstanding data has been collected and analysed.

Methods

Multiple methods were employed in the study's design:

1) interviews with the Community Connectors project team;

2) interviews with participants (follow-up interviews to be completed);

3) interviews with external stakeholders, and;

4) analysis of anonymised quantitative socio-demographic and outcome data collected from

participants by the provider. It had originally been planned to undertake an on-line survey with external stakeholders, but a similar survey was already underway with stakeholders to feed into a review of social prescribing services in Hackney. The findings of this survey were shared with the research team and these are drawn upon as appropriate when they add value to the findings of this study.

Findings

The key findings from the study are summarised below. As noted above, these are initial findings which may change as more data becomes available:

- ***The Community Connectors project is reaching its target group of older people who are already socially isolated and lonely***. Compared to participants across the Connect Hackney Programme, project participants had less social contact, scored higher on measures of social isolation and loneliness, and were in worse health.
- ***Strategies used for reaching older people, as well as the neighbourhoods in which the project is based, are likely to impact on the diversity of project participants achieved***. Some groups of older people – such as those aged 70 and over, men, and those from Asian and other ethnicities – were less well represented amongst project participants. Targeted outreach strategies may be needed to better reach these groups.
- ***Targeted personal outreach to establish referral partners and offering the option of home visits were effective ways to increase the numbers of referrals to the project***. Personal outreach meant that members of the project team could engage directly with staff at referral organisations to help them understand who could be referred to the project and what the benefits might be. Home visits were a logical adaptation to the project to enable older people, not yet able to attend sessions in community venues, to participate in the project. There is now a waiting list for the project, and there are difficulties accommodating the increased demand for the service, especially with more home appointments (and the associated increase in travel time for community co-ordinators). These issues are causing a strain on resources which needs to be addressed.
- ***The personal qualities (e.g. approachable, non-judgmental) and skills (e.g. listening, empathy) of the community co-ordinators were crucial for engaging participants***. Participant interviewees reported that community co-ordinators were able to build trust, model a positive outlook, and support participants to plan and prepare for their participation in community activities.
- ***Retention could be challenging for participants with multiple or complex problems, but these could be overcome using a flexible 'open door' policy***. For example, poor health or benefit issues could stop participants engaging but they were able to put their sessions 'on hold' until they were ready to re-engage.
- ***One-to-one sessions between the community coordinator and participants were a powerful catalyst for change within the Community Connector model***. Positive impacts perceived by participant interviewees included: improved wellbeing (e.g. feeling more optimistic), self-esteem, and confidence. One participant summed up the impact of the sessions as leading to *'feeling human again'*. These findings resonate with both anecdotal evidence and learning from Community Connectors projects in other Ageing Better areas, as well as previous qualitative research on the relationship between social prescribing link workers and patients in primary care.
- ***The ways in which participants were supported into community activities were most effective when they were tailored according to participants needs, circumstances, and aspirations***. For example, provider interviewees highlighted step-by-step approaches working best with those that had been socially isolated for a number of years. Focusing on the activity worked better for those who did not like 'groups', and linking with community transport projects could help those with physical disabilities.
- ***No longer feeling alone through connecting, interacting, and sharing experiences with others was a key outcome reported by participant interviewees who had gone on to participate in community activities.*** Some participant interviewees reported that new friendships or networks had been developed. Others were simply enjoying the feeling of being noticed and remembered as a result of regular attendance at community activities.

- ***The confusion was found amongst some participant interviewees around the number of one-to-one sessions on offer.*** When these end, and how they fit alongside group and community activities, needs to be addressed.
- ***Partnerships with external organisations build reciprocity for generating and receiving referrals between projects, and each partner can build on the others work in developing a trusting relationship with the participants being referred***. There is an appetite amongst other voluntary and community sector (VCS) organisations not already working with the Community Connectors project to receive referrals from them. A perceived challenge to be addressed for those organisations within the Connect Hackney programme is who is 'credited' with the participant who is referred in and out.

Conclusion

Overall, this study found that the Connect Hackney Community Connector model can support older people living with or at risk of social isolation and loneliness into community activities, but the evidence so far is not yet clear on the extent to which this participation can be sustained over the longer term. The update of this report will analyse additional data, including qualitative and quantitative follow-up data, to explore further the role of the Community Connectors project in reducing social isolation and loneliness.

1.0 Background

'Connect Hackney' is one of 14 programmes across England aiming to tackle social isolation and loneliness amongst people aged 50 and over.

These programmes are funded by the National Lottery Community Fund under their 'Ageing Better' programme. The intended outcomes of the Connect Hackney programme are shown in Box 1.1.

As part of its programme of work to tackle social isolation and loneliness locally, Connect Hackney has commissioned a Community Connectors project to support already isolated older people to (re)connect with the people, activities and services within their local community. There is increasing evidence that participating in community activities is associated with a wide range of health and social benefits.[2] Community Connectors projects, defined as "any mechanism that works to identify isolated people over 50 and then works with them to help them transition from isolated to less isolated through person-centred structured support", are a key part of nearly all 14 Ageing Better programmes around the country.[3]

The Community Connector model has much in common with social prescribing. Models of social prescribing vary but usually operate within a primary health care setting providing a way for health professionals to 'prescribe' community activities and support to their patients.[4]

The Community Connector model can operate within or outside of primary care and, like many social prescribing models, involve a 'link worker'

Box 1.1: Connect Hackney programme outcomes

OUTCOME 1: Increased numbers of older people who are socially isolated engage in meaningful and enjoyable activities which result in new friendships, sustained networks, improved resourcefulness, more confidence and thus, ultimately, a better quality of life.

OUTCOME 2: Increased numbers of older people who are at risk of social isolation engage in meaningful and enjoyable activities which result in new friendships, sustained networks, improved resourcefulness, more confidence and thus, ultimately, a better quality of life.

OUTCOME 3: Embed an asset model towards ageing and older people, where the latter are more actively engaged in the community and valued for the contributions they make (updated October 2017).

OUTCOME 4: Increased direct involvement of older people and people as they age in shaping policy and holding key stakeholders to account, leading to stronger partnerships.

2 Fancourt D, Steptoe A (2019) The art of life and death: 14 year follow-up analyses of associations between arts engagement and mortality in the English Longitudinal Study of Ageing. BMJ; 367 doi: https://doi.org/10.1136/bmj.l6377

3 Ageing Better: Learning Report No 2 – Community Connectors. October 2018, p2.

4 Frostick C, Bertotti M (2019) Social prescribing in general practice. British Journal of General Practice. Nov: 59-39.

(or 'navigator'/ 'social prescriber') who provide one-to-one support to participants in a time-limited number of sessions. Suitable community activities and groups are identified for participants depending on their specific needs and aspirations. The link workers will then support participants to attend these activities.

The Community Connectors project commissioned within the Connect Hackney programme[5] has the characteristics of a high-intensity model in the Ageing Better classification of Community Connector models. It provides support to people whose isolation may be compounded by particular stressful life events, acute or chronic health conditions (including mental health conditions), and provides sustained one-to-one flexible support over a three month or more period.[6] Participants receive up to 12 one-to-one sessions delivered by link workers called 'community co-ordinators'. The community co-ordinators use motivational interviewing and positive psychology to build participants' confidence and motivation to engage with local community activities. Together, the participant and community co-ordinator create an action plan to guide their work together including planning for which activities they might attend, at what point, and with what support.

There is currently great interest and significant investment in social prescribing at both national and local levels. An ageing population, multiple long-term-conditions and growing health inequalities have put pressure on primary care which provides about 300 million patient consultations each year. There has been a sharp rise in GP consultation rates, 20% of which are driven by social problems such as social isolation, lack of employment, debt, and poor housing. Social prescribing and community connector models offer a way to alleviate these problems by improving social and health outcomes and, ultimately, relieving pressure on stretched health and social care services. In Hackney, plans are underway for the implementation of the Primary Care Home[7] and, as part of this, a borough-wide social prescribing offer is being mapped and prototyped through the Hackney Neighbourhoods Pilot.

5 The Community Connectors project in Connect Hackney was developed from an existing health coaching project run by the provider organisation for the past eight years.

6 Ageing Better: Learning Report No 2 – Community Connectors. October 2018, p2.

7 https://napc.co.uk/primary-care-home/

Appendix A provides further background on:
a) the evidence for social prescribing from the national and international research literature;
b) the local and national policy context;
c) the theoretical basis of social prescribing and community connector models, and;
d) key learning points from Community Connectors projects across the Ageing Better programme.

Appendix B provides further detail on the Community Connector model in the Connect Hackney programme.

2.0 Research questions

The broader evaluation of the Connect Hackney programme is guided by a set of eight test-and learn questions. One of these questions is focused on whether the community connector model has been able to support older people living with or at risk of loneliness and social isolation to take part in community activities and projects (Box 2.1).

Box 2.1: Community Connector test-and-learn question

"How successful has Connect Hackney connector model been to recruit and retain older people living with or at risk of social isolation and loneliness in sustained activities?"

The in-depth study described in this report of the community connector model in the Connect Hackney programme has been designed to address this test-and-learn question in particular. We also collected data from the project and its participants to address some of our other test-and-learn questions.

Indicative research questions and lines of inquiry for the research were co-developed with the Connect Hackney programme team leading to the following overarching research questions (see also Appendix D)[8]:

1. How effectively is the Community Connections project reaching its target population?
2. How effectively is the project engaging participants?

8 In the context of the Community Connectors project, question one is focused on the referral process to the project. In this report we do not have a major focus on engagement and retention.

3. What features of the project encourage the retention of participants across the Community Connector sessions?
4. Is the project being implemented as initially intended? How has the model adapted and changed based on learning?
5. Can Community Connectors help to reduce social isolation and loneliness, and what are the key mechanisms through which this happens? (i.e. are participants empowered with the necessary skills and support to start taking part in community activities? Is this sustained over time?). What are the perceived changes in participant well-being (e.g. confidence, new friendships) achieved through the Community Connectors project?
6. What is the local context in which the Community Connectors project is operating? (e.g. how does the project fit with new and existing local health and social care support services? What partnerships have been developed and how valuable are these?)

3.0 Methods

3.1 Study design and sampling

A study using multiple methods was designed, carried out, and written up between September and December 2019 using: 1) interviews with project providers; 2) interviews with participants; 3) interviews with external stakeholders (e.g. from organisations that referred into the Community Connectors project) and; 4) anonymised participant data.

It was originally planned to undertake an online survey of external stakeholders. During the conduct of the study the research team became aware of an online survey of the Community Connectors project participants and external stakeholders from VCS sector organisations. This was conducted within the prevention workstream of the integrated commissioning programme at the London Borough of Hackney and the City of London Corporation. It was carried out with the collaboration of the community organisation running the Community Connections project. The survey aimed to help inform decision making and the drafting of a specification for the new integrated City and Hackney Social Prescribing and Community Navigation Service. The survey asked participants to rate their engagement and experience of the Community Connectors project. It asked external stakeholders about their organisations experience of receiving referrals from the project. A summary of the methods used to conduct the survey and its findings is presented in ***Appendix D,*** and we draw on these findings as appropriate in the report when they add to, or illuminate, our findings. Findings from this survey should be treated with caution as responses were only received from 12 participants and 14 external stakeholders.

The research aimed to interview five members of the project provider team, ten participants, and four stakeholders. It had also been planned to interview up to five volunteers working with the Community Connectors project, but no interviews with volunteers were achieved due to low numbers of active volunteers working with the project during the fieldwork period.

All six members of the project delivery team (two managers and four community co-ordinators) were invited to take part in interviews, and three members of staff agreed to be interviewed. The three participants included both project managers and one community co-ordinator.

For participant interviews, the aim was to interview ten participants with a diverse range of characteristics in terms of age, ethnicity, health and social care needs, as well as the four sites within the borough in which the community Connectors project was operating. Project managers were briefed on the participant sample required for the research. Community co-ordinators were then asked to approach the participants they were currently or had previously worked with to ascertain whether they would be willing to be contacted by a researcher to take part in an interview. Within the fieldwork period, community co-ordinators obtained agreement from nine participants for their details to be passed onto the research team. Seven participants subsequently agreed to take part in the research and were able to attend an interview within the timescale of the fieldwork.

The project management team also identified external stakeholders for us to approach for interview, with a brief to identify two from organisations that made referrals into the Community Connectors project and two from organisations that Community Connectors referred into. Three out of the four stakeholders identified were able to be interviewed within the field work period.

Table 3.1 Characteristics of interviewees

	N		N		N		N
Gender		**Age**		**Ethnicity**		**Site**	
Female	3	50 to 59	2	Black	4	Site 1	2
Male	4	60 to 69	3	White	3	Site 2	2
		70 to 79	1	Asian	0	Site 3	2
		80 and over	1	Other	0	Site 4	0
						Unknown	*1*
Total N	**7**	**Total N**	**7**	**Total N**	**7**	**Total N**	**7**

Fieldwork took place in various locations including within the community sites and central office from which the project operated. Fieldwork notes were taken throughout this period. These notes were used to aid analysis and interpretation of data. Ethical approval was granted by the UEL ethics committee (ref ETH1819-0216). Written informed consent was received from all participants before interviews. Findings and quotes in the report are pseudo-anonymised to minimise the risk of identifying participants.

3.2 Data collection

a) ***Provider interviews***
Interviews were conducted face-to-face with the three staff members[9] from the project management and delivery team. Interviews with providers covered the project design and implementation process, what is working well and not so well, partnership working, perceived impact and key mechanisms (see ***Appendix E*** for the interview schedule). Two out of the three provider interviews were digitally recorded and transcribed verbatim. The third interview was not digitally recorded due to noise levels within the community centre in which it took place. Detailed notes were taken during this interview.

b) ***Participant interviews***
Participants agreeing to take part in an interview were given the choice of a telephone or a face-to-face interview. All participants opted for a telephone interview. Interviews covered issues of reach, engagement and retention, whether the project met their needs/ expectations, any perceived changes or improvements to their lives as a result of taking part in the project, what they viewed as the best aspects of the project, and what they thought could be improved about the project (see ***Appendix F*** for the interview schedule). Five of the seven interviews were digitally recorded and transcribed verbatim. Two participants did not want their interviews to be recorded. In these cases detailed interview notes were taken.

The gender, age, and ethnicity of interviewees are shown in Table 3.11 alongside which of the four Community Connector implementation sites interviewees were drawn from. The sample achieved included a good level of diversity in terms of gender and age. The lack of participants of 'Asian' or 'Other' ethnicity reflects the ethnic profile of participants within the project as a whole. Participants from three out of the four implementation sites were interviewed.

Five of the participants were recorded by the provider organisation as self-referrals into the project whilst two were recorded as being referred from other organisations. Interview participants had entered the service with a variety of health, social care and other needs. Two participants had experienced a stroke within the last few years which had left them with some mobility issues, two had diagnosed mental health problems, and four had experienced recent significant life events such as bereavement (NB: participants could have more than one need).

Participants were at various points through their 12 sessions with the Community Connectors project. One participant had completed all of their sessions, three had completed between four and eleven sessions and three had completed two to three sessions. Four of the participants had started to attend community activities. Interviewees who had two or three sessions with their community co-ordinator, or were receiving home visits at the

9 The project currently has six part-time or full-time staff members of which two are managers and four are community co-ordinators (see Appendix B). It was planned to interview a total of five members of staff: both project managers and three of the four community co-ordinators.

time of interview, had not yet started to engage in community activities. Three of the participants received home visits from community co-ordinators. The other four participants attended sessions with their community co-ordinator in community locations.

c) ***Stakeholder interviews***

We were able to interview three out of the four stakeholders identified for us by the provider within the timescale for the fieldwork. Telephone interviews were conducted with these stakeholders. The stakeholders interviewed included two from organisations who make referrals into the Community Connectors project and one from an organisation who receives referrals from the project. Interviews sought to understand what works well in collaborating with the Community Connectors project and how the project fits within the wider local health and social care landscape in Hackney (see ***Appendix G*** for the interview schedule). These interviews were not digitally recorded but detailed notes were taken.

d) ***Anonymised participant data***

Socio-demographic and outcome data was collected from participants by providers of all Connect Hackney projects including the Community Connectors project using the Ageing Better 'Common Measurement Framework (CMF)' at entry to the projects and at the end of projects.[10] Socio-demographic data covered: gender, age, ethnicity, religion, LGBT+, living arrangements, presence/absence of a long-standing illness or disability, and carer status. Data is collected on a range of outcomes in the CMF covering: social contact and participation, social isolation and loneliness, health and wellbeing, co-production and influence (including volunteering). In this report we present baseline values for all outcomes measured except for those on co-production and influence as these are less relevant to the main questions of interest in this report:

Social contact and participation

- *Social contact with children, friends and family* measured on a scale of 0 to 5 with higher scores equating to more frequent social contact.
- *Social contact with non-family* measured on a scale of 0 to 8 with higher scores equating to more frequent social contact.
- *Participation in clubs organisations and societies* measured on a scale of 0 to 8 with higher scores denoting greater participation.
- *Participation in social activities* measured on a scale of 0 to 4 with higher scores representing greater participation.

Social isolation and loneliness

- *De Jong Gierveld (DJG) social and emotional loneliness* measured on a scale of 0 (least lonely) to 6 (most lonely).
- UCLA loneliness measured on a scale of 3 (least lonely) to 9 (most lonely).

Health and wellbeing

- *Shortened Warwick-Edinburgh Emotional Wellbeing Scale (SWEMWBS*) which measures wellbeing functioning on a scale of 7 to 35 (high scores = greater wellbeing).
- *Quality of Life* (EQ-5D-3L) measured on a scale of 1 (in perfect health) to -0.594 (in the worst possible health).
- *Self-reported health score (EQ-VAS)* measured on a scale of 1 to 100 with higher scores equated to better health.

In this report we analyse baseline outcome data only to provide a description of the participants taking part in the Community Connectors project. At the time of writing, only 10 participants had completed a follow-up CMF. A reliable analysis of change in outcomes would not be possible with such a small number of participants. We report the overall average scores on the outcome measures for participants at project entry.

3.3 Data analysis

Interview data was analysed using a thematic approach. Data was organised into the question, from the interview guides and under each question text was inductively coded to capture key patterns (themes) in the data. Data from the CMF was downloaded from the Connect Hackney dashboard. Data was analysed using descriptive statistics to describe the socio-demographic profile of participants and baseline outcomes. Data on socio-demographics was available for 73 participants. The data on baseline outcomes for Community Connector participants was accessed

10 The Common Measurement Framework is a questionnaire which all Ageing Better project participants are asked to complete. It covers participant demographics and measures social isolation and loneliness, social contact and social participation [4]. Optional measures on wellbeing, quality of life, volunteering, co-design and ability to influence are also included for Connect Hackney participants.

Table 3.2 Research findings

Findings section	Research question/line of inquiry
4.1 Overview of the Community Connectors project	How does the project fit with new and existing local health and social care support services?
4.2 Reaching the target group and the referral process to the Community Connectors project	How effectively is the Community Connectors project reaching its target population?
4.3 Who has taken part in the Community Connectors project?	How effectively is the Community Connectors project reaching its target population?
4.4 Engagement and retention of participants	How effectively is the project engaging participants? What features of the project encourage the retention of participants across the Community Connector sessions?
4.5 Perceived impact of one-to-one sessions on participants	Can Community Connectors help to reduce social isolation and loneliness, and what are the key mechanisms through which this happens?
4.6. Process and impact of moving onto community activities	Can Community Connectors help to reduce social isolation and loneliness and what are the key mechanisms through which this happens?
4.7 Partnership working and the wider health and care context	What partnerships have been developed and how valuable are these?

as part of a broader data set to examine the baseline profile of all Connect Hackney, phase two project participants completing a CMF. Baseline outcome data wa available on 67 Community Connector participants in this data set as this data set (which excluded participants who had taken part in previous Connect Hackney projects).[11]

3.4 Presentation of findings

Table 3.2 illustrates how the findings are presented in the report, indicating the research questions and lines of inquiry addressed by each of the findings sections.

4.0 Findings

4.1 Overview of the Community Connectors project

The Community Connectors project aims to support older people to get involved in groups and activities in their local community. The project was developed from an existing health coaching project which the provider organisation has been running since 2011. Older people who are socially isolated and lonely, or at high risk of social isolation and loneliness, can self-refer to the project or referrals can be made by other organisations (e.g. GP practices, other community projects). The target group are typically experiencing chronic health conditions, including mental health conditions, stressful life events such as bereavement, housing, employment or debt problems, or are recovering from acute health conditions.

Once a referral is made, the project co-ordinator will get in touch with the person to arrange an initial meeting to determine if the project is right for them (e.g. the person is over 50 and shows signs of, or is at high risk of, social isolation and loneliness, able to engage with the programme). They will then be offered a place on the project and assigned a community co-ordinator who will work with them in up to 12 coaching sessions over three to four months.

In the coaching sessions, the community co-ordinators use motivational interviewing and strategies from positive psychology to build participants' confidence, motivation and understanding to overcoming barriers to taking

11 Six out of the 73 participants had taken part in a previous Connect Hackney project and were not included in the data set for the broader analysis of the socio-demographic and baseline outcomes for all Connect Hackney project participants.

part in community activities. Together, the community co-ordinator and the participant create a personal action plan to guide their work including planning for which activities they might attend, at what point and with what support. At the end of the sessions, a continuation action plan is created to assist the participant in embedding changes beyond this period.

The project was set up and implemented in August 2018 using a phased approach across the four community locations in which it operates within the borough. The project has been adapted in two major ways since it started. Firstly, home visits have been introduced so community coordinators can conduct one-to-one sessions in participants' homes for those who are not yet ready or able to travel to community venues. The delivery team report that these home visits allow the community coordinator and participant to start building a relationship and to develop trust and confidence in the project. Secondly group activities are now offered to complement the one-to-one coaching sessions (e.g. a regular group walk). The group activities are designed as a bridge between the one-to-one sessions and taking part in activities in the community. It is intended that participants will "graduate into" the groups from, or alongside, their one-to-one sessions, and that group activities will replace some of the one-to-one sessions for some participants so that the project team have greater capacity to provide more one-to-one sessions for participants who are still "really struggling" after a number of sessions and are not ready to be in a group situation:

> *'we're trying to focus those one-to-one sessions to people that are really struggling and could really do with a bit more intensive support… by providing a group programme [participants].. could have, say, three or four one-to-one sessions with a coordinator, and then the rest of their sessions would take place in a group….." (Provider)*

Volunteers are encouraged on the programme in different roles (e.g. accompanying community coordinators on home visits, helping with administration tasks, or helping to run the group activities), including the option for previous participants to become volunteers. The project also aims to offer up to six months of follow-up support provided by a peer volunteer for those participants who still need support at the end of the 12 one-to-one sessions with the community coordinator.

As noted in the background section of this report, the community connector model overlaps with social prescribing. With the introduction of the NHS Long Term Plan, social prescribing models are mandated as a key part of the health and social care infrastructure. In comparison to social prescribing models based in primary care, the Community Connectors project differs in the following ways:

- **Location of sessions -** these are in community settings as opposed to a clinical setting such as a GP practice. This community location offers immediate advantages for building social connections (see section 4.7).
- **Number of sessions –** although the number of sessions social prescribing services can offer varies, the maximum number of sessions on offer is much lower than maximum 12 sessions for the Community Connectors project. One social prescribing service in Hackney can currently only offer one or two sessions, and older people needing longer term support are referred to the Community Connectors project.
- **Wider reach –** the Community Connectors project can accommodate referrals from other statutory, community, and voluntary sector organisations, not just from primary care.

4.2 Reaching the target group, and the referral process to the Community Connectors project

a) ***Provider perspectives***

In the early days of the project, participant numbers were low. This was due to a number of factors, including the fact that the project was new, the relatively 'hidden' nature of the target group,[12] and the phased approach to the implementation of the project. The latter allowed time for the project to get set up, recruit community coordinators, and start to raise awareness of the project and build relationships with potential referral partners. The lower than anticipated referral rate and many inappropriate referrals[13] in the early months of the project led the team to extend its outreach work to

12 Identifying someone as/self-identifying as socially isolated and lonely is not always easy, partly due to the stigma involved and partly due to being hidden by other more visible problems such as health conditions.

13 The project team estimate that between 10 and 20 per cent of referrals made are 'inappropriate', in that the project is not able to help, for example, those who have significant health or social issues that prevent them from being able to fully engage with the programme.

raise awareness and understanding of the project amongst potential referral partners and participants, including greater clarity on who might benefit from the project. This has included promoting the project with GP practices, housing associations, foodbanks, hospital discharge teams, adult social care and the local voluntary sector. Outreach has also been undertaken at community events such as health fairs. Increasing engagement numbers, referrals and participants entering and exiting the project are documented in project monitoring reports. The project now has a waiting list.

Personal targeted outreach, whereby a member of the project team meets with potential referral partners or the community, have been the most successful strategies. For example, the project team arranged to present at a GP practice that did not already have a social prescribing service, and at a local befriending project. Both of these examples led to an increase in referrals from these organisations. Providers felt that these strategies were successful as the talks enabled members of staff to gain a thorough understanding of how patients or clients from their organisation (and the organisation itself) might benefit from the Community Connectors project:

> *'So, we recently did a short presentation … at one of the GP practices not far from here. And interestingly some of the feedback, and they were all very keen obviously to engage their patients with the projects that we have on offer, but also some of the feedback that we got from them was that they know that there is a wealth of support services out there in the Borough but when they just have that limited interaction with a patient and its being able to… immediately know straight away that they can simply refer someone to this programme…..And the idea of coming to see a coordinator is to kind of take that pressure of, of people researching and finding out what is out there themselves" (Provider)*

The success of outreach in the community was again felt to be related to the personal approach, whereby people could engage with project staff. This could lead to immediate recruitment into the project:

> *" So, we're out in the community and people can actually speak to someone, see if they see a person, hear a bit more about it and sign up there and then. And erm, that's been quite successful. (Provider)*

Articulating the boundaries of the Community Connector model clearly and consistently to referral partners, and to participants, is another strategy that has helped the project team to manage the challenges of inappropriate referrals. Boundaries had been particularly unclear between the Community Connectors project and other services and projects, such as befriending schemes, social prescribing, counselling or care co-ordination:

> *"So we're not there to befriend, we're not there to counsel so it can be a bit challenging ….it's often we would have to reiterate that throughout… our kind of interactions…. it's a definite challenge…we make it clear that we are not support workers, such as a floating support worker who will do say a range of extensive form filling with people but we are, there to help …. people to engage with the community, to build those connections erm, access the support that they need, and support them through that as well, rather than just sign posting them and referring' (Provider)*

b) ***Participant perspectives***

Based on interviewee accounts, four of the participants interviewed reached the project via self-referral, two were referred to Community Connectors by other community-based projects. For one interviewee the referral type was not clear. Self-referrals were made after participants had seen a leaflet or advert for the project, or after the project was recommended to them by someone they knew. From the description of what was on offer (see Box 1 in ***Appendix B***), participants felt the project might be able to provide what they needed to help them break out of the loneliness they had been feeling due to experiencing major adverse life events such as bereavement or mental health problems.

> *I thought, 'Well yeah why not?' ….. I'm sort of making all efforts really to fill the day a bit. [laughing] I'd go to the opening of an envelope if it's free you know. Not quite that bad, but there are a lot of things going on but something that is local and offers one-to-one support I thought, 'Mm yeah why not.' You know". (Participant M)*

Participant interviewees who had been referred to the project from other organisations or for whom it was unclear had all experienced an acute health episode (e.g. a stroke) or injury (e.g. a fall). These participants tended to be older than those who had self-referred and their recall around the

referral process was often hazy and could be lost within a myriad of contact from a variety of health and social care professionals during this period.

> *"I can't remember how, but all of a sudden you know, letters, teams, through the door, …… get in touch with so and so and so and so." (Participant C)*

An interesting aspect in interviewees accounts relating to referral to the project (regardless of type of referral) was a feeling of surprise that such a project existed (e.g. "I never knew there was people like [community coordinators] about actually" (Participant N); "somebody's actually kind of paid to pay attention, its actually quite rare" (Participant M)) or 'being lucky' to be able to take part in the project. Some of those who self-referred expressed an underlying uncertainty as to whether they were really entitled to be project participants given, for example, their perception that other people may be in much greater need than themselves. For many of the participants there was a sense of anticipation and of looking forward to what the project might offer and lead to at the referral stage. For example, participant T, who was referred to the project via another organisation, was initially unclear about what to expect until they met with a project staff member who was able to sit down with the participant and explain what was involved in the project:

> *"I like the way she present what she's, she said, we get in to it now, what she's doing and what's going to do [in the project]" (Participant V)*

From the perspectives of the four participant interviewees who self-referred, the practical elements of the referral process were reported by two to be fairly smooth and relatively quick overall, whilst the other two noted they had to chase up their initial enquiries. These mixed experiences are consistent with the survey of Community Connector participants carried out by the London Borough of Hackney and the City of London Corporation between October and November 2019. Eight out of the twelve participants who completed the survey rated the referral process itself as 'excellent' or 'very good' and seven out of twelve participants rated the 'amount of time waiting for an appointment' with a community co-ordinator as 'excellent' or 'very good'. The remaining participants rated these aspects of the project as 'good', 'fair' or 'poor'. (see ***Appendix D***).

4.3 Who has taken part in the Community Connectors project?

In this section, key findings from an analysis of the socio-demographic and baseline outcome profile of those taking part in the Community Connectors project are highlighted. This was based on an analysis of 67 participants who had completed a CMF questionnaire that had been entered onto the database as of early December 2019. The analysis compared the Community Connector participant profile to: participants across all Connect Hackney projects, the general population of older people in Hackney overall, and the general population of older people in England. A detailed description of the analysis from which these key findings are drawn is provided in ***Appendix H.***

a) Socio-demographic profile

The majority of Community Connector participants were female (70 per cent) and aged under 70 years (76 per cent). The majority were also from a 'Black' (48 per cent) or 'White' (40 per cent) ethnicity and described themselves as 'Christian' in terms of religion (63 per cent). Nine per cent of participants were LGBT+. Over half of the participants were living alone (67 per cent), and all but 11 per cent reported that they were living with a long-standing illness or disability. Ten per cent reported themselves to be a carer.

Compared to all Connect Hackney participants, there was a greater concentration of Community Connector participants in the younger age band of 50 to 59 years (45 per cent compared to 17 per cent across all projects) and a higher proportion of participants with a long standing illness or disability (89 percent compared to 66 per cent). The latter is perhaps expected given that this group is at higher risk of becoming socially isolated and lonely and the focus of the Community Connectors project on those older people who are already social isolated or lonely.[14] It is not clear from the research conducted so far why Community Connector participants were more likely to be younger, but there could be

14 Indeed, in the project description on the provider website, a health condition linked to social isolation and loneliness is an example given of who the project is for ("you've not been well and you don't get out much anymore"). This is in line with the Ageing Better definition of high-intensity Community Connector models outlined on page 7 in this report as providing "support to people whose isolation may be compounded by particular stressful life events, acute or chronic health conditions, including mental health conditions".

several possible reasons. The project target group includes those experiencing adverse life events such as losing a job and those with chronic health conditions who may be unable to work. These groups are likely to be the 'younger old'. It may be that the project has been more successful in reaching this group of 'younger old' than the 'older old'. There may also be less awareness of the project amongst those organisations who work with older age groups. These potential explanations will be explored further and reported on in future updates of this report.

A larger proportion of Community Connector participants were female (70 per cent) compared to participants across all Connect Hackney projects (62 per cent). This difference reflects the fact that four of the other Connect Hackney projects focus exclusively on men. Community Connector participants showed a similar balance to all Connect Hackney participants in terms of ethnicity, religion, LGBT+, living arrangements and carer status (see Tables 1a and 1b in ***Appendix H***).

Like Connect Hackney participants overall, compared to older residents in Hackney as a whole, Community Connector participants were more likely to be female, of black ethnicity, living alone, and to have a long standing illness or disability (see Tables 1a and 1b in ***Appendix H***). The participation of a greater number of women reflects more general trends. It is well documented that women are more likely than men to access services and support, for example, primary care. Nationally, Ageing Better participants are also more likely to be female. The factors influencing the participation of men in Connect Hackney is being explored in another part of the broader local evaluation. The greater proportion of those living alone or with a long standing illness or disability again reflects the focus of the Community Connectors project and Connect Hackney overall. The greater proportion of participants of black ethnicity may reflect the demographics of the areas in which the Community Connectors project is being implemented and the need for targeted outreach to other BAME communities.

b) Baseline social contact and participation

As might be expected, Community Connector participants had lower average levels of social contact and participation compared to Connect Hackney participants overall and compared to older people nationally (see table 2 in ***Appendix H***). For example, Community Connectors project participants reported a lower average level of social contact[15] outside of the family and with neighbours and the local community (6.0) compared to Connect Hackney project participants overall (6.8) and the older population in England more generally (7.36).

An unexpected finding, given the focus of the Community Connectors project on already socially isolated and lonely participants, was the proportion of Community Connector participants who were a member of a club, group or organisation (43 per cent) which was slightly higher than older residents in Hackney as a whole (39 per cent), although much lower than Connect Hackney participants overall (73 per cent). However, the types of membership included in this measure may not always involve social contact with other people such as being a member of a political party or a charitable organisation. A more detailed analysis of the types of membership indicated by participants which feed into this measure is required. This will be undertaken for the next update of this report.

c) Baseline social isolation and loneliness and health and wellbeing

Again, in line with expectations, Community connector participants were more socially isolated and lonely as measured by both the De Jong and the UCLA scales compared to all Connect Hackney participants as well as the local and national comparator groups (table 3 in ***Appendix H***).

Given that poorer health is both a cause and a consequence of greater levels of social isolation and loneliness, it was not surprising that Community Connector participants were in poorer health compared to all Connect Hackney participants, as well as the local and national comparator groups. Differences in health and wellbeing were very large: the proportion of older people in England that have no health problems is 12 times higher than the same proportion amongst Community Connector participants (see table 4 in ***Appendix H***).

4.4 Engagement and retention of participants

The location (**home based or very close to home**), **regularity** and **flexibility** of the one-to-

15 Level of social contact with non-family members is measured on a scale of 0 to 8, with 0 being 'less than once a year' and 8 being 'every day or almost every day'.

one sessions were all highlighted by provider and participant interviewees as important features of the project which enhanced participants' ability to engage and stay with the project. Provider interviewees described the base of the project within participants' local communities as vital for engagement for those who had problems with anxiety:

> *Attending appointments in non-community settings [i.e. statutory services such as GPs or council offices] can cause [those with anxiety problems] stress if they feel they will be late and might miss their appointment. The Community Centre, even if they are unfamiliar with the building, provides participants with a less-pressured meeting space, and if they are running late, they feel less anxious about it. It is far easier to walk into a Community Centre than into a formal space. (Provider – paraphrased from interview notes)*

In the survey of Community Connector participants carried out by the London Borough of Hackney and the City of London Corporation, only four out of the twelve participants completing the survey rated the location of appointments as 'excellent' or 'very good'. The remaining participants rated the location of appointments as 'good', 'fair' or 'poor' (see ***Appendix D***). In light of the qualitative findings above, lower ratings may reflect dissatisfaction when appointment locations were not close to home or home-based.

The **personal qualities and skills** of the community coordinators had an influence on participant engagement. The qualities that were valued by participant interviewees were being 'friendly', 'approachable', 'lovely', 'kind', 'easy to talk to', 'able to have a laugh', 'non-judgmental' and 'supportive'. As one participant interviewee elaborated when recalling her first session with her community co-ordinator, such qualities were able to put people at ease and facilitate honest conversations:

> *"Well I didn't know what to expect, because I didn't know this person. You know I didn't know what she was or how she was going to be but er, she was very friendly, very kind and very approachable, I felt perfectly comfortable with her and you know, I had a really nice talk. You know I didn't feel at all shy or perhaps withhold anything." (Participant M)*

This participant interviewee felt that these qualities were particularly important for older people who had been raised by parents from a generation who were not used to talking about feelings and who just 'got on with things', having been exposed to terrible events during the Second World War.

Provider interviewees also noted that the quality and skills of the community co-ordinators were a key feature of the positive feedback they received from participants:

> *"…having someone that they feel really actually cares about what it is that they're going through. Somebody that doesn't make any judgements as well, we have a very empathetic erm, approach. We try and be as flexible as we can as well…." (Provider)*

In terms of the skills of the community coordinators valued by participant interviewees, being able to really listen, and really hear and understand what was said, were key across the board for participants. Other skills mentioned by participant interviewees included: being knowledgeable about how to promote health and wellbeing, and local community activities that could support this, being able to judge 'how little or how much people need', and taking a 'calm' approach with no pressure.

This 'calm' approach in which 'no pressure' (Participant S) was put on participants to do things too quickly resonated with how project providers described the success of their person-centred approach working at a pace participants felt comfortable with:

> *'[Participant] was first unsure about accessing a Community Centre, so we did no paperwork on her first appointment, we just talked. The next appointment she decided to stay for lunch at the weekly community lunch club at the Centre…..' (Provider – paraphrased from interview notes)*

Some participant interviewees did report **feeling rushed or pressured,** and as a consequence overwhelmed, but were able to communicate this to their co-ordinator and get things slowed down.

> *"Everything is coming like a rush, I was parked on the shelf and then everything is coming, the rain, the storm, the flood everything….. So, I'm taking my time with her and she's quite nice and I feel encouraged by her, to even do a bit more." (Participant V)*

Project providers reported that retention posed challenges for the project team as some

participants were not able to attend sessions due to **emergent crises** related to the **complex problems** many of the project participants faced:

> *"…retention can a bit of an issue predominantly because a lot of it is related…to…some of the complex health conditions that, you know that [the people we are supporting have] …what we're finding is that …..they don't want to end their sessions you know, they are getting value from them, but it's just …they're going through a bereavement, their health isn't great or they've got massive benefit issues that have suddenly come out of nowhere…" (Provider)*

The team were able to overcome these challenges in some cases through a flexible 'open door' approach they took when participants stopped engaging. Participants were able to put their sessions 'on hold' until they were ready to re-engage, and community co-ordinators maintained contact in between times through catch-up phone calls.

4.5 Project implementation and adaptation

As noted in the overview of the Community Connectors project in section 4.1, the project has undergone some adaptations, although the main component of the project – the one-to-one sessions provided by the community coordinators – has been implemented as intended. Provider interviewees highlighted the importance of the **person-centred approach** as being a key factor in the success of the one-to-one sessions. Feedback by participants to the provider suggest that the one-to-one sessions had provided a rare opportunity for participants to sit down and talk to someone to try to get to the bottom of the problems that they are facing. The **goal setting**, another aspect of the person-centred one-to-one support, was also felt to be crucial in terms of "helping people to really make [their] goals achievable and relevant in their situation".

The project offers up to 12 one-to-one sessions, and the aim is to be able to "guide people as easily and quickly as possible out of isolation". Fewer sessions were judged by provider interviewees to be sufficient for some participants, but for those with more complex needs the maximum number of sessions were usually needed, as well as follow-up support. These latter cases have been one of the drivers for the project to develop the option for participants to have six months of follow-up support with a volunteer, but finding volunteers to provide this support has proved to be challenging.

Provider interviewees reported that the addition of home visits was a very successful adaptation to the project. The home visits, together with the targeted outreach strategies described in section 4.2, have been the turning point in increasing referrals to the project ("we are now inundated with people that need home visits"). The home visits have also brought benefits in terms of the providers gaining greater insight into the challenges faced by their participants ("when you step inside someone's home you realise sometimes how they're living and the barriers that they have…you know that has really opened up our eyes"). There are also challenges with the introduction of the home visits. Referrals have increased but community coordinators must factor in additional travelling time which reduces the number of participants they can see in a day.

How well the group sessions have been working was less clear from the data collected so far from providers. Participant interviewees reported positive experiences and impact from attending the groups (see section 4.7 below). A few participant interviewees expressed **some confusion around the different components of the project**, in particular between the one-to-one sessions and the group sessions, or the community activities they had started to attend. They were not sure whether the group sessions or community activities replaced or would replace, the one-to-one sessions, or whether one-to-one sessions would continue alongside them. Ensuring participants have clear information about the different components of the project and how they run alongside each other could alleviate some of the anxieties associated with this confusion.

The groups were co-designed with participants, and provider interviewees highlighted their aspirations for the groups to eventually become self-sustaining peer groups and run by participant-turned-volunteers.

4.6 Perceived impact of one-to-one sessions with community co-ordinators

All participant interviewees spoke highly of their community co-ordinator and were largely

enjoying their one-to-one sessions. Ten of the twelve participants completing the survey of the Community Connectors project conducted by the London Borough of Hackney and the City of London Corporation rated the helpfulness of the project staff as 'excellent' or 'very good' (see ***Appendix D***).

Participants interviewed in this study had all felt a ***positive impact*** from the one-to-one sessions offered by the project, although it was not always easy for them to articulate the nature of the impact. All described the impact of the sessions in slightly different ways, including: feeling more optimistic, uplifted, motivated or confident, feeling a bit less lonely, being able to manage their stress better, not feeling so "offish" when interacting with others, or feeling useful again and able to contribute or offer something to others. Several participants, especially those who had experienced social isolation and loneliness after an acute health episode such as a stroke or a fall, reported a sense of ***'feeling human again'***:

> *"Talking to someone who shows an interest and who cares… that's a big deal you know…. It makes you feel human again. Makes you feel you've got something to offer, you're not over the hill.… you don't feel so offish when you're dealing with people" (Participant V)*
>
> *"They spoke to me like a fellow human being, you know at a time when I felt that I was only a, a quarter of a human being you know…They reassured that you are who you are. You're still [name of participant]. " (Participant C)*

Throughout participant accounts, adjectives and phrases such as 'wonderful', 'lovely', 'not just a tick box exercise', 'real human engagement' were repeatedly used which reinforced the 'stand out' nature of the project compared to previous services participants has used.

All of the participants had either already started to ***participate in community activities*** with support from the community coordinator, or had ***started the process of deciding which community activities they might like to try*** (for more details on the process of moving into these activities from one-to-one sessions and the impact of these activities see section 4.7 below). Those still considering activities reported how their community co-ordinator had helped them think through or challenge barriers to participating in their one-to-one sessions such as feeling embarrassed or conspicuous because of disabilities or injury.

> *"No no I haven't done nothing, no its all, it will be, cos I said to her, 'When I go, go,' I say, 'I will have to take us, I've got a trolley and I do rely on it, you know when I'm walking,' she said you can take it with you when we go and no-one takes no notice. And I think that's nice. " (Participant N)".*

The largely positive participant perceptions of the personal qualities and skills of the community coordinators were noted by one participant as a way of ***building trust***, essential for a participants' (re)entry into community activities.

> *"[Interviewer]: And that's made you feel, since you first started, that's made you feel?*
>
> *[Answer]: Accommodating if you want to put the word there, because in accommodating then a bit of trust comes in doesn't it…..and any group that she's a part of [the community coordinator], it must be nice?....I feel comfortable with her advice and initiative" (Participant V)*

Another participant felt that the positive outlook expressed by her community coordinator helped her to have a more ***positive outlook***:

> *"Maybe just I, basically erm, I just like the fact that she's a cheerful, more, she presents herself to me as a cheerful happy positive person. And like I appreciate that, because I, in a sense she reflects that to me and that sort of helps me." (Participant M)*

This participant also characterised the help and support she got from her community coordinator in her one-to-one sessions as like having "a professional friend" who was helping her to ***develop strategies*** to combat her loneliness and depression and "keep her head above water". Such strategies were conceptualised by the participant as a "little treasure chest of things that are helpful and useful" or a "kind of map I've got of [how] not to sink back into depression". She valued the strategies she was learning as she felt they helped her not to rely on her friends inappropriately ("when you've only got a handful of friends you don't want to lean on any one of them too much you know, otherwise they start edging away"). A fear of relying on friends in this way was shared by other participants too.

Provider interviewees were often quite surprised at the transformative effect the person-centred and goal-orientated, one-to-one sessions could have on participants' lives, particularly when seemingly small changes were implemented which then had a huge impact:

4.7 Process and impact of moving onto community activities

Four out of the seven participants had started to engage in community activities. This engagement was supported by the community coordinator either in a light touch way (e.g. through the coordinator making a referral) or through more intensive support such as accompanying a participant to a group activity. Those furthest along in their journeys with the Community Connectors project were now readily participating in a mix of regular weekly activities. Activities attended included: lunch clubs, digital inclusion projects, cooking classes, the local gym, the Community Connectors walking and 'calm and connect' groups, and a theatre project. The project provider interviewees reported that local community activities had more take-up than, say, activities organised for further afield (e.g. trips to theatres in the West End of London) although the lack of take-up of trips to the West End was thought to be related to a lack of interest in the actual activities themselves rather than the fact that they were further afield.

Provider interviewees reported using a step-by-step approach to supporting participants into community activities which would be tailored depending on needs and aspirations:

> *"...our banding system, from A through to D. …a lot of people would come in at band A that you know don't have that kind of support network around them.. they don't feel motivated, don't have the confidence.. And then the idea is that we guide them through the support that we offer, to hopefully, for them to reach kind of band D where they're achieving their goals, they're confident in how they're going to continue on, erm, you know without that consistent support of the community coordinator." (Provider)*

For those participants who had been socially isolated and lonely for several years and who were very unsure of getting out into the community again, this step-by-step approach could start with encouraging them to attend a one-to one session at the local community centre after initial home visits, moving on to joining in an activity together at the community centre after the one-to-one sessions such as a lunch club, and then introducing the participant to welcoming peers (or 'social butterflies') in the community centre "who they can pair up with and attend a community activity together with later".

Provider interviewees reported challenges for those participants with physical conditions that made it very difficult for them to leave their home, although links with a community transport project and finding activities on participants' 'doorsteps' provided solutions in some of these cases.

Although providers reported low levels of awareness amongst participants of the community activities going on in their local areas, they also reflected that giving information about activities was not enough, the community coordinator needs to build up confidence and motivation to attend activities:

> *"It's not good enough to say, 'Oh there's gonna be a reading group, or a walking group, or just a friends group, or a coffee morning.' Give them the leaflet and they'll go, we know that that doesn't work for a number of people. So, this approach is specifically trying to address that…" (Provider)*

Provider interviewees also highlighted that the prospect of attending groups could be off-putting to some participants, particularly for men. Other participants did not want to join groups or 'chat' to people, so provider interviewees reported finding a group which ran an activity that the participant would enjoy, such as gardening. Attendance at the group was therefore 'sold' on the activity itself rather than the group.

Common to all participants in terms of the perceived impact of taking part in these activities was a sense of no longer feeling alone, summed up by one participant as knowing "**I am not alone**":

> *"Sometimes when we feel down we feel we are the only person in the world and the group help us to see that everyone is struggling with their own problems. It has encouraged me to feel a bit more optimistic with my life. My problems have not been resolved but I am in a better place" (Participant I)*

> *"I do not cry anymore because I know I can get into contact with people. I am not alone" (Participant C).*

> *'It makes so much of a difference having something to get up for, putting on your clothes and have contact with people. Waking up with a purpose' (Paraphrased from interview notes with Participant K)*

One participant was initially sceptical about the benefits of joining the walking group but was surprised at how the walk turned out to be "not just a walk" but an **opportunity to connect**

with others, "talk about the week and what is happening in our lives….laugh and giggle… sing a song…" (Participant I). Participants also highlighted how getting out and about meant that they were now **more physically active,** potentially leading to health benefits as well as feeling less socially isolated and lonely.

Whilst two of the four participants reported **making new friends**, one participant explicitly discussed the fact that she had not made any new friends, as she had hoped, despite meeting lots of new people through the activities she was taking part in.

> *"I'm signed up to various sorts of things and you see people erm, you know and you chat to them but I can't say I've actually made any new… er I mean I was hoping that I might meet some other people in the same- or women particularly in the same situation er you know that I'm in that we could kind of chum up and you know go to the cinema and go out for a lunch that sort of thing but er, I haven't really erm- " (Participant M)*

Friendships of course take time to develop and may not be a realistic outcome, especially if the lifespan of the activities attended is relatively short. The same participant did recognise this and also saw the mutual benefits of simply **interacting with others and sharing experiences**. Another participant highlighted the benefits of social interaction in terms of simply **being noticed and remembered** when she attended her weekly digital inclusion course:

> *"Even the teacher they say, when I come through the door, 'Oh my god here comes the nicest lady.' You know. [laughing] …..well they introduce me every way and people never forget me" (Participant C).*

Ten of the twelve participants completing the survey of the Community Connectors project conducted by the London Borough of Hackney and the City of London Corporation reported that they had taken part in the project to 'find ways to connect more with family, friends or other people in your local community' and of these ten, six rated the project in terms of how well it had helped them with this as 'excellent' or 'very good' (see ***Appendix D***).

4.8 Partnership working in the wider health and care context

As described in section 4.2, the provider interviewees reported that they have invested considerable time in outreach work to develop relationships with a range of partners. Project monitoring information (not included in this report) indicates that referrals into and out of the project have been made from and to organisations across the statutory (e.g. primary care, local authority), third, and private (e.g. pharmacies) sectors.

The value of these partnerships from the perspective of the provider interviewees and external stakeholder interviewees is the **reciprocity** that is created in generating and receiving referrals between projects which, in turn, can lead to **quicker, more appropriate or longer term support** offered to older people:

> *"The Community Connectors project has helped us because we cannot manage to respond to the high number of referrals we receive due to our small staff team and lack of volunteers to help. The Community Connectors project kindly pickup individuals who would benefit from this service from our waiting list." (Paraphrased from external stakeholder interviewee representing one of the Connect Hackney projects focused on men).*

> *"We are unable to provide longer term support beyond one or two sessions because social prescribing has become so popular. This is where the Community Connectors project is more appropriate for some of our patients. These are typically patients not leaving the house and with no confidence who require home visits. The Community Connectors project tackles the key issues with our patients who have social needs and not medical needs. The fact that they are seen in the community rather than in a clinical setting is a positive outcome for these patients." (Paraphrased from external stakeholder interviewee representing a social prescribing service).*

The external stakeholder from the organisation which only received referrals from the Community Connectors project highlighted that the value to them of partnership working was the **ability to capitalise on the established and trusted relationship** that the Community Connectors project had built up with the individual being referred:

> *"We are able to capitalise on this trusted relationship and immediately start working with people. We often join the Community Connector staff members on home visits to introduce ourselves to referees and provide them with more*

information about our service." (Paraphrased from an external stakeholder interviewee representing a community transport service).

The challenges reported by the external stakeholder interviewees were: uncertainty over whether the project has resources to work with people who cannot speak English, not being able to refer patients who have complex health care needs, and, for other Connect Hackney-funded organisations, uncertainty over which project is 'credited' with the participant who is referred in or out:

"The significant barrier to making a referral is the Common Measurement Framework (CMF). Referred residents do not count as a unique person. We are still waiting on clear instructions on how they should be counted. This has not stopped us from making referrals but remains an area of concern nonetheless." (Paraphrased from external stakeholder interviewee representing one of the Connect Hackney projects focused on men).

Despite the partnerships already developed by the Community Connectors project, there is still scope for the project to improve its visibility to, and awareness of, new external referral partners. The survey of external stakeholders representing community and voluntary sector organisations in Hackney, carried out by the London Borough of Hackney and the City of London Corporation between October and November 2019, received 14 responses. Of these, only two reported receiving a referral from the Community Connectors project, although nine organisations were interested in receiving referrals (see ***Appendix D***). External stakeholders from organisations who had never received a referral either did not know the Community Connectors project existed before taking the survey, or knew the project existed and were keen for referrals to be made to them. The organisations who knew the Community Connectors project, but had not received any referrals from them, reported that they did not know how to get on the list of suitable services that the project refers on to.

5.0 Discussion

This report focuses on one of eight test-and-learn questions from the Connect Hackney programme evaluation: 'How successful has the Connect Hackney connector model been to recruit and retain older people living with or at risk of social isolation and loneliness in sustained activities?'. To contribute to answering this question, a small-scale, in-depth study of the Community Connectors project in Hackney is being undertaken. The Community Connector model in Hackney offers support for already socially isolated and lonely older people through a series of one-to-one sessions with a community co-ordinator who works with the participant to build confidence and motivation to attend community activities. The research undertaken aimed to address the following areas of inquiry: the reach and referral process, engagement and retention of participants, project implementation and adaptation, the impact of the project on participants, and the wider local context in which the Community Connectors project is operating.

This report presents the findings from the data collected so far. As of December 2019, qualitative data has been collected from seven out of a planned ten participants, three out of a planned five providers, and three out of a planned four external stakeholders. We had also planned to interview up to five volunteers working within the project, but these were not undertaken due to the low numbers of volunteers active within the fieldwork period. Available quantitative data from 67 participants completing a CMF questionnaire has been analysed to determine the socio-demographic and baseline outcome profile of the Community Connectors project participants'. Follow-up interviews to qualitatively assess participants journeys and project impact over a longer period are planned for 2020. The findings presented in this report should therefore be regarded as tentative until qualitative data collection has been completed and more CMF questionnaire data is available to quantitatively assess the impact of the project on social isolation and loneliness. This report will be updated once the outstanding data has been collected and analysed.

In this final section of the report, key findings are discussed in relation to previous research and the implications for the Connect Hackney programme team and those delivering the Community Connectors project. The discussion is organised according to the areas of inquiry addressed by this study (project reach, participant engagement and retention, project implementation and adaptation, impact on participants of the project and subsequent participation in community

activities, and partnership working), and includes a final conclusion section in relation to the overall test-and-learn question.

a) *Project reach*

Whilst the Connect Hackney Community Connectors project is reaching its' target group of older people who are already socially isolated and lonely, like other Connect Hackney projects it is reaching a greater proportion of female rather than male participants, as well as participants from both white and black ethnic minority groups as opposed to Asian and 'other' ethnic groups. As noted earlier, the greater proportion of women reflect trends at the national level. Ageing Better participants are also more likely to be female and the use of primary care is often found or assumed to be greater amongst women.[16] The factors influencing the participation of men and Black, Asian and Minority Ethnic (BAME) groups in the Connect Hackney programme will be explored in future stages of the broader local evaluation.

In contrast to other Connect Hackney projects, participants in the Community Connectors project were more likely to be under 70 years of age. As described in section 4.3, it is not clear from the research conducted so far why this might be the case. One possibility might be that the project target group includes those experiencing adverse life events, such as losing a job, and those with chronic health conditions who may be unable to work. These groups are likely to be the 'younger old'. It may be that the project has been more successful in reaching this group of 'younger old' than the 'older old'.

Targeted outreach strategies may be needed to reach the above underrepresented groups in the Community Connectors project. Indeed, alongside the introduction of home visits, targeted personal outreach by the project team was linked by provider interviewees to the increase in referrals seen in the project.

b) *Engagement and retention of participants*

From both provider and participant perspectives, the personal qualities and skills of the community co-ordinators appeared to be crucial for engaging participants. Participant interviewees reported that these skills and qualities led to the building of trust which provided a solid foundation for the subsequent work between the participant and the community co-ordinator to plan and prepare for their participation in community activities. In addition to building trust, the community co-ordinators were able to model a positive outlook and support participants to plan and prepare for their participation in community activities. These findings are supported by previous research. A recent evaluation of a social prescribing pilot in Hackney found that the relationship between the participant and the social prescribing coordinators was pivotal to its effectiveness. Key skills were empathic listening genuineness, and a non-judgmental approach.[17]

Retention was found to be challenging for participants with multiple or complex problems, but provider interviewees found that these could be overcome using a flexible 'open door' policy. For example, poor health or benefit issues could stop participants engaging, but they were able to put their sessions 'on hold' until they were ready to re-engage. Anecdotal evidence and learning from other Ageing Better Community Connectors projects also found that allowing people to return was a key factor for project retention.

c) *Project implementation and adaptation*

As noted above in section 4.5, the project has had to adapt and innovate to address low levels of referrals to the project through building in more extensive targeted outreach work and introducing home visits. Referrals have increased and there is potential for this to increase further still, given the relatively low awareness of the project revealed in a small online survey of stakeholders that was undertaken locally during the same period as this study. Whilst outreach and relationship building have been documented in the previous literature as facilitating referral to social prescribing schemes,[18] adaptations such as building in group activities alongside one-to-one sessions, and setting up an option for six months of further support from a volunteer, have received less attention so far in the literature. How well these are functioning will be further explored in the update to this report once additional data has been collected.

16 Hunt K, Adamson J, Hewitt C, Nazareth I (2011) Do women consult more than men? A review of gender and consultation for back pain and headache J Health Serv Res Policy. 2011 Apr; 16(2): 108–117. doi: 10.1258/jhsrp.2010.0091312

17 Bertotti, M., Frostick, C., Hutt, P., Sohanpal, R. & Carnes, D. A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector. Prim. Health Care Res. Dev. 19, 232–245 (2018).

18 Pescheny, J. V., Pappas, Y. & Randhawa, G. Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. BMC Health Serv. Res. 18, (2018).

Areas identified for further improvement or development included addressing confusion amongst participants around the different components of this complex intervention, in particular being clear and transparent about the number of one-to-one sessions and how group activities fit alongside these. The difficulties accommodating the increased demand for the service, especially for home appointments, and the associated increase in travel time also need to be addressed. The 'ask' from external stakeholder interviewees to be able to refer those who do not speak English is also relevant here.

d) *Impact on participants of the Community Connectors project and subsequent participation in community activities*

Like other research on social prescribing,[19] this study found that the one-to-one sessions between the community coordinator and participants were a powerful catalyst for change within the Community Connector model. Positive impacts perceived by participants were improved wellbeing (e.g. feeling more optimistic), self-esteem, and confidence. These were summed up by one participant through the notion of 'feeling human again'. These impacts were directly linked to the personal qualities (e.g. approachable, non-judgmental) and skills (e.g. listening skills) of the community co-ordinators who were able to build trust, model a positive outlook and positive role model, and help participants to develop strategies to combat loneliness.

This study provided some qualitative evidence on the process and perceived impact of participation in community activities and this will be further explored in the update to this report when additional data has been collected. No longer feeling alone through connecting, interacting. and sharing experiences with others was a key outcome reported by participant interviewees who had gone on to participate in community activities. Some participant interviewees reported that new friendships or networks had been developed. Others were simply enjoying the feeling of being noticed and remembered as a result of regular attendance at community activities. The ways in which participants were supported into community activities were most effective when they were tailored according to participants' needs, circumstances, and aspirations. For example, provider interviewees highlighted that step-by-step approaches worked best with those that had been socially isolated and lonely for a number of years. Focusing on the activity rather than the group worked better for those who did not like 'groups', and linking with community transport projects could help those with physical disabilities.

e) *Partnership working and the wider health and care context*

Community Connector models, like social prescribing in general, is a new innovation in the health and care landscape. The Community Connectors project described here has a number of unique features in comparison to other social prescribing schemes located in primary care. It is able to receive referrals from a wider set of organisations outside of primary care, it is community based, and offers a greater number of sessions than typical social prescribing schemes. There has also been wider scope for the project to introduce adaptations such as the group sessions. The relative novelty and uniqueness of the Community Connectors project was recognised by participants themselves who were often surprised that such a service existed.

Partnerships with external organisations were crucial for generating referrals to the service and referring participants out of the service. These partnerships built the necessary reciprocity for generating and receiving referrals between projects, and each partner could capitalise on the others work in developing a trusting relationship with the participants being referred. A perceived challenge to be addressed for those organisations within the Connect Hackney programme is who is 'credited' with the participant who is referred in and out.

f) *Conclusion and next steps*

Overall, this study found that the Connect Hackney Community Connector model can support older people living with or at risk of social isolation and loneliness into community activities, but the evidence so far is not yet clear on the extent to which this participation can be sustained over the longer term. The update of this report will analyse additional data, including qualitative and quantitative follow-up data, to explore further the role of the Community Connectors project in reducing social isolation and loneliness.

19 Bertotti, M., Frostick, C., Hutt, P., Sohanpal, R. & Carnes, D. A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector. Prim. Health Care Res. Dev. 19, 232–245 (2018).

Appendix A: Further background evidence, policy, and learning relevant to Community Connectors project

For the evaluation of the Community Connectors project, it is important to note the following learning on community Connectors projects nationally, and the wider local and national policy context:

1. Learning from existing research literature

Existing evidence on the whole suggests social prescribing improves health and wellbeing and/or usage of health services, however, the low quality of studies means these findings should be considered with caution.[20 21] A recent evaluation of a social prescribing pilot in Hackney and City found that the relationship between the participant and the social prescribing coordinators was pivotal to its effectiveness. Key skills were empathic listening, genuineness, and a non-judgmental approach.[22] Factors affecting uptake and adherence to social prescribing through primary care include trust in the referral source, the initial phone call from the navigator, the quality of support from navigators and service providers, free services, and perceived needs and benefits.[23] Facilitators (f) and barriers (b) to implementation of social prescribing projects include: staff turnover (b), staff engagement (f), a shared understanding of what can be expected by each partner (f), relationships and communication between partners and stakeholders (f or b), and the local infrastructure – having a wide range of good quality, accessible services and activities (f).[24]

2. Wider and local policy context

NHS Long Term Plan[25]

In the Long Term Plan, NHS England is committed to building the infrastructure for social prescribing in primary care. There will be 1,000 new social prescribing link workers in place by 2020/21, with significantly more after that, so that at least 900,000 people will be referred to social prescribing by 2023/24. This is part of the drive to Universal Personalised Care.

> *'Within five years over 2.5 million more people will benefit from 'social prescribing', a personal health budget, and new support for managing their own health in partnership with patients' groups and the voluntary sector.' (NHS, 2019, p.6)*

Plans are underway across Hackney in the implementation of the Primary Care Home model, which includes the mapping and prototyping of a social prescribing offer being developed through Hackney CVS Neighbourhoods Pilot, based within Hackney CVS.

Hackney CVS Neighbourhoods Pilot

The Neighbourhoods Programme is a critical vehicle in the delivery of the Integrated Commissioning (IC) Vision and Objectives. The programme has a strong focus on **preventative work** and an aspiration to deliver change across the broader determinants of health within neighbourhoods which impact on an individual's health and wellbeing.

3. Evidence from Ageing Better so far

Ageing Better (2018) Learning Report No.2 – Community Connectors. Birmingham. Big Lottery Fund.

Ageing Better partnerships report that Community Connector approaches can reduce demand for

20 Bickerdike, L., Booth, A., Wilson, P. M., Farley, K. & Wright, K. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. BMJ Open 7, e013384 (2017).

21 Pescheny, J. V., Randhawa, G. & Pappas, Y. The impact of social prescribing services on service users: a systematic review of the evidence. Eur. J. Public Health (2019). doi:10.1093/eurpub/ckz078

22 Bertotti, M., Frostick, C., Hutt, P., Sohanpal, R. & Carnes, D. A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector. Prim. Health Care Res. Dev. 19, 232–245 (2018).

23 Pescheny, J., Randhawa, G. & Pappas, Y. Patient uptake and adherence to social prescribing: a qualitative study. BJGP Open bjgpopen18X101598 (2018). doi:10.3399/bjgpopen18X101598

24 Pescheny, J. V., Pappas, Y. & Randhawa, G. Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. BMC Health Serv. Res. 18, (2018).

25 NHS. The NHS Long Term Plan. (2019).

local statutory services responsibly by **empowering people** with the **skills** and **self-confidence** to live independently for longer and better manage their own health, whilst knowing who to ask for support when they need it. The Ageing Better reports also highlight the mechanism and processes of Community Connectors projects producing the above outcomes – shown below.

Model	
Entry points and first engagement	• Provide choice and focus on strengths. • Keep referral process between organisations simple. • Capacity of others means potential waiting lists on both sides.
Relationship building/activities	• Keep talking to people, create equal relationships, and collaborate.
Moving on	• Have a framework for managing caseloads, allow people to return, and signposting is not the same as moving on.
Referral routes	• Passed complex cases and relationships with referral partners, and clarifying types of circumstances the service is best able to support.
Other services will be involved	• Signposting to appropriate services (e.g. debt, housing and benefits).
Follow-up	• Regular check-in calls.
Support functions	• Helps manage eligibility and appropriateness for the services.

4. Theories underpinning community connectors

The theoretical ideas underpinning the community connections model can be summarised using the ideas of 'social capital' and 'life course theory'. Social capital focuses on social relations or networks that have productive benefits to the individual, in this case reducing the effects of social isolation and loneliness. The two central tents of social capital focus on the 'value' or 'quality' of social networks, which are built overtime through 'bonding' (e.g. peer support group) and 'bridging' (e.g. community activities) connections with others.

The life course approach considers the growth and decline in connections with people based upon age. As we age we potentially increase our social capital through family ties, associations with clubs and groups, and through work. However, along the 'life course trajectory', we experience major life events and transitions such as retirement, ill-health, or bereavement. These can all limit or prevent social contact and participation in social activities, weakening both 'bonding' and 'bridging' social capital.

Through this lens, the community connectors model can be seen as helping individuals unlock or rebuild social capital first, through one-to-one support and secondly, through support to (re)connect with local communities and activities. In other words, the community connectors model attempts to reverse the trend of increasing social isolation and loneliness in older people by building confidence and brokering new local ties, networks and relationships.

Appendix B: Key features of the Community Connectors project implemented within the Connect Hackney programme

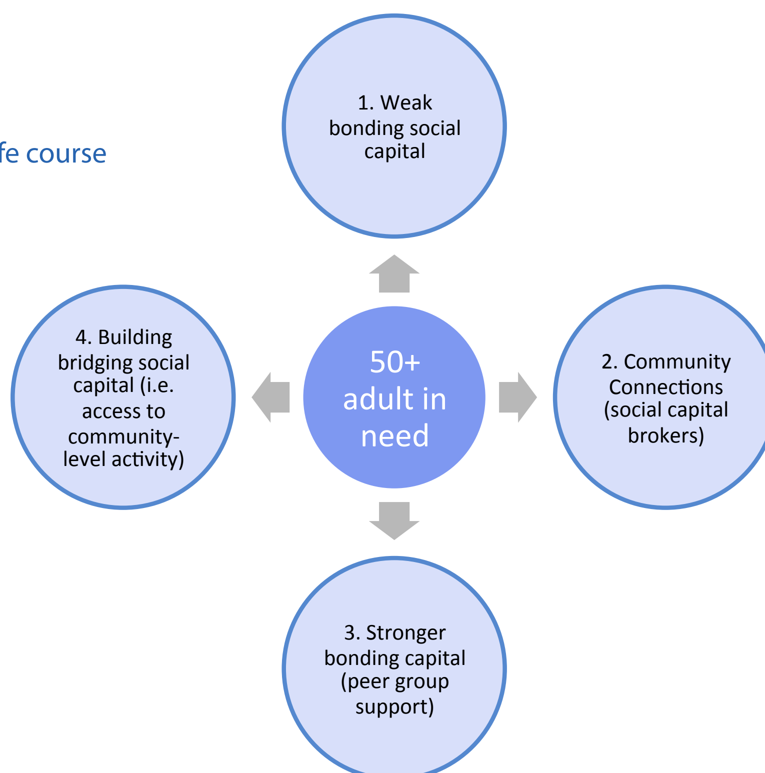
Key features of the project are listed below with an example of the way the project is described in promotional material (e.g. website, leaflets) shown in Box 1 on page 27.

- The project started in August 2018 and will run until March 2021.
- The project aims to work with statutory services to reach out to target clients, in particular, general practices, social care, and occupational therapists. The project also aims to recruit volunteers from the target group to assist with outreach and support to new clients.
- Participants receive up to 12 one-to-one sessions delivered by link workers called 'community co-ordinators'. The community co-ordinators use motivational interviewing and positive psychology to build participants' confidence, motivation, and understanding of opportunities to overcoming barriers to their social engagement. Co-ordinators aim to build participants' resilience and avoid dependence.
- Sessions are flexible, person-centred, and responsive to the different needs of participants. For example, coaching sessions can be face-to-face or on the phone, home visits can be arranged, frequency and length of contact is flexible (e.g. weekly, fortnightly) with the option of receiving additional sessions beyond the 12 if necessary.
- Community co-ordinators create a personal Action Plan with the active involvement of clients. Action Plans sets SMART objectives that are specific, measurable, achievable, realistic, and time-bound.
- The project is delivered out of four community-based locations in Hackney.
- The project maps local assets including community venues and projects, and uses this information to expand the social world of the client.
- The Community Connector delivery team consists of an overall project manager (responsible for strategic and line management and monitoring of budgets and targets), an assistant project manger (responsible for day-to-day operational oversight, line management and targeted outreach work to promote the service) and two part-time and two full-time community coordinators (responsible for delivering the one-to-one case work with service users, including associated admin such as booking appointments and sending reminders, as well as outreach and relationship building with local stakeholders (approx 80% delivering services and outreach, 20% supervision, programme development, and admin tasks)). There are currently two active volunteers out of 25 who have registered their interest.
- In practice, on their first meeting, the[26] Community Coordinator[27] will encourage people who are interested in the service to come and have a chat about their wellbeing to determine if the support available is right for them. If so, the community coordinator will guide the participant through registration forms to collect information such as demographics, medical background, and living situation. If they are over 50 and show signs or risk of social isolation, they will be offered a place in the project, comprising up to 12 sessions with the community co-ordinator. At the end of the sessions, a 'Continuation Action Plan' will be created to assist the client in embedding changes beyond this period.
- The Community Coordinator will continually assess the readiness of a participant to engage with the programme and will resume support at a later stage if the client chooses to stop or their behaviour indicates that they are not ready. The Community Coordinator will systematically return to participants that have stopped engaging in recognition of the challenges that they may face.

26 The Community Coordinators also work with an 18+ cohort which gives them variety and experience and additional community knowledge which can be of benefit for their work with the older, more isolated cohort.

27 https://www.shoreditchtrust.org.uk/health-and-wellbeing/community-connections/

Figure 1:
Social capital and life course



Appendix C: Indicative operational research questions and lines of inquiry for fieldwork topic guides

a) ***(Reach): How effectively is the community connectors (CC) model reaching its target population?***

- How is the project being promoted to the target population?
- What have been some of the challenges so far in reaching these groups?
- What strategies have been put in place to overcome some of these challenges, and how well are they working?

b) ***(Engagement): How effectively is the CC project engaging participants?***

- Why do participants sign up for the projects? What are their expectations and/or goals?
- What are the characteristics of the users that are attending a first appointment with CC? (e.g. gender, ethnicity, age)?
- What is the nature of the problems that participants are facing?
- What have been some of the challenges so far in engaging (recruiting) participants? (e.g. entry points, referral mechanisms)?
- What strategies have been put in place to address these and how well have they worked?

c) ***(Retention): What features of the CC project encourage participants to stay for the full 12 weeks?***

d) ***(Implementation): Is the CC project being implemented as intended? What changes have been made?***

- Have there been differences in implementation across the different sites? If so, have differences had an impact on the project's effectiveness?
- What do participants and providers view as the best aspects of the project?
- What do participants and providers think could be improved?

e) ***(Outcomes and mechanisms): Can the CC project help to reduce social isolation and loneliness (SIOL), and what are the key mechanism?***

- How does the community connector model work (i.e. social prescribing for older people – theory of change)?

Box 1: Example of promotional content for the Community Connectors project[26]

What does the Community Connectors project do?

The project team know all about the exciting activities happening in Hackney, from bingo sessions to free lunches.

We are here to help people get involved with things, especially if you have had problems which mean you find it hard to go out.

The project is available across Hackney. We can meet you in a local community centre (or if you are over 50, and struggle to go out or travel alone, then we can meet you at home) to talk about things that interest you, activities you might like to try, and changes you want to make in your life.

If you decide to join a class or become a volunteer somewhere, we can come with you a few times to help you feel more comfortable.

Who is Community Connector for?

Community Connector is for anyone in Hackney who wants to try something new. We often support people who have recently been through a big life change or who are looking for a new direction.

Maybe your children have left home or you've retired and you have more free time.

Or you've not been well and you don't get out much anymore.

Perhaps you've lost someone close to you and life feels a bit empty without them.

Maybe you don't know many people locally these days.

We can help you get back on track if you've recently been homeless or moved out of a hostel, and it's ok if you don't have recourse to public funds.

We offer longer term help for people over 50.

What kind of activities can I get involved with?

We help people to get involved with bingo, dancing classes, gardening, zumba, chair exercise, volunteering, cooking groups, ping pong, mens' groups, days out, new jobs, community walks, yoga, tea dances, pilates, friendship groups, Taekwondo, lunch clubs, swimming, book clubs, karaoke, and lots, lots more.

How much does it cost?

The service is completely free. It is funded by Connect Hackney and Hackney Council. Some activities and classes may ask you for a small fee, but we will always check this in advance and make sure it is ok for you.

- Did participants attend the activities that they were referred to? (that is, did it boost their motivation?)
- Did the project improve participants' confidence in accessing services and activities in the community?
- Did the project improve participants' knowledge of activities in their area?
- Has the project met the needs of participants and improved their health and social care outcomes?

*f) **(Context): What is the context in which the CC model is operating?***

- How does the CC model work fit into new (and emerging) health and social care support services in Hackney?
- Who are the local competitors and collaborators for the project?
- What partnerships have been developed? What has been the value of these partnerships?

Appendix D: Summary of methods and findings of an online survey of Community Connector participants and external stakeholders

Past participants of the Community Connectors project and external stakeholders from community and voluntary sector organisations were surveyed between October and November 2019 as part of a larger survey examining experiences of social prescribing and community navigator services in the borough. The survey was carried out by staff in the prevention workstream of the integrated commissioning programme at the London Borough of Hackney, and the City of London Corporation, between October and November 2019. The survey aimed to help inform decision-making and the drafting of a specification for the new, integrated City and Hackney Social Prescribing and Community Navigation Service. The survey asked participants to rate their engagement and experience of the Community Connectors project. For external stakeholders, the survey asked about their experiences of receiving referrals from the Community Connectors project. Anonymised survey findings from past participants of the Community Connectors project and external stakeholders were shared with the UEL team.

D:1 Summary of survey methods and findings with participants

The provider organisation distributed paper and electronic copies of the survey to current and past participants of the project via post, e-mail or through face-to-face contact. The number of surveys distributed was not reported but only twelve participants completed the survey. This is likely to be a very low response rate given that there have been 105 older people taking part in the Community Connectors project at the time this report was written. Eight of the twelve participants responding to the survey had exited the programme within the last month, whilst four had exited the programme in the last three to six months.

Tables 1 to 3 summarise the findings from the participant survey.

Table 1. Participants rating aspects of the Community Connectors project as 'very good' or 'excellent'[28]

	N
The process of being referred	8
Amount of time waiting for an appointment with a Community Coordinator	7
Number and length of appointments	9
Location of appointments	4
Helpfulness of the staff	10
Information given by the Community Co-ordinator	9

28 Other possible response options were: 'very poor', 'poor', 'fair', 'good'.

In terms of the seven different aspects of the Community Connectors project which participants were asked to rate, the majority of ratings were positive with nearly all ratings at 'good' or above. Location of appointments and the referral process were the aspects of the project rated the least frequently as 'very good' or 'excellent' (Table 1).

In relation to ratings of how well the service helped participants with particular issues, again the majority of ratings were positive with nearly all participants rating the help as 'good' or above. Around two thirds of participants rated the service as 'very good' or 'excellent' at helping them to find ways to connect more, plan goals, and find activities for healthy living or mental health and wellbeing, and to find services to support them with challenging issues such as debt or benefits (Table 2).

Table 2: Participants rating how well the service helped them with particular issues as 'very good' or 'excellent'

	N (Total N for whom this was an issue)
Finding ways to connect more with family, friends or other people in your local community	6 (10)
Planning goals and finding activities for healthier living (e.g. stopping smoking, alcohol, exercise or weight loss)	8 (12)
Planning goals and finding activities for mental health and wellbeing e.g. to build confidence, manage depression or anxiety	8 (12)
Finding services to support you to deal with debt, benefits, housing, or other challenging issues in your life	5 (7)

The participants surveyed were very likely to recommend the Community Connectors project to family or friends, and the majority of participants rated the support they received as helping to improve their health and wellbeing 'a great deal' (Table 3).

Table 3: How likely participants would recommend the Community Connectors project and its perceived impact on participant health and wellbeing

	Mean/N (Total N)
How likely would you be to recommend the service to family or a friend? rated 0 (not at all likely) to 10 (extremely likely)	8.8
Number of participants rating the support they received as helping to improve their health and wellbeing 'a great deal'[29]	8 (11)

D:2 Summary of survey methods and findings with external stakeholder organisations

Hackney CVS distributed the survey through the e-mail list of the City and Hackney Health and Social Care forum, which is a network of over 100 community and voluntary sector organisations. The survey had a very low response rate with responses received from 15 individuals representing 15 different organisations, although one organisation focused on young people reducing the number relevant to the Community Connectors project to 14.[30] Eleven survey questions were focused specifically on the Community Connectors project.

Only two of the external stakeholder organisations reported receiving a referral from the Community Connectors project but nine organisations were interested in receiving referrals (Table 4).

29 Other possible response options were: 'a fair amount', 'not very much', 'not at all'.
30 The survey consisted of groups of questions for different types of social prescribing projects.

Table 4: Organisations receiving referrals/interested in receiving referrals

	N
Received any referrals, or people attending your services who have been signposted, from the Community Connector service?	
Yes	2
No	9
No response	3
If you have not received referrals, would you be interested in receiving them?	
Yes	9[31]
No	0
No response	4

One of the organisations who had received referrals reported that they received approximately one referral per month. The other organisation reported receiving one or two referrals over the past two months. None of the referrals were reported as being inappropriate and all of the people referred took up the service or activity provided by the organisation. One organisation had people referred who had additional support needs and the organisation were made aware of this as part of the referral process, but were able to meet these additional needs. Both organisations reported that they had the resources to work with the people referred to them (with the exception of those with additional support needs which could not be supported by the organisation). These resources were from both local and national funding organisations. Only one of the two external stakeholders whose organisation had received referrals from the Community Connectors project responded to a question about how long those referred to them use their service for. The length of time was reported to be variable according to the needs of individuals.

The final questions gave external stakeholders the opportunity to leave comments on their experience of the Community Connectors project. Seven of the external stakeholders left comments. No comments were received from those organisations who had received referrals. External stakeholders from organisations who had never received a referral either did not know the Community Connectors project existed, knew the project existed and were keen for referrals to be made to them, or knew the project existed but felt that the Community Connectors project had not heard of their organisation. Of the two organisations that knew the project existed and were keen for referrals to be made to them, one did not know how to get on the list of suitable services that the project refers onto, and one organisation felt that working in partnership with the Community Connectors project would be valuable as they know some local residents need support to attend their activities.

31 One of the providers who had received a referral from Community Connector also answered 'Yes' to this question.

Appendix E: Provider interview topic guide

Introduction

We are speaking to Community Connector managers and team members to learn more about the Community Connectors project and how it has helped individuals to overcome or avoid social isolation and loneliness. The interview will focus on your **experience or insights of the project,** on what worked well, and what worked less well. The interview should take about **60 minutes**.

The interviews are part of an evaluation of the Connect Hackney programme, who have funded the Community Connectors project through the National Lottery Community Fund 'Ageing Well' programme which aims to tackle social isolation and loneliness amongst older people aged over 50 years. The results of the evaluation are intended to help improve services in Hackney, ensuring that they are responsive to the needs of older people.

Prompt for interviewer:

Share participant information sheet with the interviewee followed by the consent form.

Context

1. Please describe your role and responsibilities within the Community Connectors project?

2. Tell me from your perspective how the Community Connectors project works?

Prompts:

Tell me about the different elements in the project.

What do you see as the key elements of the project?

3.Who are your target groups?

Prompts:

How does social isolation and loneliness manifest itself in the groups you work with?

4.What have been some of the immediate needs for people most at risk, before they engage the Community Connector service?

Prompt:

Have they been the same for

a) all age groups?

b) all ethnic groups?

c) all levels of mobility?

d) gender

e) social economic status

In what ways have they been different?

Reach, engagement, and retention	
5. Can you tell me how the project has been promoted to reach your target groups? Prompts: What specific strategies have been used and how well have they worked? What have been some of the challenges in the promotion of the project? **6. What are the different pathways into the Community Connectors project?** Prompts: Please describe the referral process into the project. What have been the challenges? How have these been overcome? In what ways are participants supported to engage in their first few sessions? Prompts: Do participants need support to get to the sessions? What happens at the first session? What features of the project encourage participants to stay for the duration of the project? Prompt: Do participants exit the project early? (Acknowledging early exit may not necessarily be a negative) What have been the main reasons for people who drop out of the project?	

Implementation	
9. What have been some of the challenges in the delivery of the project? Prompts: Have some aspects of the project worked better/ worse than others? (e.g. numbers of participants referred, health action plan, etc.)? **10. How has the project adapted and changed?** Prompts: Has the project been implemented as intended? If not, why not? What difference have the changes made? **11. Have there been differences in implementation across the different sites?** Prompts How has the project worked across the different sites?	

Mechanisms and outcomes	
12. What does success look like for participants? What kinds of outcomes have been achieved? Prompt: Have they been the same across different groups? e.g.: a) all age groups? (60-74; 74+) b) all ethnic groups? c) all levels of mobility? *In what ways have they been different?*	
13. What do you see as the key beneficial aspects of the project? Prompts: How do you provide personalised help, advice and support? What elements of your service specifically address self-help? How does new-found confidence manifest itself in different groups? How do you enable participants to make and maintain a network of support? What do participants view as the best aspects of the project?	
14. Who do you refer participants onto? Prompt: Please tell me about your 'top' projects or organisations you refer participants onto.	

Whole system	
15. What partnerships have been developed? What has been the value of these partnerships? Prompt: How well are you networked? What are your challenges and successes? Who are your Community Connector local competitors and collaborators, and how does the project fit in to the broader health and social care landscape? Prompt: What do participants think could be improved? **16. What do external stakeholders view as the best aspects of the project?** Prompt: What do external providers think could be improved?	
Other	
17. Can you tell me what involvement you have had with the Connect Hackney Learning Network? **18. Do you feel being part of the network has impacted your delivery or approach?** Prompt: In what way? Signposting to other projects? **19. What other types of support have you had for the project aside from the Learning Network?** Prompt: Is there any other type of support you would like? **20. Is there anything else you would like to say?**	

Thank you!

Appendix F: Participant interview topic guide

Introduction

We are speaking to individuals using the Community Connector service to learn more about how the Community Connectors project has helped you to overcome or avoid social isolation and loneliness. The interview will focus on your **experience or insights of the service,** on what worked well, and what worked less well. The interview should take about **20-30 minutes**.

The interviews are part of an evaluation of the Connect Hackney programme, who have funded the Community Connectors project through the National Lottery Community Fund 'Ageing Well' programme which aims to tackle social isolation and loneliness amongst older people aged over 50 years. The results of the evaluation are intended to help improve services in Hackney, ensuring that they are responsive to the needs of older people.

Prompt for interview:

Detailed personal information is not required. Focus on experience of the pathway.

If you do not want to answer a particular question, you don't have to, and if you feel uncomfortable, we can stop the interview at any point.

Prompt for interviewer:

Share participant information sheet with participant, followed by consent form.

Context

(first interview only)

1. Can you tell me about your situation and what led you to make contact with the Community Connectors project ? OR Why do you think you were referred to the project?

Prompt:

What were your immediate needs before you engaged with the project?

2. What were/are your hopes or expectations of what the project can offer you?

3. Have you ever taken part in a similar project before?

Prompt:

When, where, and how long for?

(follow-up interview only)

4. Can you tell me a bit about how your experience with the Community Connectors project has progressed since we last talked?

Engagement

1. How did you find out about the Community Connectors project?

2. What information were you given about the service?

3. How long was it before you got to see you community co-ordinator?

4. Can you tell me about the first session and how it went?

Mechanisms 5. Can you tell me a bit about how the rest of the Community Connector sessions have been going? 6. What (if any) has been your attendance/ experience of activities that you have been referred to through the Community Connectors project? 7. What (if any) has been your experience of the volunteer? *Prompt:* *Would you ever consider becoming a volunteer? If yes, why?* 8. What is working well for you? 9. What hasn't worked so well for you? 10. If you could, would you suggest any changes to improve the Community Connectors project? Prompt: *Have you discussed this with Community Connector staff?*	
Outcome 11. What (if anything) has changed for you since you started the sessions with the health coach/volunteer? 12. Would you recommend the service to others? *Prompt: if yes/no, why?* 13. What else would you like to say about your experience of the service?	

Thank you!

Appendix G: Stakeholder interview guide

Questions	Notes
1. Please describe your service and target group? 2. What do you consider the best aspects of the Community Connectors project? 3. What do you think could be improved? 4. What is the context in which the Community Connector are operating in? 5. Who are the local competitors and collaborators of Community Connectors project? 6. How does the Community Connectors project fit into the local landscape? 7. Is there anything else you would like to say?	

Thank you!

Appendix H: Socio-demographic and baseline outcome profile of participants

*a) **Socio-demographic profile***

Tables 1a below and Tables 1b on the next page provide a detailed profile of the 67 Community Connector participants completing a CMF baseline questionnaire (as of early December 2019) according to gender, age, ethnicity, religion, LGBT+, living arrangements, carer status, and whether they have a longstanding disability or health condition (first column).[32] The tables also enable a comparison of this profile to: a) participants across all Connect Hackney projects (second column) and; b) older people in Hackney as a whole, using data from the 2011 Census (third column).[33]

Table 1a: Participant gender, age, and ethnicity

	Community Connector participants (%)	All Connect Hackney participants (%)	Hackney Census data (%)
Gender			
Female	70	62	52
Male	30	38	48
Total N	**66**	**289**	-
Age[34]			
50 to 59	45	17	55
60 to 69	31	36	18
70 to 79	14	27	18
80 and over	10	21	9
Total N	**67**	**281**	-
Ethnicity			
Black	48	43	26
White	40	42	56
Other[35]	12	15	18
Total N	**63**	**286**	-

Compared to all Connect Hackney participants, there was a greater concentration of Community Connector participants in the younger age band of 50 to 62 years (56 percent compared to 29 per cent across all projects) and a higher proportion of participants with a long standing illness or disability (90 percent compared to 60 per cent). The latter is perhaps expected given the focus of the project and illustrates that the project is reaching those with higher levels of need. Community Connector participants showed a similar balance to all Connect Hackney participants in terms of ethnicity, religion, LGBT+, living arrangements and carer status. In terms of gender, although 70 per cent were female compared to 62 per cent overall, this difference reflects the fact that four of the other Connect Hackney projects focus exclusively on men. Like Connect Hackney participants overall, compared to older residents in Hackney as a whole (third column), Community Connector participants were more likely to be female, of black ethnicity, living alone, and to have a long standing illness or disability.

32 67 refers to the number of completed CMF questionnaires that were also available to download from the central CMF database.
33 Comparative data was not available for all variables. This is indicated by a '-'.
34 Original age bands '70 to 74' and '75 to 80', and age bands '80 to 84' and '85 and over', are combined due to small numbers (n less than or equal to 3).
35 Due to small numbers, 'Other' was combined with 'Mixed ethnicity'.

Table 1b: Participant religion, LGBT+, living arrangements, carer status, and presence/absence of longstanding illness or disability

	Community Connector participants (%)	All Connect Hackney participants (%)	Hackney Census data (%)
Religion			
Christian	63	64	58
Other religion[36]	20	22	24
No religion	17	14	18
Total N	**60**	**266**	-
LGBT+			
Total LGBT+	9	7	-
Heterosexual	91	93	-
Total N	**55**	**224**	
Living arrangements			
Living alone	67	59	34
With others[37]	33	41	-
Total N	**66**	**291**	-
Carer			
Yes	10	16	14[38]
No	90	84	86
Total N	**60**	**277**	-
Disability			
Have longstanding illness or disability	89	66	45[39]
Total N	**664**	**273**	-

b) Baseline social contact and participation

Table 2 describes Community Connector participants' scores on measures of social contact and participation at project entry (baseline) (first column in table 4.2). These are compared to all Connect Hackney participants (second column), residents taking part in the Hackney baseline profile (third column), and the national picture (fourth column) where equivalent data is available.

36 Due to small numbers, 'Other' was combined with 'Muslim', 'Hindu', 'Sikh', and 'Buddhist'.
37 Due to low numbers (n < 3) in some categories, "With others' combines 'With spouse, partner', 'With family', 'In residential accommodation' and 'Other' response options.
38 Defined in census as a provider of "unpaid care giving help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability or problems related to age". Includes number reporting providing unpaid care for one or more hours per week.
39 Defined in census as "A long-term health problem or disability that limits a person's day-to-day activities ['a lot' or 'a little'], and has lasted, or is expected to last, at least 12 months. This includes problems that are related to old age".

Table 2: Baseline social contact and participation

	Community Connector participants	All Connect Hackney participants	Hackney Baseline profile	National Picture
Social contact with children, friends and family				
Mean score (score 0 to 5[40])	2.6	3.2	-	-
Total N	**51**	**211**		
Social contact with anyone other than family				
Mean score (score 0 to 8)	6.0	6.8	-	7.36
Total N	**61**	**255**	-	**1630**
Social participation				
% member of a club, group or organisation	43	73	39	71
Mean score	0.7	1.27	-	-
Total N	**63**	**211**	-	-
Taking part in social activities				
Mean score (score 0 to 4)	0.8	1.7	-	-
Total N	**59**	**254**	-	-

Overall the table reveals that Community Connector participants had lower levels of social contact and participation compared to Connect Hackney participants overall, as well as compared to older people nationally. Community Connectors project participants reported a lower average level of social contact with their immediate social circle of family and friends, and less participation in social activities compared to Connect Hackney project participants overall. Overall average frequency of contact with non-family members was lower amongst Community Connector participants compared to Connect Hackney participants overall and the national picture. The proportion of Community Connector participants who were a member of a club, group or organisation was similar to that found amongst older residents in Hackney as a whole. However, in comparison to all Connect Hackney participants and the national picture the proportion of Community Connector participants who were a member of a club, group or organisation was significantly lower.

*c) **Baseline social isolation and loneliness***

Community Connector participants were more socially isolated and lonely as measured by both the De Jong and the UCLA scales compared to all Connect Hackney participants, as well as the local and national comparator groups (table 3).

40 Where 0 is least frequent ('less than once a year or never') and 5 is most frequent ('three times a week of more')

Table 3: Baseline social isolation and loneliness

	Community Connector participants	Connect Hackney participants	Hackney Baseline profile	National Picture (ELSA/TNS omnibus)
De Jong Gierveld social and emotional loneliness scale				
Mean score (range from 0 = not lonely to 6 = severely lonely)	4.4	3.2	1.9	1.4
Total N	**57**	**225**	**354**	**1630**[41]
UCLA loneliness scale				
Mean score (3-9)	6.4	5.3	4.2	4.0
Total N	**63**	**249**	**354**	**5881**[42]

*d) **Baseline health and wellbeing***

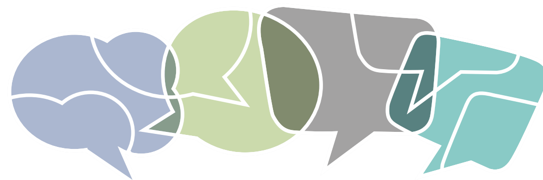
Community Connector participants were in poorer health compared to all Connect Hackney participants, as well as the local and national comparator groups (table 4).

Table 4: Baseline health and wellbeing

	Community Connector participants	Connect Hackney participants	National Picture (Understanding Society/HSE)
Wellbeing (SWEMWBS)			
Mean score (range 7 to 35)	18.3	21.1	25.2
Total N	**55**	**195**	**To ADD**[43]
Quality of Life (EQ-5D-L)			
% with no health problems	3	12	38
Mean score (range 1 to -0.594) (perfect to worst possible health)	0.3	0.54	-
Total N	**51**	**217**	**To ADD**[44]

Differences in health and wellbeing were very large. The proportion of older people in England that have no health problems is 12 times higher than the same proportion amongst Community Connector participants.

41 TNS Omnibus
42 ELSA
43 Approx 5,0000
44 Approx 2,000



CONNECT
HACKNEY
ageing better