*"Their help has been immense for me –*
*I'd have been lost without them …"* (Beneficiary)

*"It's great to have this project to refer people to"*
(Healthcare Assistant)

*"These interventions have an evidence base – they reduce the need for acute services and return visit to the GP"* (Local GP)

# Final Evaluation of Age UK Birmingham's ***Healthy Friends*** social prescribing project

by Kilbride Communications

for

**Age UK Birmingham**

December 2018

*"The income secured for beneficiaries currently offsets the project costs, before taking into account savings to reduced call on services".* (Evaluation report)

# Final evaluation of Age UK Birmingham's *Healthy Friends* social prescribing project

by Kilbride Communications

December 2018

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Appendix one: Policy and research context for the Healthy Friends project (attached as a separate document)

Appendix two: List of 107 support services and activities that Healthy Friends team referred or signposted beneficiaries to

# Final Evaluation of Age UK Birmingham's *Healthy Friends* social prescribing project, by Kilbride Communications December 2018

## 1. Introduction

This report sets out the findings of an independent, final evaluation of the *Healthy Friends Service*, a 'social prescribing' project delivered by Age UK Birmingham in the East Birmingham area, in partnership with Birmingham Cross City Clinical Commissioning Group (CCG). The report also incorporates key findings and learning from the mid-term evaluation undertaken in 2017. (This report is available from the Healthy Friends Project Manager)

The final evaluation was carried out by Kilbride Communications between August and November 2018.

### 1.1 Background to Age UK Birmingham and social prescribing pilots

**Age UK Birmingham operates under the umbrella of Age UK England** is "*a local charity working in the community to support older people, their families and carers. We want everyone to be able to love later life."* It does this through advice and signposting, and the provision of services and partnership projects.

The Healthy Friends project in Birmingham builds on the work of Age UK nationally, in delivering social prescribing pilots in other areas of England. The approach of social prescribing is to link people to non-clinical services and support in the local community to support health and wellbeing – in the case of Age UK to people aged over 50.

Age UK Birmingham developed links with the (then) Birmingham Cross City CCG, and specifically a cluster of GPs in the East Birmingham area, who agreed to be partners in a social prescribing initiative. Age UK Birmingham successfully applied to the Big Lottery Reaching Communities programme for funding and the 'Healthy Friends' social prescribing project came was rolled out.

### 1.2 Healthy Friends project

The Healthy Friends project is funded by the Big Lottery Reaching Communities Programme for a three-year period, which commenced on 1st March 2016 and will end on 28th February 2019.

The aim of the 'Healthy Friends' project is **to support the health and wellbeing of 500 older people** (aged 50 years and over) who have **two or more long-term health conditions**, reside in East Birmingham and have had regular in-patient, emergency activity and urgent care episodes within the last five years.

The project has **four outcomes**, set out below.

**Outcome one:** The health management coping strategies of older people will be improved.

**Outcome two:** Older people will have improved fitness and engage in activities within their local community to reduce social isolation.

**Outcome three:** By accessing support services and adaptations, older people will feel more independent in their homes and more financially resilient

**Outcome four:** Older people will have improved wellbeing and experience fewer interventions by primary care, acute services and adult social care

The project set out to achieve these outcomes by providing **a signposting and support service** to enable people with long-term conditions to make small steps to improve their health and wellbeing, including through reduced isolation; increase their financial resilience; navigate the health and care system; and reduce the need for unplanned hospital admission.

GPs and health professionals can refer people to the project – a 'social prescription' – whereby GPs and health practitioners seek consent from patients to refer within for non-clinical support to help with health and wellbeing needs, social support to financial resilience and independence. Other agencies can also refer people, with consent, and individuals can self refer.

In Years one and two, the project team comprised a Project Manager (30 hours), four part-time Health & Wellbeing (H&WB) at 22.5 hours; and an Admin worker (25 hours). The team provides a holistic, case work approach to support health and wellbeing through:

- initial outreach to the client's home;
- a series of one to one sessions (usually in the home) to complete goals sheet and an action plan;
- liaison with and supported referral to a range of agencies and support groups to help clients access and navigate the services they need;
- facilitation of social networks and support for clients to join local activities to reduce loneliness and isolation.

In the third quarter of Year three, the staffing structure changed with increased work hours to reflect demand of work, a substantial part-time Community Development Worker (25 hours) was also appointed to the project with re-profiling of budget.

**Healthy Friends aimed to recruit 50 volunteers** during the project lifetime to help deliver the outcomes and to build capacity locally.

### 1.3 The evaluation

Age UK Birmingham commissioned an independent evaluation of the Healthy Friends project and appointed Kilbride Communications to carry this out. The evaluation is a two-stage

process: a formative mid-term evaluation, which was completed in December 2017; and this summative final evaluation completed in the last six months of the project.

**The aims** of the evaluation and this final report are to:

- **provide independent evidence on the extent to which the project has achieved its** outcomes and related indicators for the Big Lottery Fund contract;
- **assess the project's strategic fit** with the wider policy context locally and nationally and the emerging evidence relating to social prescribing.
- **highlight the contribution of the project to more integrated health and care pathways** for beneficiaries, and to the health and social care system locally;
- **to capture good practice and learning** from the project to date to inform future work;
- **to inform the sustainability of the project** and identify opportunities to develop the work beyond the project's current funding period.

Based on the findings of the evaluation, this report:

- **reports on the progress made** in relation to outcomes, indicators and impact, identifying good practice, areas for improvement and lessons learned;
- **makes recommendations** for the final 15 months of the Healthy Friends project and sets out early thoughts on succession and sustainability beyond the project's current funding period.

### 1.4 Methodology

The Tender requirements for the evaluation set out the aims; the requirements for the contractor; and anticipated methods of data collection within the confines of the budget allocated. The evaluation included the following data collection:

- secondary data analysis, including an overview of current national and local health policies; and emerging evidence relating to social prescribing in UK;
- semi-structured, face to face interviews with:
  - Healthy Friends project team (at interim and final stages)
  - Healthy Friends Project Manager (at interim and final stage)
  - Semi-structured, telephone interviews with partners as follows:
    - Senior Manager from Birmingham Community Healthcare NHS Trust (delivery partner), and a member of the project steering group (interim stage)
    - Senior Manager from Birmingham Cross City CCG (interim stage)
    - One GP at Final stage.
    - One Health Care Assistant (Final stage).

  - Email questionnaire, completed by one GP at interim evaluation stage.

- focus group discussions with ten beneficiaries of the project: four in Year one of the project; and six in Year three of the project;

- observational visit to a Health & Wellbeing Day attended by 37 project beneficiaries in the first quarter of Year three;

- case studies of beneficiaries (three are included in the interim evaluation report; and four in this report).

### 1.5 Assessing the policy and evidence context of Healthy Friends

The policy context in which the Healthy Friends project operates impacts on its delivery, current and future. For this reason, the evaluation reviewed emerging evidence from social prescribing pilots in the UK; and local and national policies relevant to the project. This review is attached as a separate document, Appendix one. A summary and commentary of the key documents is included in Section 5. of this report, which sets out how Healthy Friends fits the policy context, and both reflects and contributes to the evidence base.

## 2. Findings 1: performance against outcomes and targets

The first set of findings from the evaluation data relates to the overall performance of the Healthy Friends project against its intended **outcomes and change indicators**[1].

The findings are set out below in three sections:

- Analysis of project performance of Healthy Friends project by end of third quarter of the third and final year.
- Unintended outcomes of the project.
- Summary of key findings on performance.

The **revised outcomes and indicators** for the lifetime of the project are set out in Table 1 below.

| Outcomes | Change indicators | Change expected |
|---|---|---|
| **Outcome 1**: The health management coping strategies of older people will be improved | • People using services will report having better coping strategies and will feel more able to manage their long-term health condition<br>• People from the BME community will feel more engaged following community language support from mentors and volunteers | 350 people (70% of beneficiaries)<br>200 people (40% of beneficiaries) |
| **Outcome 2**: Older people will have improved fitness and engage in activities within their local community to reduce social isolation | • People using the service will be signposted to wellbeing programmes and leisure centres<br>• People using the service will feel more connected to their community and feel less isolated | 350 people (70% of beneficiaries) –<br>350 people (70% of beneficiaries) |

[1] at the end of Year one, based on the early learning of the project, Age UK and the Lottery Reaching Communities agreed revised targets across outcomes. These changes were discussed in the Interim Evaluation report.

| Outcomes | Change indicators | Change expected |
|---|---|---|
| **Outcome 3:** By accessing support services and adaptations, older people will feel more independent in their homes and more financially resilient | • People will access a benefits check<br>• People will access home adaptations allowing them to live more independently<br>• People will feel more financially resilient | 500 people (100% of beneficiaries)<br>250 people (50% of beneficiaries)<br>250 people (50% of beneficiaries) |
| **Outcome 4:** Older people will have improved wellbeing and experience fewer interventions by primary care, acute services and adult social care | • People will feel a greater sense of wellbeing<br>• People will report reduced use of GP and other primary and acute services | 350 people (70% of beneficiaries)<br>350 people (70% of beneficiaries) |

***Table one:*** *Healthy Friends: outcomes and change indicators, project lifetime*

### 2.1 Analysis of project performance against outcomes

The Healthy Friends Project Manager monitors progress monthly and quarterly and provides End of Year Reports to the Big Lottery. The End of Year Reports for Year one and two (2016-17) and the monitoring data for the first three quarters of Year three have been analysed. The performance against overall project targets (people reached) and against each outcome and indicator is set out in this section. This also includes a sub-section on any unintended outcomes identified by the evaluation; and a commentary on the performance findings.

#### *2.1.1 People reached*

**In total, 409 people have been directly helped by the project** by the end of November 2018, with one quarter of the three-year project remaining. It is anticipated that 40 new people will be seen in the final quarter. **The project is therefore expected to help 449 people in total - 90% of its overall project target of 500 people.** Table 2 below sets out the figures against annual targets.

<table>
<tr><th>Project Year</th><th>Clients helped</th><th>Target</th><th>% Achieved</th></tr>
<tr><td>Year one</td><td>119</td><td>150</td><td>80%</td></tr>
<tr><td>Year two</td><td>137</td><td>200</td><td>68.5%</td></tr>
<tr><td>Year three to date</td><td>153</td><td rowspan="2">150 for year</td><td rowspan="2">102%<br>+<br>26.5%</td></tr>
<tr><td>Year three final quarter estimate</td><td>40</td></tr>
<tr><td>OVERALL PROJECT</td><td>409<br>+40</td><td>500</td><td>82%<br>+ 8% = 90%</td></tr>
</table>

***Table 2:*** *Numbers of people helped by the Healthy Friends project*

Based on the above, **the project will have helped 449 people by the end of the current funding period**.

**Commentary on numbers of project beneficiaries**

The number of referrals and cases taken on in Year one was fewer than anticipated; Year two showed a gradual increase; in Year three, beneficiary target numbers for the year have been over-achieved by the end of the third quarter, with the demand for service remaining high.

The evaluation identified a number of reasons for the slow start:

- Initial referrals to the project were only taken from GPs and primary care health practitioners; referrals were slow to come through as the Healthy Friends project and the social prescribing approach was new to many. It took time and trust for the potential impact of the approach to be understood among NHS practitioners, and therefore for them to embrace referrals to the project.

- It also took time to embed referral systems because different practices within the same CCG cluster had different clinical IT systems.

- In Year one, the project started taking referrals a month later than planned due to delays in appointment of staff, office/IT logistics and promotion of the project.

- Some referrals, especially earlier in the project lifetime, were of frail elderly people who fell outside the project referral criteria due to their more complex clinical needs and associated higher risks. The project could not directly support them and referred them to adult social care or other specialist services.

- As a new project, it has taken time for isolated people, often with low self-esteem, to learn about it and to recognise that they may benefit from the project, even after referral by a health professional (see 3.1 below).

The evaluation identified the following as reasons for the increase and continued high demand in Year three:

- Within six months of the project launch in 2016, the project referral pathways were opened up beyond health practitioners to social workers, social housing officers, and community-led organisations (e.g. sheltered housing schemes). These have produced small but significant number of referrals.
- The Healthy Friends team also started to run community events such as coffee mornings, in partnership with local sheltered housing schemes and supermarkets, to promote and raise awareness of the project to local residents in the community and to encourage self-referrals of those who met the criteria and willing to engage with the service. (see section 2.2 Unintended Outcomes below).
- A more integrated approach to health and social care is embedding in the NHS, supported by and a growing understanding of the extent and impact of social isolation on health and wellbeing, especially among the older population.

*2.1.2 Analysis of performance against outcomes and change indicators*

The outcomes achieved by the project are summarised in the tables below, for each of the outcomes and indicators. The final column in each Table provides an indication of expected progress (%) towards end of project target, to take account of cases ongoing in the final quarter of Year three.

**Outcome 1: The health management coping strategies of older people will be improved**

| Change indicators | Change expected by end of project | Change achieved by Qu. 3, Year 3 | | | Change at end of project<br><br>Target reached */ Target expected* |
|---|---|---|---|---|---|
| | | Year 1<br><br>(119 cases) | Year 2<br><br>(137 cases) | Year 3 Qs1-3<br><br>(153 cases to date) | |
| Users report better coping strategies and feel more able to manage long-term health conditions (LTHCs) | 350 people (70% of all bene-ficiaries) | 42 people (35% of cases) | 66 people (48% of cases) showed improvement in their SWEMWBS[2] surveys<br><br>23% people who took part in the phone survey reported being more able to manage LTHCs (10 people out of 42) | 116 people (76% of cases) have shown improvement in their SWEMWBS surveys<br><br>27% people who took part in the phone /postal survey reported being more able to manage their LTHC (3 out of 11 people) | 224 *+16 Q4*<br><br>224 people = 64% of target *and 240 or 69% expected by end of project*<br><br>25% of people who completed the phone/ postal survey to date reported being more manage their LTHCs (13 out of 53) |
| People from BAME communities feel more engaged, incl. through community language support | 200 (40% of all bene-ficiaries) | 20* people (17% of cases)<br><br>*This is based on BAME people who completed surveys | 20* people (15% of cases)<br><br>*This is based on BAME people who completed surveys | 14* people (9% of cases)<br><br>*This is based on BAME people who completed surveys | 54 people **(27%** of target) – *expected to rise to **35%** in the last quarter* |

***Table three**: Healthy Friends project, Outcome 1 and indicators*

[2] SWEMWBS: the Short Warwick & Edinburgh Mental Wellbeing Scale, developed from the longer version, is used by the NHS to measure mental wellbeing. (NHS Scotland, University of Warwick and University of Edinburgh, 2006). Data here refers to people with the LTHC of anxiety and depression.

**Commentary on Outcome 1 indicators**

- **Users report better coping strategies and feel more able to manage long-term conditions:** while this was slow in Year one, the numbers increased in Years two and three and the project achieved 64% of its overall target figure.

  The project staff – reported that they feel this was in reality higher, as some people who were referred to the project, did not necessarily describe themselves as having a long-term health condition, even though the majority had two or more LTHCs (one of the referral criteria). This is also backed up by the NHS referral partners interviewed, whose observation was that their patients who had been referred to the project, were better able to manage their LTHCs.

- **People from BAME community feel more engaged, including through community language support:** this is lower than anticipated and has been the subject of ongoing review throughout the project. A number of positive measures have been put in place to ensure that the project reaches more beneficiaries of BAME origin. There is also a distinction here between the numbers of BAME people who have been reached by the project – which is 56 out of 409 (13.6%) and the number who have completed the surveys, which is relatively low and impacts on the outcome data. There are three staff who speak community languages now employed by the project, and this is reported to be having an impact, along with the appointment of a community development worker who can give time to promoting the project to harder to the BAME population. This issue is discussed further in Section 4.6 below.

**Outcome 2: Older people will have improved fitness, and engage in activities within their local community to reduce social isolation**

| **Change indicators** | **Change expected by end of project** | **Change achieved by Qu. 3, Year 3** | | | **Change at end of project**<br><br>**Target achieved *I Target expected*** |
|---|---|---|---|---|---|
| | | **Year 1**<br><br>**(119 cases)** | **Year 2**<br><br>**(137 cases)** | **Year 3 Qs1-3**<br><br>**(153 cases to date)** | |
| People using the service will be signposted to wellbeing programmes and leisure centres | 350 (70% of beneficiaries) | 25 people (21% of cases) | 9 people (7% of cases) | 44 people (29% of cases) | 78 people *+14 Q4 = 92 people expected by end of project = 26% of target* |
| People using the service will feel more connected to their community and feel less isolated and lonely (1)<br><br>*Note: Various measures – continued below* | 350 (70% of beneficiaries) | 46 people (39% of cases)<br><br>*Above figures*<br><br>Feeling less isolated based on *UCLA Loneliness Scale*[3] surveys at baseline<br><br>Continued below | 48 people (35% of cases)<br><br>*are across the*<br><br>Feeling less isolated based on *UCLA Loneliness Scale* surveys at baseline and post intervention<br><br>Continued below | 119 (78% of cases)<br><br>*measures below*<br><br>Feeling less isolated based on *UCLA Loneliness Scale* surveys at baseline and post intervention<br><br>Continued below | 213 people (61% of final target)<br><br>213 *+32 Q4 = 245 expected by end of project = 70% of target* |

[3] The revised UCLA Loneliness Scale is a short scale of four questions designed to measure subjective feelings of loneliness and social isolation (Russell, D., Peplau, L.A., & Cutrona, C.E. University of California, Los Angeles, 1980).

| | | **Year one** | **Year two** | **Year three** | **Change to date/ *expected at project end*** |
|---|---|---|---|---|---|
| People using the service will feel more connected to their community and feel less isolated and lonely<br>*(Continued)* | | People completed the *UCLA Loneliness Scale*[4] baseline survey only in year one – no follow ups completed | 19% (8 out of 42 people who completed phone surveys) reported feeling more socially connected | 36% (4 out of 11 people who completed phone surveys) reported feeling more socially connected | Small sample an ineffective measure; and survey questions problematic |
| | | | 65 people (47%) were referred to befriending service | 84 people (55%) were referred to befriending service | 149 people to date referred to befriending service *+20 Q4 =169 expected by project end* |
| | | 24 people (20%) attended two or more HF events | 84 people (61%) attended coffee mornings | 46 people (30%) attended coffee mornings or HF sessions | 154 people feel more connected by attending HF coffee mornings and events *154 +15 Q4 = 169 by project end* |
| | | | 51 people (37%) were signposted to local activity groups | 54 people (35%) were signposted to 30 local organisations activity groups | *105 to date signposted to local activities 105 +15 Q4 = 120 people by end of project* |

[4] The revised UCLA Loneliness Scale is a short scale of four questions designed to measure subjective feelings of loneliness and social isolation (Russell, D., Peplau, L.A., & Cutrona, C.E. University of California, Los Angeles, 1980).

***Table four**: Healthy Friends project, Outcome 2 and indicators*
**Commentary on Outcome 2 indicators**

- **Referral to wellbeing programmes and leisure centres:** this proved to be a more challenging target than anticipated. A number of reasons have been identified:
    - This appeared to be less of a priority for the project beneficiaries, few of whom were seeking engagement with leisure centres, or even with broader wellbeing programmes; but rather, wanted advice and information on: health conditions, income-related issues and on localised social activities.
    - Distance and transport to/access to services was an issue for some – either as a result of people's limited mobility, or availability of/reduction in bus services (see Sections 3, and 4 below) The project team provided support where possible to help introduce people to leisure and wellbeing centres but cannot provide transport or accompany people on an ongoing basis.

  All team members felt that this was an unrealistic target for the project; and that going forward 25% of beneficiaries would be a more realistic, though still challenging target.

- **People using the service will feel more connected to their community and feel less isolated:** as the project developed there were a number of different indicators used to measure this. Across these indicators, the project is expected to achieve approximately 70% of its target, with **245 people expected to report feeling more connected and less isolated** as result of engagement with the Healthy Friends project.

  A number of issues arose in measuring this outcome:

    - Initial progress on this indicator was affected by the low number of referrals in Year one.
    - The tool used to measure this outcome was the UCLA Loneliness Scale, which was designed to measure subjective feelings of loneliness and social isolation. However, the team members reported the following issues:
        - progress can be only be measured against a baseline; but some people who later reported that although they had felt lonely and isolated before contact with the project, they had not felt able or willing to disclose this at the time to the H&WB Advisers, who they had not met before. As time went on many beneficiaries did report how isolated they had been feeling – but this was after the baseline had been collected.
        - The survey for tracking was usually completed by phone and occasional home visits; however, some people opted out, resulting in a low sample, and impacting on its usefulness as a measure.
    - The measures used to assess increased sense of connection and reduced isolation included:
        - referral to befriending services (169 expected by the project end)

- feeling connected through monthly coffee mornings and events provided by Healthy Friends (169 expected by project end)
- referral to activities in the community (120 expected by project end).

The above outcomes impacted 245 individual people and are a clear indication that the project made an impact on reducing people's isolation in their community in line with the Public Health England's (2017a) guidance: 'Living Well in older years'. See Outcome 4 below for additional impact relating people's sense of wellbeing.

**<u>Outcome 3</u>: By accessing support services and adaptations, older people will feel independent in their homes and become more financially resilient**

| **Change indicators** | **Change expected by end of project** | **Change achieved by Qu. 3, Year 3** | | | **Change at end of project**<br>**Target achieved** ***/Target expected*** |
|---|---|---|---|---|---|
| | | **Year 1**<br>**(119 cases)** | **Year 2**<br>**(137 cases)** | **Year 3 Qs1-3**<br>**(153 cases to date)** | |
| People using the service will access a benefits check | 500 people offered a benefits check (100% of beneficiaries) | 119 people (100%) were offered a benefits check | 137 people (100%) were offered a free benefits check | 153 people (100%) were offered a benefits check | 409 people (100%) were offered a benefits check<br>409 +*40 Q4 = 449 people expected by project end = 100% of beneficiaries ; and 90% of original target* |
| People using the service will access home adaptations allowing them to live more independently | 250 (50% of beneficiaries) | 12 people (10% of referrals) | 33 people (24% of cases) were referred for aids and adaptations; and 'Safe and well' checks | 102 people (67% of cases) referred for aids and adaptations, 'Safe & well' checks, key safe and care line | 147 people to date (59% of target)<br>147 *+24 Q4 = 171 expected by end of project = 68% of target*<br>*171/250 = 68%* |

| | | | | | |
|---|---|---|---|---|---|
| People using the service will feel more financially resilient | 250 (50% of beneficiaries) | 24 people (20% of those assessed) were eligible for additional income.<br><br>Total awarded to 24 people: £59,521 | 46 people (34% of those assessed) were eligible for additional income.<br><br>Total awarded to 46 people: £107,979 | 37 people (24% of those assessed) to date were eligible for additional income.<br><br>Total awarded to 37 people: £177,258 | 107 people (26% of those assessed out of possible 409 people) 43% of the original target to date) 107 *+15 Q4 = 122 (49% of target)*<br><br>Total awarded to 107 people: £344,758 to date<br><br>£344,758 + £58,000 Q4 =£402,758 |

***Table five:*** *Healthy Friends project, Outcome 3 and indicators*

**<u>Commentary on Outcome 3 indicators</u>**

- **People using the service will access a benefits check:** 100% of people referred have been offered a benefits check; this was usually carried out by phone by Birmingham Age UK's Benefits Adviser. Where follow up work was identified (e.g. application for Attendance or Allowance, hardship grants etc) this was taken forward by the Health & Wellbeing Advisers. As a result, 107 have accessed additional income (see bullet point below on financial resilience).
- **People using the service will access home adaptations allowing them to live more independently:** 59% of beneficiaries – 147 individuals - have accessed aids and adaptations in their home through referrals made to Occupational Therapy or Age UK Birmingham Handy Fix scheme. There had been a three-fold increase in this, year on year, and it is expected to rise to 68% by the end of the project; This illustrates an unmet health need. There is a strong body of evidence (examples include NICE, 2018 and Royal College of Occupational Therapists, 2015) on the

effectiveness of aids and adaptations in the home in enabling people to remain independent and safer at home for longer. Public Health England (2017) also provides a summary of evidence of a reduced rate of falls, and a reduced risk of

- falls. Public Health England (2018) also identifies opportunity and costs savings of falls prevention measures for older people, living in the community.

- **People will feel more financially resilient**: to date, **£344,758 has been accessed by 107 project beneficiaries**, as a direct result of engagement with the project. This equates to an average of £3,222 per beneficiary. Tables six below summarises the income type across years. The majority of this money is for previously unclaimed benefit entitlement, or entitlement based on new circumstances (e.g. Attendance Allowance); the remainder is from fuel discounts, savings on utilities, reductions in Council Tax and small hardship grants, all received with the help of the H&WB Advisers.

  The majority of income secured - **£324,600 - will remain in place beyond the project lifetime**, namely income from benefit entitlements, fuel discounts and savings on utilities. The remainder were one-off payments through hardship grants.

| **Year** | **Amount in benefit entitle-ments** | **Amount in fuel and utilities savings** | **Amount in hard-ship grants** | **TOTAL** | ***One-off*** | ***Annual*** |
|---|---|---|---|---|---|---|
| Year one | £ 56,521* | **included in benefit entitle-ments for year one* | £ 3,000 | **£ 59,521** | *£3,000* | *£ 56,521* |
| Year two | £ 93,955 | £6,919 | £ 7,105 | **£107,979** | *£7,105* | *£100,874* |
| Year three to date | £166,249 | £ 956 | £10,053 | **£177,258** | *£10,053* | *£167,205* |
| Total all years to date | **£316,725** | **£7,875** | **£20,158** | **£344,758** | ***£20,158*** | ***£324,600*** |

***Table six**: summary of income secured by Healthy Friends project for beneficiaries, across years and by type*

A contributory factor in the achievement of the financial resilience outcome was the Healthy Friends project being part of the wider Age UK Birmingham, which meant that all new Healthy Friends clients could be referred to a central Benefits Adviser for an

initial assessment (this service was 'matched funding' for the project). If the assessment identified scope to apply for benefits entitlements, hardship grants, or fuel and utilities savings, the H&WB Advisers took this forward and completed the necessary paperwork. They could call on the Benefits Adviser for further advice if needed.

**Outcome 4: Older people will have improved wellbeing and experience fewer interventions by primary care, acute services and adult social care**

| **Change indicators** | **Amount of change** | **Change achieved by Qu. 3, Year 3** | | | **Change at end of project**<br>**Target achieved** ***/ Target expected*** |
|---|---|---|---|---|---|
| | | **Year 1**<br>**(119 people referred)** | **Year 2 Qs 1&2**<br>**(137 cases)** | **Year 3 Qs1-3**<br>**(153 cases)** | |
| People using the service will feel a greater sense of wellbeing | 350 (70% of bene-ficiaries) | 87 people completed a SWEMWBS[5] baseline and follow-on SWEMWBS survey. 42 (48%) had shown improvement (45 were still active cases crossing in to Year two.) | 66 people completed baseline and follow-on survey for SWEMWBS.<br>48% showed improvement - 66 people including some carried forward from Year one.<br>23% also reported vis phone survey that they can better manage their health conditions (10 of 42 surveyed) | 116 people completed baseline and follow-on survey SWEMWBS.<br>76% showed improvement.<br>27% also reported via phone survey that they can better manage their LHTC (3 out of 11 surveyed) | 224 people to date feel a greater sense of wellbeing (64%)<br>224+*26 Q4 = 250 expected by project end = 71% of original target*<br>See also Outcome 2 on feeling more connected and less isolated. |
| People will report reduced use of GP and primary and acute services | 350 (70% of bene-ficiaries) | Originally to be based on data from the Commission-ing Unit (NHS Information & Governance team). | Unable to obtain data due to restructuring and resource issues at the Unit. | Corrective actions put in place and self-reported data collected from August 2018 | Raw aggregate data for end of project report to the Lottery in March 2019 |

[5] SWEMWBS: the Short Warwick & Edinburgh Mental Wellbeing Scale, developed from the longer version, is used by the NHS to measure mental wellbeing. (NHS Scotland, University of Warwick and University of Edinburgh, 2006)

***Table seven**: Healthy Friends project, Outcome four and indicators*

Commentary on Outcome 4 indicators:

- **Indicators of improving people's sense of wellbeing**: It is a positive outcome for the project that a high percentage of beneficiaries, especially in Year three, completed the baseline and follow-on (post intervention) SWEWMBS surveys. In Year one, it inevitably took time to generate data as the project got established; more referrals later in Year one resulted in a higher percentage of Year one clients completing baselines towards the end of the year, which meant that follow-on surveys were conducted in Year two.

  However, as with the UCLA Loneliness Scale reported under Outcome 2 above, the staff reported similar issues with the survey itself: collecting baselines from people who are new to the project and may not want to disclose how they feel; this is a limiting factor on the effectiveness of the SWEMBS and the Loneliness Scale surveys as measurement tools. (This is discussed in 4.6 below). However, the combined results of the two surveys, supported by the qualitative data in Sections 3 and 4 below, provide **a strong indicator of the positive impact the project has made on people's sense of wellbeing and of reducing their feelings of isolation**.

- **People using the service will report reduced use of their GP and other primary care services**: this outcome was more difficult to evidence. At the project planning stage, it was agreed that the monitoring of this outcome would be supported by the data from the NHS Information and Governance team at the NHS Midlands and Lancashire Commissioning Support Unit. However, this support was not available due to re-structuring and pressure on resources. This left the project in a difficult situation regarding this indicator: as a non-clinical project it cannot directly access clinical data.

  Nevertheless, evaluation found that **the project beneficiaries have accessed a wide range of support through the project, much of which remains in place** beyond their direct engagement with the project: increased income; aids and adaptations to promote independence at home and reduce falls risk; social connections; and awareness of services and activities available locally; information on managing long-term health conditions. **The evidence with respect to the positive impact of these interventions on health and wellbeing is both high quality and strong**, (Royal College of Occupational Therapists, 2015; NICE 2018, Public Health 2015a, 2015b, 2015c, 2017a, 2017b, and 2018) and they are **associated with a reduced need for health and social care interventions, including unplanned admissions and savings through opportunity costs and in some cases actual costs**.

  However, the above progress has to be balanced with the fact that the target group comprises older people with two or more long-term conditions and they are likely

over time to require further interventions. Measuring the effectiveness of the project in reducing the need for services and interventions in future, would have to take this into account.

The project's actual and potential impact on both individuals and on services is highlighted in Sections 3 and 4 below (Findings from beneficiaries; Findings from staff and partners). This issue of effective measurements for this population group should be taken forward with GP Practices, health commissioners and researchers if the project continues. Other non-clinical measures could also be identified and piloted. For example, a project in northwest Birmingham that supports older people, people with disabilities and their carers is working with a local university to pilot measuring 'GP time saved' as a result of their interventions.

#### *2.1.3 Volunteers*

Seven volunteers have been recruited and involved in the project, three during the first year and four more in Year three – though they are still being trained and will not be active until the final quarter. One volunteer is a 'peer volunteer', who first engaged with Healthy Friends as a beneficiary and then become a volunteer.

The target for volunteers to be recruited during the project lifetime was 50. The project has performed below target on this, and the evaluation identified the following reasons:

- The project team members all feel that this was an ambitious and unrealistic target in the original project funding application.
- There are fewer volunteering opportunities than anticipated:

*"We are an outreach team and we don't have a base that can accommodate regular volunteering. The main opportunities are helping out at coffee mornings, some clerical duties for setting up trips, to support community events and engagement activities". Project Manager*

- Some of the 'peer volunteers' who have put themselves forward from the beneficiary group, were frailer than anticipated and it was harder to find appropriate, meaningful opportunities for them, support and retain them within the resources available.

Now that the Community Development Worker is in post, she is empowering the clients to take part in local social events and as their confidence grows it is hoped that more clients will consider volunteering and leading on group activities in their communities. Some have already provided ideas going forward.

### 2.2 Unintended Outcomes

A number of unintended outcomes have emerged from the project:

- **Wider engagement through one-off events –** in addition to the numbers of people engaging with specific support from the Healthy Friends project, the team has

run regular community events, including awareness events in health centres and sheltered housing schemes; patient participation groups and carers' meetings. It was not anticipated that these would be so popular. These attracted 550 in Year one, 720 people in Year two, and 278 people so far in Year three, who have benefited, on a 'one-off' basis, from health and wellbeing information, and awareness of and signposting to services and activities. The outreach events have also led to **108 people self-referring** to the project.

The Healthy Friends coffee mornings often have guest speakers with relevant expertise, to provide information and advice to beneficiaries.

Due to their success they have become an integral part of the project and should be included as a core strand going forward.

- **Wider engagement in Age UK Birmingham events –** 46 individual project beneficiaries attended AGE UK Birmingham events as a result of signposting from the Healthy Friends project; 30 additional people also attended Age UK events as residents of a local sheltered housing scheme, where Healthy Friends holds events; or general public who heard about events through their GP practice.

- **Housing: repairs and maintenance -** this was a key issue for many beneficiaries and one that was impacting on their physical health (e.g. cold due to central heating boiler not working; damp due to a leaking roof; risk of falls;) and their mental health (stress and anxiety). This need is supported by evidence on the cost of poor housing to health (Public Health England 2015a). The staff team also identified housing as a key issue and took more of their time than they had anticipated (see Section 4 below).

  While this partly relates to financial resilience, this was seen as a stand-alone issue and the project was able to make a positive and often lasting impact on this through the case work of the H&WB Advisers.

- **Housing: support to find suitable alternative accommodation** - this was identified as a need by the team members who at times had to support people to seek alternative accommodation as their mobility and care needs changed. This had the potential to take up a lot of time where the client had little or no family support; yet all agreed it was a hugely important and sensitive issue to the person concerned (see Section 4 below).

- **Support for carers**: through the services provided to people referred to Healthy Friends, the project also reached carers and directly helped 35 carers with their health and wellbeing, reducing isolation and their own financial resilience.

- **Responding to safeguarding issues:** As a preventive project, it was not in the remit of the project to engage with clients who had safeguarding issues. However, when referrals were beyond the criteria of the project, and a safeguarding issue was identified, the team referred promptly to the relevant service/multi-disciplinary team

to ensure that vulnerable older people would receive appropriate assessment and support.

- **The project team reaches out to vulnerable beneficiaries and adds value** through:
  - Sending birthday cards and special occasion cards to clients – this was reported to have lifted their mood and to be very much appreciated.
  - Providing Christmas Hampers to clients who are assessed as in financial difficulties and socially isolated has been extremely valued; one commented that it had "restored their faith in humanity".
- **Repeat referrals**: a small number (20) of cases have been referred back into the Healthy Friends service by GPs or self-referral by previous beneficiary (closed case). This is mainly as a result of changes in circumstances and further support is required (e.g. for benefits assessments, or a change in health). Anecdotal evidence from the team suggests that this may also indicate that clients who have engaged once with the project are more willing to engage again; and more motivated to make the change; and/or may also be feeling lonely – but confident enough to return to address this. This has implications for resources as the service focuses on low-level interventions and short-term goals with the hope that issues are addressed for the medium to long term. However, some clients want to return to engage with the project to get their needs met rather than progress. This may also be in part due to the lack of community-based activities.

  In Years one and two, the team aimed for a turnaround of ten days between referral and first home visit. However, in Year three, the demand and higher rates of referral, coupled with repeat referrals, made this more challenging to achieve. This has led to a review of practice for Year three, when a referral is acknowledged with the patient/client within 48 hours; and the client is then contacted within two weeks if the referral is accepted; or if not, they are signposted for appropriate support. If the referral is accepted, Healthy Friends H&WB Advisers will make a home visit within 30 days of referral being received.

  In some cases, **the Project has been bridging the gap where more complex cases were waiting for statutory social care assessments**. Where a referral was made of someone whose needs were complex and required a higher-level response than the project could offer, the team would still put in some low-level interventions so the person wasn't left without support. Sometimes these went up to medium to high-level intensity interventions which, strictly speaking, did not fit the project criteria and were very time consuming, and pushing the boundaries of the skills and experiences of the H&WB Advisers. This has **highlighted an unmet social care need** for people with complex needs. Once Social Services assessment was completed and provisions in place, the Healthy Friends team would gradually withdraw from their engagement as the appropriate social care support was in place.

## 2.3 Summary of key findings on performance

Key findings from the data analysis of the data on the project's performance against outcomes are:

- **Healthy Friends has made good progress on achieving its Outcomes and indicators** by the end of the project lifetime, despite a slow start to getting referrals.
- **Progress was slower than anticipated in the first half of the project,** especially in Year one, for the reasons set out in 2.1.1 above, relating to:
    - delays in establishing referrals from key referring GP Practices;
    - slower than anticipated staff recruitment at the start of the project
    - a number of 'inappropriate' referrals, especially in Year one, of people who did not meet the project criteria.
- **Promoting financial resilience is a clear success of the project**: **£344,758 has been accessed by project beneficiaries** in welfare benefits, fuel discounts and hardship grants so far, as a direct result of engagement with the project.
- The evaluation has found that **the project has been successful in reducing loneliness and improving the sense of wellbeing** among its beneficiaries.
- The evaluation has found that the project **has successfully supported its beneficiaries to find coping strategies for long-term health conditions**.
- **It has been a challenge to engage volunteers** in the project for the reasons stated in 2.1.4 above.
- **There have been a number of unintended outcomes** that have added value to the project as a whole. These highlight some wider unmet needs, such as:
    - housing issues;
    - need for improved referral of frail elderly people for social care assessment;
    - needs of carers
    - the ongoing support the project beneficiaries with clinically complex, long-term conditions may need beyond the project lifetime.

## 3. **Findings 2: what we learned from the beneficiaries**

This section summarises the findings on the i**mpact and key issues identified by project beneficiaries**, taken from the

- focus group interviews with ten beneficiaries;
- nine client case studies;
- the Healthy Friends customer satisfaction survey.

The findings are set out below in three sections:

- **Referral to and initial engagement with the project**.
- **Specific impacts of the project,** with reference to the key project outcomes and unintended outcomes, identified by beneficiary interviews and case studies
- **Holistic impact on multiple needs**, identified by beneficiary interviews and case studies.

### 3.1 **Referral to and initial engagement with the project:**

Based on the monitoring data, the project received referrals from a range of sources as follows:

- 208 (51%) from health professionals (GPS, Practice Nurses, District Nurses, Community Psychiatric Nurse)
- 6 (1.5%) from social housing staff
- 13 (3%) from Age UK
- 74 (18%) statutory and voluntary organisations e.g. Social Services, Disability Resource Centre, Citizen's Advice, Stroke Association, and many others.
- 108 (26%) self referred to the project.

All but one of the beneficiaries interviewed were referred through a health professional: GP, Practice Nurse, Diabetic Nurse, District Nurse and a Mental Health professional. One was referred by Age UK.

Some of the interviewees said they were generally reluctant to visit GPs due to a perception that GPs' time is very constrained. This highlighted the importance of expanding referrals to the project beyond GPs, which has been successful.

- On receiving the referral letter some beneficiaries were hesitant about engaging with the project, as they perceived Age UK to be an organisation that supports frail older people, for example in their 80s and 90s, but not necessarily for people in their 50s, 60s and 70s.

*"My first reaction was, I'm not that old, I'm only 63!"*

- Further, there was a strong sense of "independence" among the beneficiaries, coupled with fear of letting people into their home:

  *"I still thought I could cope"*

  *"I don't like to show my vulnerability…it is very hard letting strangers into your home".*

  One person expressed a background fear of being "put in a care home" as an initial barrier to taking up the referral.

  A majority of beneficiaries felt that the initial home visit(s) had provided the time and environment to build trust with the project team and had facilitated further engagement.

  *"The personal contact helped - coming to the house, where you could speak privately and connect."*

- The initial reluctance of some beneficiaries was countered by the fact that the beneficiaries recognised 'Age UK' brand as a genuine and trustworthy organisation.
- All interviewees said that the approach of the Healthy Friends team had been a key to helping them engage and benefit from the project.

  *"They are all nice, approachable, friendly. When you're down that's what you need."*

  - Once engaged with Healthy Friends H&WB Adviser, beneficiaries were very aware and appreciative of the **advocacy role** that the team took up on their behalf when trying to access support and services:

  *"When they fight on your behalf they won't take 'no' for an answer… Age UK Birmingham has more clout than you".*

  *"I didn't have the confidence…Sometimes you need a bit of backing, someone to stick up for you."*

  *"I'm illiterate, and they helped me tackle all the paperwork and helped me claim legal entitlements."*

3.2 **Specific impacts of the project reported by beneficiaries** (with reference to the project outcomes)

The beneficiaries interviewed gave powerful testimonies about the positive impact of the project, and the number of different ways the project has contributed to their health and wellbeing. The impacts are illustrated through examples, quotes and case studies. They are set out under separate headings, to reflect the project outcomes, but there is overlap between them. This holistic approach is captured by the case studies.

- **The health management strategies of older people will be improved (Outcome 1)**

All people referred to the project had two or more long-term health conditions. There were numerous examples from the beneficiaries themselves and from the case studies collected about how the project had helped them with these conditions and positively impacted on their health and wellbeing.

- *"Healthy Friends has helped me manage my diabetes in between my Nurse visits – through a session on diet and on urinary tract infection – it was really helpful."*

- *"I have arthritis and I'm finding that I'm able to do things I didn't think I could do any more".*

| **Case Study 1: health management strategies** |
| --- |
| Mrs B was referred to the project by her GP. Her arthritis restricted her mobility and day to day living, she was feeling isolated and needed support with weight gain issues.<br><br>The H&WB Adviser referred Mrs B for a physiotherapy assessment, which resulted in her getting a 'rollator' walking aid. She also registered her with Ring and Ride and helped her get a bus pass.<br><br>An Age UK benefits assessment identified that Mrs B could apply for Personal Independence Payment, which she was helped with and was awarded. This helped her pay off some debt and live more comfortably.<br><br>The above have helped Mrs B become less isolated and she is now planning on going swimming at the local leisure centre to help with her arthritic joints.<br><br>The Adviser also helped Mrs B register with Birmingham City Council Housing to be considered for an adapted property. |

- **Improved fitness and reduced loneliness and isolation (Outcome 2)**

All interviewees said that the project had reduced feelings of loneliness and isolation.

*"It's helped me through social activities – the coffee mornings. I used to be in my shell until I came here."*

*"I feel less lonely – I don't mix very well but I feel comfortable here and I feel far better now. I feel revived and have something to think about. I've made*

*friends with two others and have exchanged phone numbers." [Another beneficiary] "She phoned me up the other week!"*

*"It's given me the motivation to come out and I've learned to get my words back – I was losing my vocabulary!"*

*"I had someone to talk to and talking has helped me greatly. If it wasn't for Healthy Friends I would have been stuck in my own home."*

Despite the above impact, all interviewees said they still experienced some loneliness and isolation and wanted to stay linked to the project after the one to one the case work support of the H&WB Adviser comes to an end.

*"I'd like more face to face contact with people".*

*"Fortnightly groups would be better instead of monthly."*

All said they would welcome "a calendar of events". Two male interviewees requested that any such events should appeal to both men and women.

In terms of improved fitness, there were serval examples of this being addressed through beneficiaries:

- getting out and about more and being less sedentary;
- attending Tai Chi classes;
- taking up swimming for joint health;
- having the confidence to do more than they were doing before:
  *"I walk more to get the joints going. Before I didn't think I should or could. But now I know I should, and it helps."*

- **Living independently (Outcome 3a)**

  In addition to the above outcomes, all of which contribute to more independent living, there were many examples where beneficiaries identified how the project had helped them continue to live safely and independently in their own homes, and to get out more safely (including the above case study for Outcome 1). This was as a result of:

  - Referrals to Occupational Therapist for:
    - aids and adaptations fitted (e.g. grab rails, bath and shower aids, a new bannister)
    - rollator, wheelchair and other mobility aids.
  - Support to get a Blue Badge for disabled parking.
  - Registering people for Ring & Ride and helping them get a bus pass.
  - Referring people on a low income for a grant for a new boiler.
  - Helping people get repairs and maintenance done in their homes.

| **Case Study 2: supporting people to live independently** |
| --- |
| Mrs G is a 91- year old woman who lives alone. Her GP referred her to healthy friends requesting help for her to access appropriate support services and to maximise her income.<br><br>The H&WB Adviser referred Mrs G Occupational Therapy service for a bathing assessment; this resulted in the fitting of grab rails and bathroom equipment to enable safer bathing.<br><br>Following a benefits assessment by Age UK Birmingham, the H&WB Adviser helped Mrs G apply for Attendance Allowance, which she was awarded at the higher rate. The Adviser also referred her to the DWP for help to apply for a Pension credit, which was also awarded.<br><br>Mrs G was referred for a 'Safe and Well' check from the Fire Service which resulted in her having a vibrating smoke alarm fitted suitable for someone with hearing impairment.<br><br>Mrs G said these things had really helped her feel more independent at home and she was very pleased with the outcome of the help she had: *"I feel more confident…I'm doing as good as gold!"* |

- **Financial resilience (Outcome 3b):**
  409 (82%) of beneficiaries were offered a benefits assessment; of these 107 (26%) were eligible to apply for further entitlement and, as reported above, £344,758 has been accessed to date for beneficiaries, with more expected in the last quarter of the project. The following paragraph provides an example of the impact of this:

| **Case study 3: supporting financial resilience** |
| --- |
| After spending time in hospital, during which time his benefits were stopped, M returned home where he lives alone in warden-controlled accommodation. He had no benefits for 12 weeks, little food and what he described as a *"mountain of bills".* He was still unable to walk. Two Healthy Friends staff came to his home and they brought him food parcels.<br><br>"*John and Helen came in and went through the bills and said don't worry about that, don't worry about this one but worry about these three". They then asked me about my benefits and Helen immediately got on to the phone and* I heard her say, "he *is entitled to this…"*<br><br>M received all the benefits he was entitled to: "*money was coming in to my account, I couldn't believe it…I got food, I got my benefits, I got a bus pass and I got my finances sorted".* |

- **Improved wellbeing experience and fewer interventions by health and social care services (Outcome 4)**

  Through Healthy Friends, 409 people to date have been able to navigate the short-term services they need, e.g. Occupational Therapy assessment, benefits assessments and health and wellbeing advice. These have had longer-term benefits, reported by beneficiaries as improved management of health conditions, safer and warmer homes, feeling less lonely and isolated, and greater mobility and independence.

  None of these factors can on its own directly be attributed to reducing the need for health and social care interventions. However, there is an established, accepted and growing evidence base (Dept of Health & Social Care, 2015; Public Health England 2018a, 2018b; and various NICE guidelines) that underpins national and local health and social care policy: early interventions that support management of health conditions, reduce isolation and promote independence, all reduce the need for future health and social care services.

  The Case Studies set out above and in the interim evaluation report all indicate that the project is successful in this regard. This is backed up by the data collected from both project staff and referral partners in Section 4 below. However, it is important to remember that the beneficiary group is made up of older people with long-term conditions who, by definition, will in future need health and social care interventions. The evaluation suggests that the project has contributed to delaying the need for such interventions and/or reduced the frequency of them.

- **Other impact identified:** Support with housing repairs (see 2.2 and 2.3 above) and fuel poverty was identified by several beneficiaries as a key impact and is also illustrated by the Case Studies and data from the beneficiary interviews and reinforced in the findings from staff and partner interviews in Section 4 below.

## 3.3 Holistic impact on multiple needs, as illustrated by case studies

It was clear that many beneficiaries receive a holistic service that can address different but related needs, and that it can take time and trust to identify these needs and help people address them. The project has demonstrated that addressing one need can provide immediate impact, but can also lead to tackling other needs, resulting in a cumulative impact that has the potential to prevent other needs arising. This is illustrated by the case study below.

| **Case study 4: holistic approach addresses multiple needs** |
|---|
| Mr W is a 59-year old man who lives alone. His GP referred him to Healthy Friends. He felt isolated due to health problems and found personal care very difficult as his bathroom was poorly equipped for his needs.<br><br>The H&WB adviser referred Mr W to Occupational Therapy for external grab rails to be fitted to reduce his risk of falling outdoors; and to Community Physiotherapy for advice on walking aids.<br><br>She referred back to Occupational Therapy and requested support from his GP to reapply for a Disabled Facilities Grant to adapt his bathroom. This was approved and a wet room with grab rails and a shower stool put in place. This has made a huge difference to his ability to carry out his personal care independently.<br><br>Mr W was informed of Healthy Friends events and support offered to enable him to attend. He has not taken this up but has expressed appreciation of knowing he is welcome to attend.<br><br>The Adviser referred him to Age UK Birmingham for a benefits check and advised him on 'personal budgets' so he could consider employing someone to assist him in the future.<br><br>Mr W was also referred to a local Befriending service for a home visitor, who now visits regularly to provide friendship and support.<br><br>Mr W told us *"I feel happy"* |

In terms of achieving and sustaining the above outcomes, **the Healthy Friends Team referred or signposted beneficiaries to 107 different services and activities** either locally or citywide. These are listed in Appendix two.

## 3.4 Customer Satisfaction Survey

To date, 53 beneficiaries (13%) have completed a customer satisfaction survey administered by the project. They have completed this by post or by telephone, whichever they preferred, after the case is closed. When completed over the phone, this is done with the Project Administrator (and not their H&WB Adviser) to encourage honest feedback. The findings are set out in Table eight below, with the highest scoring response highlighted in bold.

The project team would have liked more people to complete these surveys and are looking at ways to encourage this. In summary, **the survey to date shows a high level of satisfaction with the Healthy Friends team and service received**, and **the level of customer care is clearly a success factor** of the project.

| Survey question | Response No. (%) |
|---|---|
| Are the Advisers professional, polite and respectful? | **Yes: 53 (100%)**<br>No: 0 |
| How helpful were your Healthy Friends Advisers? | **Very helpful: 52 (98%)**<br>Helpful: 1 (2%)<br>Not v helpful: 0 |
| Do Advisers spend enough time with you to address your goals and needs properly? | **Always: 52 (98%)**<br>Usually: 1 (2%)<br>Sometimes: 0<br>Never: 0 |
| Do the Advisers explain why they are there and how they can support you? | **Always: 51 (96%)**<br>Usually: 0<br>Sometimes: 2 (4%)<br>Never: 0 |
| Do the Advisers explain what you are expected to do? | **Always: 46 (86%)**<br>Usually: 2 (4 %)<br>Sometimes: 5 (10 %)<br>Never: 0 |
| Overall, how helpful do you find your Healthy Friends Advisers? | **Very helpful: 51 (96%)**<br>Quite helpful: 2 (4%)<br>Not helpful: 0<br>Never helpful: 0 |
| Are your appointments [with Healthy Friends staff] normally attended at the date and time arranged? | **Always: 50 (94%)**<br>Usually: 1 (2%)<br>Sometimes: 2 (4%)<br>Never: 0 |
| Overall, how satisfied are you with the service received from Healthy Friends? | **Very Satisfied: 47 (89%)**<br>Satisfied: 6 (11%)<br>Less than satisfied: 0<br>Dissatisfied: 0 |
| How do we compare with other care services you have received at home? | Much better: 23 (43%)<br>Better: 2 (4%)<br>About average: 2 (4%)<br>Not as good: 0<br>**Not applicable: 26 (49%)** |

***Table eight***: *Customer Satisfaction Survey (to end of quarter three, Year three).*

## 4. Findings 3: what we learned from project staff and partners

This section summarises the findings from across the interviews with project staff and partners, under the following headings:

- **Referral process**
- **Engaging with clients**
- **Impacts of the project**, relating to key project outcomes and any unintended outcomes
- **Success factors**
- **Gaps and lessons learned**
- **Value for money considerations.**

### 4.1 Referral process

Healthy Friends has a clear referral process which is set out in Figure 1 below. Nevertheless, referrals came through slowly partly as a result of GPs and primary care health professionals not knowing about the project or not really understanding its potential offer and benefits. Further, some early referrals were of people with complex clinical needs beyond the project's remit.

Being based at a GP practice did not yield the number of referrals from that practice as soon as had been hoped, though this has changed over time. Reaching other GP practices took time. One GP fed back positively on a presentation that had first informed her of the project:

> *"Coming to the local commissioning meeting to talk about the service – this was good way of reaching GPs – it may not have reached me otherwise. I get so many emails and flyers."* (Local GP from single-handed practice)

The location of the Healthy Friends project office, although at a GP Practice, was not in an area accessed by the public, this impacted on opportunities for self-referrals to the project by the patients visiting the practice. However, co-location in a practice was welcomed by NHS staff referring patients and wanting the opportunity to provide a case history.

Through continued promotion, outreach and partnership working this has been addressed and more **referrals are now coming through from 16 different GP practices**, representing the majority of all referrals to the project. (This has increased from nine practices at the mid-term evaluation). Referrals come from a range of health professionals at the practices: GPs, Practice Nurses, District Nurses, Community Psychiatric Nurses and Health Care Assistants.

The feedback from partners on the referral process is very positive:

> *"The referral process is excellent…they can also respond quickly. I've never had a patient come back to me saying they've not heard anything. They're very efficient." (Practice-based Health Care Assistant)*

Referral routes were also set up with wider health and social care professionals, including relevant third sector services, which soon yielded results. The number of self-referrals has

also increased over the project lifetime, with 55 in Year three to date, 42 in Year two, compared to 11 for the whole of Year one. Self-referrals are now the second biggest source of referrals to the project; and the findings identified the following reasons for this:

- word of mouth about the project over time
- bus campaign held in winter 2017-18 which led to a rise in self referrals
- outreach events in Year two – which reached 726 people, some of whom then self-referred to the project.

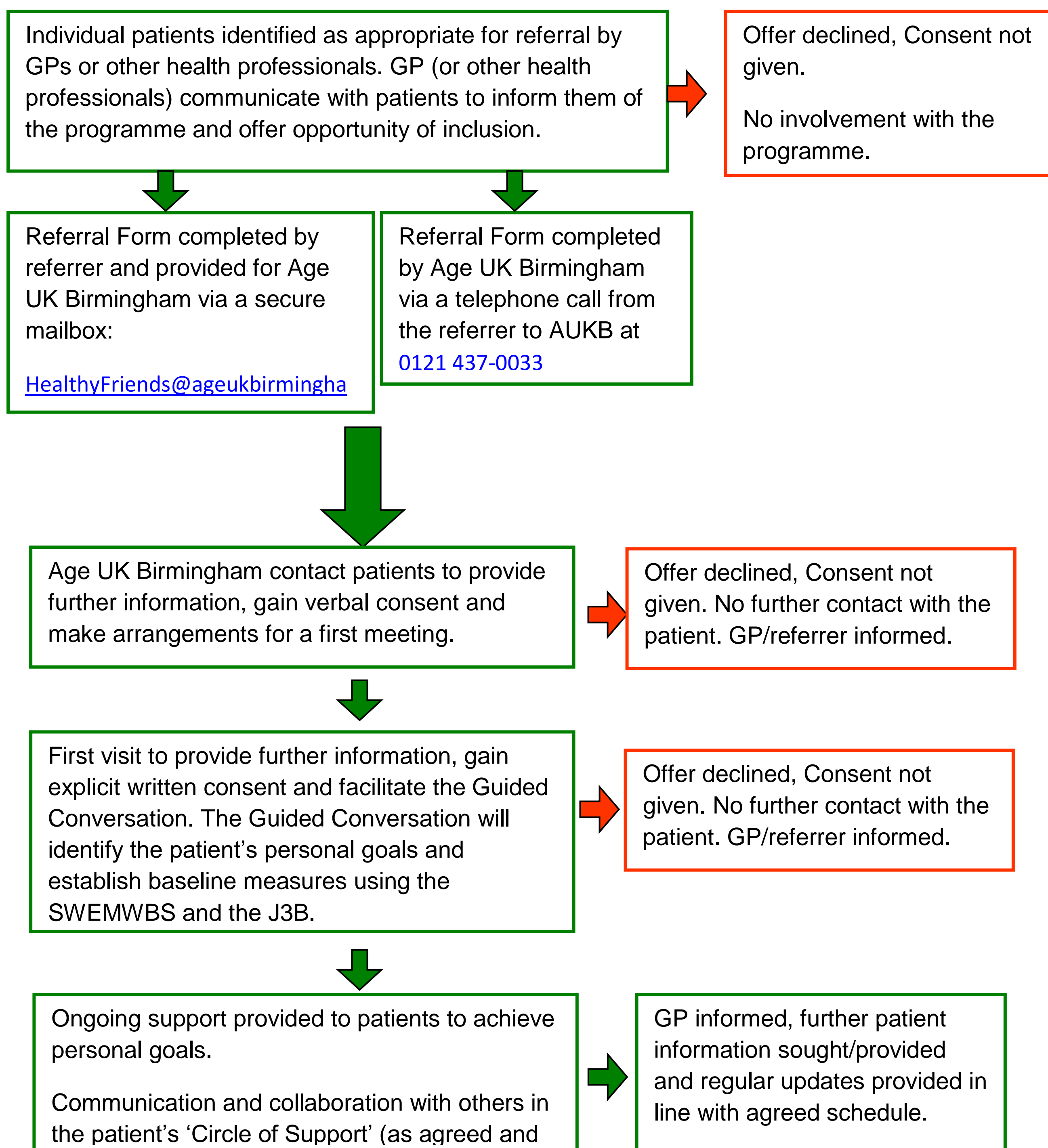


***Figure 1**: Healthy Friends project referral and integrated care pathway*

## 4.2 Engaging with clients

Having **time to engage meaningfully** with clients and building trust was seen as a key – if not the most important - success factor. One team member explained:

> *"Building rapport takes time. We see clients face to face, sometimes sitting in their front rooms. They have a lot going on in their lives and they forget things. We can take our time and explain things, which is better than just giving them leaflets".*

All team members agreed that many clients are *"frightened that when someone comes to their house it is because they might have to go in to care".*

As a result, they describe their initial relationship with the client *as*

> *"a process of negotiation, we build the relationship slowly…We help them to accept that they cannot do what they did 30 years ago, we have to get them to accept that…We then give them hope for the future."*

As trust was clearly a critical issue, the Project Manager tried to ensure that the client had the same H&WB Adviser working with them throughout their case; though this had to be managed to avoid creating an emotional dependency on staff members.

The time the H&WB Advisers gave to the clients was also seen as a critical success factor by NHS partners referring to the project:

> *"When we're in clinics we have limited availability. And now we can refer patients to Healthy Friends for non-medical help where we couldn't fit it in to help them. For example, a patient with mental health issues needed help filling some forms in and I referred them."* (Practice-based Health Care Assistant).

## 4.3 Impact against project outcomes

The impacts of the project that the staff and partners identified during the evaluation are set out below, under the headings of the agreed change indicators for each project outcome.

### 4.3.1 Help clients to manage and cope with long-term conditions (Outcome 1)

There were numerous examples from staff of the ways in which they have helped clients understand, cope with and manage long-term health conditions (LTHCs), including diabetes, anxiety and depression, arthritis, and stroke, among others.

Staff reported that when given information on their health by a GP or nurse:

> *"…clients don't have time to digest this information or they have simply not understood it and sometimes they have forgotten what was said to them."*

As well as helping people to understand information the Advisers helped people to go on line for information and generally played a role in supporting health literacy. They also referred

and signposted people to specific services (e.g. diabetes clinics, Healthy Minds service), and signposted to support groups such as Dementia UK and to Expert Patients courses, and signposted carers to support.

Another example involved a client who was very independent and didn't want a nurse to come to the house to give her an injection (for diabetes). The H&WB Adviser provided her with advice to help her to learn to use the epi-pen and thus manage her diabetes more independently.

The most common health conditions that arose for information and signposting were reported to be diabetes, arthritis/mobility issues, anxiety and depression, and nutrition. In some cases, clients sought advice on issues they didn't want to raise with their GP for fear of seeming unable to cope on their own – incontinence was cited as an example.

Staff also felt they had made huge impact on LTHCs through referring people for aids and adaptations (see 4.3.5 below)

A GP commented on how the project supports people with LTHCs:

> *"They have empowered them [the patients referred], they have helped their physical wellbeing, for example they have supported the mobility of people with osteoarthritis and have given a lot of support to patients with dementia."*

All staff, however, felt that supporting people to better manage their conditions was an area that could be developed further and would welcome a more structured framework or pathway to follow when supporting people with specific issues. They would welcome more training on specific conditions; some staff have undergone the Dementia Friends training, for example, but felt they needed a higher level to support their practice. This is something that could be developed in the next phase of the project.

#### 4.3.2 Reduce Isolation (Outcome 2)

The Healthy Friends team has put together a calendar of social events for clients to encourage them to come out of the house, meet other people and socialise. These have included pampering events, themed coffee mornings, Christmas dinner, and an outing to local heritage site, Blakesley Hall. There is an event approximately every six weeks and clients are encouraged to make their own way as part of independence and empowerment. For members who visit for the first time and are nervous about attending, they are encouraged by their Advisors and transport is arranged for first visit only.

Staff members agreed that one of the main issues facing their clients in reducing isolation (and indeed the other project outcomes) is a lack of confidence and self esteem.

> *"They have had busy lives and then all of a sudden they have grown old and become ill".*
>
> *"The key to our role is to improve confidence of the clients."*

Several examples were cited, such as:

- A H&WB Adviser worked closely with a client who had mental health issues and was nervous of going out. First, she walked with them to a bus stop; later she encouraged and accompanied the client on to the bus for a shopping trip. The staff member gradually withdrew once the client regained the confidence to do this independently.
- Another H&WB Adviser accompanied a client with mental health needs to their first session on a computer course.

Confidence can only be gained through interaction and support from others and the staff and partners felt that one of the key outcomes of the project was successfully referring people to befriending schemes. By the end of the project it is expected that the team will have referred 169 clients to befriending services such as Age UK's Call in Time (telephone) befriending service and to Birmingham City Mission's ElderLink service (lunch clubs and home and hospital visits).

The Team members also keep a record of clients' birthdays and send them a card (including after their case is closed) so they do not feel forgotten; and Christmas hampers are put together as gifts for clients without family, who are on a low income.

During the evaluation, many comments were made by staff and partners on the project's impact on isolation:

> *"My clients are enthused, they are now taking part in social events".*

A local GP commented:

> *"It's a resounding 'Yes' for reducing isolation. The project gets people out and interacting…They sit and have nice chats with people, they make them feel wanted and loved."*

Staff gave examples where people were referred to befriending services or to a lunch club, and where people had exchanged numbers from the coffee mornings.

However, it was also acknowledged that reducing loneliness and isolation is difficult; it may be a fortnightly or monthly activity that people are referred to but they have very little in between.

> *"A lot of community resources have closed and finding somewhere locally can be difficult. Then transport can be a barrier. Ring and Ride may not be available. It would be great if we had a minibus!"* (H&WB Adviser)

Staff felt that reducing isolation is hard for people to sustain themselves after their case had closed, especially if mobility is deteriorating. A lady had engaged with the project and was over time referred on to activities; but she gradually had lost motivation to go out on her own and wanted visits at home again from the H&WB Advisers. Her GP referred her back to the project based on loneliness, and while the team was happy to pick up her case again, it

could only be with a view to referring her on to another activity or service. The Project Manger pointed out "*the project itself can't provide an ongoing befriending/visiting service. There is a need for more accessible activities in the community.*"

#### 4.3.4 Improve fitness and engage in activities (Outcome 2)

Staff have accompanied and encouraged clients to participate in physical activities, such as Tai Chi classes, that are taking place in local areas and have also accompanied clients to Leisure Centres. To date, 78 people have been referred to local physical activity through the project and it is expected to be 92 by the project end.

The project manager and staff team all feel, based on experience, that the original target of 350 estimated by Age UK was very optimistic – and unrealistic (see Section 2.1.2 above). They feel that referring 92 people over three years to physical activities is a real achievement; this is backed up by partners, especially given that clients referred to the project have multiple health conditions.

> *"We were able to get one lady to Tai Chi at Hawthorn Court and two to Birmingham Settlement's sessions in Kitts Green, and they still go as far as we know. I also supported someone to go to the gym and he still goes…"* (H&WB Adviser)

There are also issues of local access – many clients do not live close to a leisure centre or community sports venue, especially as many have closed in recent years, so the issue of transport (cost and accessibility) can be a further barrier.

> *"It's hard to find places for people to go to. One lady went to Easy Gym on her mobility scooter – it was two and half miles. But then her scooter broke so she stopped. There are barriers, even where people can travel alone. The issue is having somewhere local."* (H&WB Adviser)

#### 4.3.5 Help clients to access support services and adaptations to live independently (Outcome 3)

There are two indicators within this:

- **Accessing support services:** Staff have signposted 350 clients to a wide range of services and activities - 107 different organisations and groups in all. These are set out in Appendix two.

  Staff have also helped several clients find and move to more suitable accommodation. Examples include: helping someone move from a private rented house in poor condition to a better social housing; and helping a client register for and move into sheltered accommodation.

  One staff member said, "*We always find ways to help clients*".

  Again however, there was reported concern at the reduction in available services:

  > *"So many services have closed, people don't know where to go anymore".*

Project staff also reported that the waiting times for benefits assessments and reviews and for social care assessments have increased and this was perceived as a factor in slowing down the progress of beneficiaries.

- **Aids and adaptations to support independent living at home**

The project has helped 197 clients to access various aids and adaptions to keep them safe and independent in their own homes by organising Occupational Therapist assessments, which have led to provision of appropriate aids, adaptations and in some cases, home improvements. Based on evidence that underpins these interventions (see 'Commentary on Outcome 3' in Section 2.1.2 above, and Section 5.6.1 below) and feedback from NHS partners, this has helped to reduce the rate of falls the risk of falls as well as the fear of falling. This itself contributes to a reduced need for admission to hospital. This was reinforced by NHS partners:

*"These interventions have a knock-on effect on admission by reducing falls, and also impacts on return visits to the GP." (GP who refers to the project)*

Staff explained that once aids and adaptations installed, they will take time to explain to clients to use their aids, which they don't always grasp when they are first shown. For example, they have met many clients who had emergency call pendants but were not wearing them until they explained the critical benefits and talked through what would happen if they needed to use them.

*"Our work on aids and adaptations has been huge. We refer, we chase it up – it works. Bigger things take longer, like a level access shower or a hospital bed – but we have still got them for people. We have been able to sway it."* (H&WB Adviser)

The NHS partners also saw this area as a success of the project:

However, project staff also reported that clients sometimes do not want aids/adaptions because they are *"fiercely independent".* The team provided a couple of examples including "one client who had two falls but didn't want Occupational Therapist 'taking her independence away' ". The staff member eventually persuaded her to have some adaptations.

#### 4.3.6 Financial Resilience (Outcome 3)

One of the team members specialises in helping to improve clients' financial resilience. She explained how many clients are *"stressed because of a lack of food or they can't afford to put their heating on".* Some of the clients are described as *"practically destitute*". Lack of financial resilience was described as having a *"big impact on health and well-being".*

The support process involves undertaking a 'benefits check' (by Age UK central team) and the project staff then completing applications for any benefits the clients may be entitled to. This also included applying for hardship grants.

The outcomes the project achieved have been considerable, with £344,758 being secured across the beneficiaries, as reported above.

The process of addressing the financial situation of clients was described as "time consuming". Team members also explained that clients' financial situation can change very rapidly due to a change in their health condition and *"it was important to keep on top of it".*

The team provides support on budgeting skills which gives the skills and confidence to manage finances.

*"If clients cannot access benefits because they live in their own homes we find other ways to help them". (H&WB Adviser)*

Partners also noted the success of the project in this area, quoting individual cases where income had been increased.

4.3.7 Fewer interventions by primary and acute health services and adult social care (Outcome 4)

All partners interviewed felt that although it was early days, the Healthy Friends project had potential to reduce the pressures on primary care services. The GP interviewed echoed this and went further:

> "*this has led to reduced requests for social care reviews, improved compliance with medication as Age UK Birmingham often help with blister packs advice and liaises with the pharmacy; and also, ultimately reduced volume of requests for home visits as patients are often able to manage their health more independently. Relatives are also more aware of what help they can access other than calling the GP initially".*

The GP also felt the approach of the H&WB advisers supported independence of patients at home:

> *"I have been very impressed with how Age UK Birmingham are able to see patients quickly and comprehensively. I sat in on one of their reviews whilst I was also doing a home visit and they were thorough and professional. I particularly liked how they fed back what they have done, usually within a month of having seen the patient. This fits in with wider policy of admission avoidance and aiming to keep elderly patients at home."*

Another GP commented:

> *"All these interventions have an evidence base that they will reduce the need for acute services and reduce return visits to the GP".*

Generally, the staff team found this more difficult to comment on. One explained that their *"gut feeling"* was that they had a positive impact and, in some cases, reduced the need for medical interventions; but in other cases, they were initially referring clients in to the medical profession to make sure they got the support they needed, and that it would take longer to see this Outcome materialise.

Nevertheless, examples were provided of preventive activities such as better management of diabetes at home; and falls prevention; and easing anxiety and depression. One team member explained that

> "*We are an alternative [primary care service] because we have time to sit and listen and they confide in you".*

All NHS partners interviewed, commented on the importance of the time that the project staff gave to people and the impact of this on health and wellbeing.

> *"They look out for people and feed back to me, for example, a patient of mine with dementia that I had referred for support. They spent time and fed back to me 'this person is having difficulty in hearing – please could you have a look at her ears next time you see her' ".* (GP)

> *"A lady who had diabetes, she wouldn't go out of the house she was so shy and isolated. When I first saw her, she wouldn't let me touch her [feet]. After I had been able to help her with her diabetes and footcare, I handed her over to the team for ongoing lifestyle support as well as isolation. And they got her out of the house and got her finances sorted. When I saw her, she said 'I'm just going to get my nails painted at an activity day'. This is someone who wouldn't even let me touch her [feet] when I first met her. I would never have the time to achieve that – it's great to have the project to refer people to" (Health Care Assistant)*

Other examples from staff related not to fewer interventions but to easier access to the support people needed:

- a client was attending three different hospitals for different treatments and was very stressed by this and the travel involved. The H&WB Adviser helped to organise Ambulance Transport Services to facilitate easier access to the services.
- a client was spending a lot of money on incontinence pads because she was too embarrassed to go to the surgery about it. Through the support of the H&WB Adviser, she became registered to receive free incontinence pads.

## 4.4 Impact from unintended outcomes

The project team and partners identified the following impact from unintended outcomes:

- **Increased confidence and self-esteem among beneficiaries**: staff and partners gave several examples of beneficiaries having improved self-esteem through social connection and support; and feeling more confident as a result of information and advice they had from the project.

> *"One lady now gets out regularly - these sort of things we take for granted, but she wouldn't have had the confidence without Healthy Friends". (Healthcare Assistant)*

The case studies and the Loneliness Scale and SWEMWBS surveys provide a strong indicator of improved confidence, self-esteem and mental wellbeing.

- **People living in improved or safer housing**: team members identified that they spend a lot of time helping resolve housing issues; sometimes this is related to financial resilience but not always, and it was felt that this aspect was not fully captured in the four Outcomes, given how central it was to the beneficiaries affected.

- **Vulnerable adults safeguarded**: when a safeguarding case presents, the project refers to Birmingham City Council Adults and Communities Access Point (ACAP). There have been nine such cases to date; although they did not fit the criteria, the referrals are a positive outcome - they may otherwise have come about through an emergency.

- **Positive outcomes for carers**: the project has had a positive impact on the health, wellbeing and financial resilience of 35 carers as a result of the work with the person being cared for. These carers were identified as in need of support (as well as the person they cared for who had been referred to the project); they were able to benefit from the Healthy Friends project directly. Outcomes included: reduced isolation, more able to live independently with the person they care for, financially more resilient, health literacy improved, increased access to support services and better understanding of lifestyle choices. FUTURE DEVT

- **Newly-arrived migrant elders supported**: The team has spent some time addressing issues affecting older people who have recently migrated to the UK. Although these are low in number, they have been time intensive for the staff.

### 4.5 Success factors

The staff and partners identified a number of success factors for the project.

- **Approach and characteristics of staff team:** a number of success factors emerged in the overall make-up and approach of the Heathy Friends project:
    - **Having time to build trust** with the client in their own home facilitated a person-centred approach and was seen not only as a success factor but as a unique feature of the project which supported engagement with the project by people who were isolated.
    - **A strong Manager and an enthusiastic, dedicated staff team**, seen by referral partners as having a professional approach. This was cited as an important factor for the team in building trust with clinical NHS staff.
    - **A multi-disciplinary team**: although the roles of the H&WB Advisers were the same, the individuals on the Healthy Friends team came from a

diverse professional background: nursing, welfare rights, housing and community development). This provided a multi-skilled, widely experienced team, where each H&WB Adviser could tap into the expertise of their colleagues if a case required it, and which they felt increase the speed and rate of positive outcomes for beneficiaries.

- All team members felt that it was **a team where people can learn** from each other and that this was a positive, motivating factor.
- The **ethnic and linguistic diversity of the team** (which increased in Year 2) is seen as a strength in reaching more BAME clients.
- Project staff and partners welcomed **the addition of a Community Development Worker** in Year three – in particular, to builds links with BAME communities; and support local activities with community organisations to help sustain the outcomes for beneficiaries.

- **Being part of Age UK federation:** being a project delivered by a trusted and recognised organisation with a 'known brand' has been a facilitator to engagement for referral partners as well as for some of the beneficiaries. Further, having a central resource for initial Benefits Checks for clients, and also to support future funding applications for the project was cited as a strength of the project and contributed to the large sums of money secured for beneficiaries.
- **Partnerships:** The time spent by the Project Manager to build relationships with GP practices and other agencies was seen as a success factor. The decision to widen referrals beyond GPs and Nurse Practitioners in Year one to wider health and social care professionals and relevant third sector providers was seen as a positive one and helped to bring referrals from other sources. Positive partnerships have also been built with local sheltered housing schemes, a local health and wellbeing centre and local voluntary and community organisations.
- **Meeting previously unmet need**: There is clear recognition among partners, including referring GP practices, of the project's **actual and potential ability to reduce the pressures on primary care and adult social care services** by supporting better management of long-term conditions at home. The interventions provided by the project were also cited as being evidence based in **contributing to a reduction in unplanned admissions to hospital**. There was strong feedback from clinical partners of the project's **ability to reduce isolation** – something they saw as critical to health and wellbeing but that they themselves were unable to do in their time -pressured clinical roles. All partners interviewed expressed how much they valued having the project to refer patients to.

### 4.6 Gaps and lessons learned

- **Referrals:** the anticipated flow of referrals as a result of the project being based at a GP Practice took several months to materialise; and the project office being based upstairs at the health centre impacted on the initial flow of self referrals.

  Some (especially earlier) referrals did not meet the project criteria (people referred were too frail with risk factors not appropriate for the project).

  Staff and partners feel it took time for some GPs to understand what Healthy Friends project could achieve and there was an element of mistrust in the early months.

  All staff and partners agreed that the referral process in Year one was "*a hard nut to crack*" and it was important for Healthy Friends to "*build relationships with GPs*". It was also felt to be a positive move to widen referrals to other health and social care professionals and related third sector organisations and housing providers.

  There was a consensus that while referrals from clinical and non-clinical staff improved over time, the project should be promoted to new GP practices. All partners interviewed said without hesitation that they would recommend the project and its benefits to patients. The staff team is working to capacity at the moment so an increase in referrals would either require additional staff or impact on waiting times and outcomes.

- **Communications with statutory referral partners**: while the partners all found the communications from the Healthy Friends project team efficient and effective, it was not always the case the other way around:

  > *"There are no phone referrals for Adult Social Care now – it's all online. So, it's harder to build relationships…And some places such as District Nurses, you go through a main number and leave a message, but you don't know if/when it's been passed on and quite often you don't hear back; or if the client does get a visit we may not know."* (H&WB Adviser)
  >
  > *"It's been hard to even get the Carers Emergency Response team on the phone – though our Project Manager has fed this back and is meeting them about it"* (H&B Adviser)

  Some of the above issues were also linked to budget cuts (see below).

- **Measurement of key indicators:**
  - SWEMWBS: there is consensus among the team that the SWEMWBS questionnaire does not capture the impact that Healthy Friends has on clients, particularly measuring confidence and self-esteem, which was seen to be a key outcome for clients. Sometimes the completed questionnaire at the end indicates that the client may be a worse position than they were

before the intervention, when in fact team member know there has been significant improvements: *"sometimes the paper work doesn't correspond to the evidence."*

This was felt to be largely because people are reluctant to express the extent of their feelings in the baseline survey but are more honest about their problems once they have built trust with the Adviser.

Further, the sample size for follow-up stage (at case closure) and tracking stage (two months after last intervention) is still relatively small, and as such can only provide an indication of the outcome – albeit a positive one so far.

- UCLA Loneliness Scale – while this is felt to be less problematic in terms of the questions, the size of follow-up and tracking sample remains an issue, (though more people completed it in Years two and three, and the results indicate a positive outcome).

  The Project Manager identified the main issues as follows:

  - Baseline – as above there is an understandable reluctance among some clients to disclose feelings of loneliness and isolation early in the relationship with their H&WB Adviser.

  - Tracking - people do not always respond when you go back to them two months later; and although people have more support in place at case closure than they had prior to engagement with the project, they may still be missing direct engagement (home visits) with the project two months on and this may influence their response.

  - Further, in some cases, when the project has directly contacted a former client, although this is done by the Administrator and not their former H&WB Adviser, it has raised an expectation about possible re-engagement with the project when this isn't necessarily an option (in terms of need/referral criteria).

  Although baseline and follow-up tracking are important, this should be reviewed for future practice: the system needs to yield objective data, that is within the resource and expertise of the project team and is sensitive to the clients' expectations. It also presents time and resource issue for the team. This issue should be explored alongside how best to measure other longer-term outcomes on reduced need for statutory services (see nest bullet point below).

- Reduction in use of health and social care services: this is a longer-term outcome and requires tracking beyond case closure. When the project was set up the arrangement was that this would be undertaken with the support of the NHS Midlands and Lancashire Commissioning Support Unit, who would monitor clients anonymously with their NHS number. However, the

Unit can no longer offer this support due to restructuring and resource issues. It's not possible for the Healthy Friends team to conduct this tracking in terms of research expertise, staff resources and not having access to clinical data. The project should review this issue going forward with NHS referral partners, Age UK and with reference to social prescribing projects nationally.

  - Cost benefit analysis of the Healthy Friends project: the above points relate also to value for money considerations (see 4.7 below) and the need for the project to demonstrate actual or potential savings to public services as a result of engagement with the project. A broad Cost benefits analysis is set out in 4.7 below. This should also be further developed over time, alongside and linked to long-term health and wellbeing outcomes for beneficiaries.

- **Engagement of BAME residents in the project.** The number of BAME residents engaging with the project has been lower than the outcome target set for the project though this has increased in Years two and three. Staff feel that the low take up by BAME residents is in part due to wider cultural and linguistic barriers to access uptake of services; an association/misperception of Age UK as an organisation that is more culturally relevant to the white communities; and that some BAME elders are supported by extended family networks living nearby.

  The following actions have been put in place to address this issue:

  - there are two staff members who speak community languages (as well as the Project Manager);
  - engagement with new GP practices with a high percentage of BAME patients (mainly of south Asian origin), who are now referring to the project;
  - appointment of a Community Development Worker in Year three who is promoting the project among BAME communities and GP practices with a high percentage of BAME residents.

- **Project support within the wider organisation of Age UK Birmingham**. Although the project has generally benefitted by being part of a citywide organisation and under a national charity umbrella, there has at times been a mismatch of expectation between the Healthy Friends project and Age UK Birmingham.

  - Recruitment: in Year one there was a temporary delay in recruiting and Admin post to the project due to a wider recruitment freeze within Age UK Birmingham, even though external funding for the post was in place.

  - At the time of project application, Age UK nationally had agreed in principle to support the evaluation of the Healthy Friends project; however, when that time a year or so later, it no longer had the resources to do so. The project Manager addressed this by agreeing a revision of the project budget

with the Lottery Grants Officer, in order to commission an external evaluation, given that this is a pilot and a cross-sector partnership project.

- There have also been fewer resources within Age UK Birmingham than originally hoped to:
  - set up and support the IT and monitoring systems and processes, which the Project Manager has done alone on existing database used;
  - support the publicity and promotion of the project to the wider public (no communications strategy in place)
  - provide or fund staff training for example on dementia, diabetes, etc.
  - support participation in national social prescribing networks and the dissemination of the emerging evidence base emerging from the project.

- **Closure or reduction of statutory and voluntary sector services**

The effect of public sector funding cuts was cited by project staff, partners and beneficiaries as an recurring issue in finding local support for beneficiaries, as some services had reduced or disappeared. Three service areas emerged:

- Voluntary and community sector organisations – several had closed in recent years or had reduced resources and services. Examples include community centres and advice centres, charity services. Some specialist third sector services were seen has being under strain as a result of reduced resources on the one hand and greater need on the other. This has meant longer waiting times for support; more reliance on telephone rather than face to face support, or a move to online support for a demographic (age, culture, disadvantage) that is less able to access online support independently.

  *"They're all disappearing, and this makes our work more challenging."*
  (H&WB Adviser)

- Statutory sector: staff reported longer waiting times when referring people (often vulnerable) to adult social care and some primary health care services. This has placed an additional burden on the workload of the team especially in cases where they feel the needs are more complex or more urgent than they are able to meet.

  *"It's taking longer for Social Workers to get out to clients. It was a six-week wait for non-urgent referrals but now it's longer."*
  (H&WB Adviser)

Staff reported closure of local libraries and reduced opening times of leisure centres, which were seen as a loss of community resource for local communities generally and for project beneficiaries and their carers specifically.

- To a lesser extent, there was reported longer waits for primary and secondary health services, attributed to lack of resources.

The impact of the above is that the Healthy Friends project, as well as meeting the needs of its own client cohort, has frequently been a 'holding' project for cases that are too complex for the project's prevention remit but there is a gap (often of weeks rather than days) before statutory services are in place. This highlights an unmet need as well as risk management issues for the project.

- **Healthy Friends Project base**: the office in a GP Practice that hosts the project is clearly too small for the staff team; and it can be a struggle to book a meeting room in the Practice. It is, however, provided at no cost, which has clearly been of benefit to the project.

  There was also consensus that basing the Healthy Friends project in a GP Practice was initially *"a great idea"* and although it took time to yield the flow of referrals hoped for (see above), this has changed over time and referrals are regularly received from this practice - but also many other GP Practices. This raises the issue of whether the project necessarily needs to be based at one GP Practice or whether it should consider relocation to an open access office, where clients can walk in as a self-referral; and with space for clients and partners to meet at the project base.

  One member of staff explained, *"we need to be grounded in the community"* and another said, *"we need to be visible".*

  Countering this, the clinical staff from the Practice which currently provides office space to the project, felt that co-location facilitated a person-centred approach, by providing the opportunity to discuss cases at the point of referral if needed.

  > *"When I do a referral form – very often I might knock the door and explain the referral. It's not always easy to explain the context on a form. For example, one lady's circumstances – because of the sensitive nature of things [in the family] it wasn't appropriate to make a referral and for them to just ring her up... But here, I could have the conversation with them beforehand and explain the situation."* (Health Care Assistant)

## 4.7 Value for money considerations

There is a perception among the partners and staff that the Healthy Friends project represents value for money. It is not within the remit of this evaluation to provide a cost benefit analysis, and indeed this would need to be linked to measuring some of the longer-

term outcomes and savings to services discussed in 4.6 above. However, in terms of broad costs per individual and per outcome the following has been calculated:

- The total project cost is £375,716 (£358,742 from the Lottery grant; + £30,000 from Age UK Birmingham for overheads). This does not count the cost of an office base which is currently covered by the GP practice hosting the project.

- To date, the project has supported 409 individuals; all have had at least one (and most, more than one) positive health and wellbeing outcome. The number is expected to rise to 449 by the end of its current funding period (March 2019), all of whom will have one, and the majority two or more, positive health and wellbeing outcomes.

- Across all beneficiaries, this is **a unit cost of £837 per person over three years, or £279 per person per year; this included 211 complex cases (to date)** that were assessed as having higher level needs beyond the project's remit, including nine safeguarding issues which were time intensive as multiple actions/goals were identified and met while waiting for handover to the appropriate service.

- The above costs should take into account that the project referrals were lower in Year one even though the project team was in place. Year two and three have worked out more cost effective and this means in effect a lower **unit cost, estimated to be closer to £700 per person over three years, or £233 per person per year.** With fewer inappropriate referrals of complex, high need cases, it is estimated that this would fall **below £200 per person per year.**

- The project has **levered in approximately £344,758 in additional income** to its 409 beneficiaries to date. This equates to each person receiving an average of £850 per year if taken across all clients; if taken across the 107 people who received the financial resilience support, it is an average of £3,222 per person. (The average is expected to rise slightly by the end of Year three). For many, the additional income was a one-off payment but for many it has been **awarded for life** (e.g. Attendance Allowance) **so the benefits will accrue over time.**

- There have been 597 reportable outcomes to date: this equates to a cost of £573 per positive outcome over the project lifetime, or **£191 per outcome over a year**. This does not cover the unexpected outcomes that have also been achieved. Again, taken into consideration the slower flow of referrals and outcomes in year one, it is estimated that this is closer to **£150 per outcome** over a year.

The above costs per individual and per outcome are broad-brush attempt to assess value for money. The figures give a reasonable indication that the money invested in the project has brought a significant return, and that the project represents good value for money, taking into account it was a new project and referrals and outcomes were slower in the first year. While it should be taken into account that the above costs do not

include office premises, **the income secured for beneficiaries currently offsets the project costs, before taking into account savings to reduced call on services.**

Going forward, the project should seek support to develop a robust model for cost benefit analysis that links to some of the health and wellbeing outcomes and reductions in the need for health and social care services (see 4.6 above).

## 5. Analysis: key findings in context

This section of the report analyses the data and distils the "so what" issues – so what is the significance of the findings of the mid-term report? It focuses on the following key areas:

- The impact of Healthy Friends and the outcomes achieved
- The importance of the approach of Healthy Friends
- How does Healthy Friends reflect and contribute to early evidence on social prescribing?
- The strategic fit of the Healthy Friends project with local and national policy
- The sustainability of the Project beyond the current funding period and recommendations for future development.

### 5.1 The impact of Healthy Friends and outcomes achieved

The analysis of beneficiary data shows that Healthy Friends has successfully engaged adults with long-term conditions from disadvantaged communities who are traditionally harder to reach. This has achieved health and wellbeing outcomes, increased financial resilience and greater independence at home.

Healthy Friends has made good progress on the agreed project outcomes; and has exceeded the outcomes in relation to financial resilience.; and has achieved several unintended positive outcomes. The key impacts (which complement each other) identified by the evaluation are summarised as:

- Successfully supporting people to the manage their long-term conditions.
- Enabling people to live more independently at home, including through access to occupational therapy assessments for adaptations and mobility aids and adaptations, contributing to reduced risk of falls.
- Reducing loneliness and isolation.
- Promoting confidence and self-esteem among beneficiaries.
- Promoting financial resilience by maximising benefits and other income, reducing debt, tackling fuel poverty and accessing subsidy to transport costs.

All of the above are factors that have a significant impact on health and wellbeing, and the absence of which increases the need for health and social care services, including unplanned admissions to hospital and crisis calls on social care.

There are a number of **critical success factors** for the project which have contributed to its impact, that are attributed to the underlying approach of the project. This has been implied in the qualitative data from interviews, and the next section examines this approach and the evidence base for it.

## 5.2 The nature of the Healthy Friends Project approach

In considering the factors that contribute to the above impacts of the Healthy Friends project, the evaluation referred to a Thematic Review of Health and Wellbeing projects conducted by the Big Lottery Fund in 2014. It identified key factors that lead to successful projects (see Figure two below).

*Figure two - **What makes projects work?** (Big Lottery Fund, 2014)*

There is a clear fit between the above features and the Healthy Friends approach:

- The project is strategically aligned with Age UK nationally and with the emerging community of practice relating to social prescribing (see 5.5 below). It aligns with Birmingham City Council's Health and Wellbeing Strategy and Public Health priorities, as well as the commissioning priorities of the Birmingham and Solihull CCG. It is also aligned with national government policy on healthy ageing and management of long-term conditions (see 5.5 below).

- The project adopts a person-centred approach, based on knowing and responding to the needs of beneficiaries (including a focus on location and environment); and although not directly resident led, it consults with local people, liaises closely with community groups and is supported by local referring partners and a locally-based team.

- The project manager and staff team are perceived by partners and beneficiaries as able, professional and dedicated - a factor in achieving the successful outcomes to date; and the project's engagement of three local volunteers with a further four poised to start.

- The project is based on a holistic view of health and wellbeing, adopting a social model that incorporates the wider determinants of health (such as income, housing, social networks etc. as well as supporting people with medical health needs).
- Healthy Friends is evaluating its work having commissioned both a formative (interim) evaluation; and now this summative (final) evaluation. The final evaluation has found that's several lessons from the interim evaluation have been taken on board – for example, reaching more BAME residents; taking on a community development worker to reach more communities and to build capacity locally for sustainable outcomes.

Section six below, focuses on how Healthy Friends should develop and position itself to secure its long-term sustainability. There is no doubt that commissioners are facing huge challenges: delivering health improvements and tackling increasing health inequalities with decreasing budgets and continued austerity measures. **Social prescribing provides a potential way forward.**

Clearly then, Healthy Friends is and could continue to be an important vehicle to help meet some of these challenges and has the characteristics associated with successful health and wellbeing projects. But, crucial to any roll out of the project, is understanding the approaches that underpin the delivery and how to apply them effectively. The findings of the evaluation identified **a number of evidence-based approaches** that underpin the Healthy Friends project. These are summarised below:

- **Community development approach**

  The effectiveness of this was evidenced by:
  - **strong partnerships**, especially between Healthy Friends and the community organisations, based on mutual trust and respect;
  - **developing and strengthening community networks** through intensive outreach work, evidenced in the outreach work done with and through the community partner organisations;
  - **promoting inclusiveness and participation** – as evidenced through the increase in diversity of residents engaging with the project; and the person-centred and culturally competent approaches adopted in the service delivery;
  - **engaging and empowering communities through work with volunteers** and community groups. This is achieved through the work with 107 agencies that Healthy Friends has signposted its clients and its partnership with social housing organisations and community groups;
  - **enabling and building capacity** so that local people can identify their own needs and problems and work together to address them – evidenced in the individuals who have become volunteers, the support for carers, the increased financial resilience and the signposting and supported referral to local support services.

- **Person-centred and culturally competent approach**

Examples of adopting a person-centred approach were evident at every stage of the evaluation. This approach was also important to beneficiaries who commented on the listening support given by staff to understand their individual circumstances and being able to refer to different services accordingly and without pressure, as well as to group activity. The partners and beneficiaries felt the team consistently showed sensitivity to changing lifestyles that are being deeply affected by the onset of long-term illness, restricted mobility, bereavement and increased isolation.

This went hand in hand with a culturally competent and sensitive approach. Several examples were provided by Healthy Friends beneficiaries of an environment that offers an understanding of personal, generational and cultural circumstances, and supports people in their mother tongue where possible and with people who share an understanding of cultural and faith norms.

- **A focus on empowerment and health literacy for people with long-term conditions**

The Healthy Friends project approach has supported health literacy - the ability to engage with health information – and an indicator of health inequality. Low levels of health literacy are associated with poorer health status and health outcomes and higher costs in health systems (Osborne, 2014; Public Health England, 2015a). The project has supported health literacy through:

  - activities to support an understanding of as well as a better management of long-term conditions through information, advice, support in navigating services and in adopting practices that support health e.g. medications compliance.
  - Information, advice and events focusing on healthy nutrition; and
  - information on the benefits of physical activity, with supported referral to leisure and wellbeing centres.

## 5.5 How does Healthy Friends reflect and contribute to national evidence on social prescribing

The evaluation sought to establish the fit of the Healthy Friends project with the developing practice and evidence base relating to social prescribing. A **review of the emerging evidence** in the UK to date was carried out and is set out in detail in Appendix one. The key themes from the evidence are summarised below.

**Five key themes** emerge from the evidence relating to social prescribing for older people. These are set out more fully in the Appendix.

- **Loneliness**
  - Identifying loneliness is hard – it's not only physical isolation and a lack of companionship, it's also a lack of a useful role in society.

  - But loneliness is subjective and there is no 'one size fits all'.
  - Even so, the best way to combat loneliness is to tackle isolation.

  Commentary:
  The Healthy Friends project has tackled loneliness and social isolation among its beneficiaries. Success factors include an outreach approach to people's homes; incorporating social networks into all aspects of the project; and facilitating networks where none exist. Data from the loneliness and wellbeing surveys of beneficiaries set out in Section 2 above are that the project is having a positive impact on both.

- **On the importance of community**
  - Reunion with community can lead to older people volunteering
  - The wellbeing of a community and an individual are linked.

  Commentary:
  The Healthy Friends approach recognises the importance of community by helping people to attend group activities in their neighbourhood and encourage inclusion of others in this. It also encourages older people to volunteer. The project has shown its commitment to this by appointing a Community Development Worker in its final year to support setting up activities and sustaining community networks beyond project intervention.

- **On what makes schemes effective** *Healthy Friends project examples are provided in italics.*

  - Involving participants in every stage of the process.
    *Representation on Steering group, peer volunteers.*

  - Co-producing a care plan with individuals that focuses on preventative interventions relevant to them.
    *Undertaken with H&WB Advisers on first and subsequent visits and case closure.*

  - Targeting those disproportionately affected by loneliness has proven most effective.
    *Early data from loneliness surveys.*

  - Befriending schemes are effective – especially when linked to services.
    *Coffee mornings at housing schemes.*

  - Group activities are particularly useful and effective.
    *Feedback from beneficiaries and request for more.*

  - The loss of a service is worse than never having had a service in the first place, even patchy service provision.
    *Sustainability is being addressed through partnership with Neighbour Network Scheme and the appointment of a Community Development Worker to set up*

*networks beyond the project lifetime. This is also taken into account with the option that people may be referred again if needs recurs; sensitivity issues have been flagged when approaching people for tracking data after case closure.*

- Referrals to schemes need to be brief and easy – a 'champion' in GP practices can boost referrals; providing case studies to GPs can help
  *Once GPs understand the potential benefits their referrals increase. Two GPs 'championed' the project and this has improved the flow of referrals; 16 GP practices are now on board.*

- Link Officers (or 'navigators' or 'mentors') are a powerful force.
  *Impact of Health & Wellbeing advisers as the 'front line' of the project.*

Commentary:
Illustrated by the examples, the evaluation has found that the all the above factors are in place in the Healthy Friends project and have contributed to its effectiveness.

- **Difficulty of measuring effectiveness and lack of evidence**
  - More, higher quality evidence is needed to prove that schemes are successful from a cost-saving point of view – a common evaluation framework is needed.
  - But that evidence that does exist is fully supports social prescribing's ability to reduce pressure on primary and secondary services
  - Despite hard evidence, the positive effect of schemes makes them popular with the GPs and beneficiaries like these schemes
  - Social prescribing began as an organic, grass roots initiative at the bottom but it needs top-down steering to ensure that the practices that spread are the ones that work and are most effective.

Commentary:
While there are clear outcomes and indicators for the Lottery funding outcomes, these need to be developed to meet the needs of the health commissioners (GPs and the CCG) and of Public Health. More work needs to be done to show the cost effectiveness of the project in relation to savings to public services, supported by qualitative data and case studies to demonstrate impact. On a broad value for money assessment against unit costs (see 4.7 above), the project is securing more in income for beneficiaries than it is costing, as well as achieving short, medium and long-term health wellbeing outcomes.

- **Designing effective schemes**
  - How can interventions improve overall community wellbeing, in addition to personal gain?
  - How do interventions have different effects in different communities?
  - How does change differ between communities of interest and communities of place?

- How do we measure and quantify value from 'soft' outcomes?
- Will social prescribing help government save money?

Commentary:
The Healthy Friends project has begun to provide evidence towards the answers to these wider questions as reported in Sections 2, 3 and 4 of this evaluation. These questions should continue to be part of an evaluation framework as the project moves forward, a framework that should be developed in partnerships with local health and social care commissioners and providers and informed by the national networks and evidence on social prescribing.

As well as reflecting the above themes and practice, the project is contributing to the emerging body of evidence on social prescribing for example:

- Feeding into the NHS Midlands and Lancashire's Commissioning Support and Strategy Unit event on Social Prescribing
- Feeding in to local health and social care forums
- The project was recently approached by the British Medical Journal to write an article on social prescribing.

There is scope to develop this through Birmingham Age UK and Age UK national umbrella body.

## 5.6 National and local policy context

In addition to the evidence-based context for in evaluation also sought to establish the fit of the Healthy Friends project with the local and national policy relating to health and wellbeing of older people. A review of key local and national policy documents was carried out and a summary of these is set out in Appendix one.

Based on this review and the findings of the evaluation set out in Sections 2, 3. & 4. above, the evaluation found that the Healthy Friends project aims and emerging outcomes are aligned with national and local priorities. They fit with both the Government's and Birmingham City Council's policy direction in relation to older people's health and wellbeing and supporting them to live independently at home.

*5.6.1 National policy context.*

The Healthy Friends project and practice are aligned with a number of national polices and strategies set out in Appendix one. Some of the key **national policies** include:

- The Department of Health's (DH) ***Public Health Outcomes Framework 2016-2019*** (DH, 2016), which sets out the Government's desired outcomes for public health. Specifically, the outcomes of the Healthy Friends project support the two overarching key outcomes of the national Framework:
    - Increased healthy life expectancy; and

- Reduced differences in life expectancy and healthy life expectancy between communities.

Implementation is through **four key domains and objectives**, each with a set of indicators. Those of most relevance to the Healthy Friends project are:

**Domain 1: Improving the wider determinants of health**

- Indicator 1.17 – Fuel poverty
- Indicator 1.18 – Social isolation.

**Domain 2: Health improvement**

- Indicator 2.11 – Diet
- Indicator 2.12 – Excess weight in adults
- Indicator 2.13 – Proportion of physically inactive and active adults
- Indicator 2.17 – Estimated diagnosis rate for people with Diabetes Mellitus
- Indicator 2.23 – Self-report well-being
- Indicator 2.24 – Injuries due to falls in people aged 65 or over.

**Domain 4: Healthcare public health and preventing premature mortality**

- Indicator 4.03 – Mortality rate from causes considered preventable
- Indicator 4.04 – Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke
- Indicator 4.13 – Health-related quality of life for older people.

- Dept. of Health and Social Care's ***Prevention is Better than Cure (2018)*** document sets out a vision for putting prevention at the heart of the nation's health. Its stated mission is "to improve healthy life expectancy so that, by 2035, we are enjoying at least five extra years of healthy, independent life, whilst closing the gap between the richest and poorest. An accompanying ***Collection of Case studies*** showed examples of good practice in preventing health problems from happening.

- Public Health England (2017a) ***Better Mental Health JSNA Toolkit. Guidance 7: Living well in older years.*** Guidance for commissioners in planning to ensure services can meet the needs of older people in future and highlights key points that JSNAs (Joint Strategic Needs Assessments) should consider in supporting the mental health of older people.

- Mental Health Strategic Partnership's (2012) ***No Health Without Mental Health: a guide for clinical commissioning groups.*** A briefing from a partnership of national mental health charities to supplement the Government's *No Health Without Mental Health: a Mental Health strategy for England,* (DH, 2011; updated 2012); includes commissioning guidance on:
  - Older people and isolation – early diagnosis and early intervention.

- New Economic Foundation's (2008) ***Five Ways to Wellbeing***: a set of evidence-based actions adopted by the NHS, Mind and others as a tool to which promote people's mental wellbeing. They are: *Connect, Be active, Take notice, Keep learning* and *Give*. These activities are simple things individuals can do in their everyday lives.

- ***The NHS Five Year Forward View*** (NHS England, 2014) set out a new shared vision for the future of the NHS informed by patient groups, clinicians and independent experts, of how the health service needs to change if it is to close the widening gaps in the health of the population, quality of care and the funding of services. It makes reference to **increasing use of the voluntary and community sector in delivery of health and social care interventions.** This will be succeeded by an NHS Forward Plan to be published in 2019.

- Public Health England (2017b) ***Falls and fractures consensus statement: Supporting Commissioning for Prevention*** produced with the National Falls Prevention Coordination Group member organisations. These documents outline approaches to interventions and activities helping prevent falls and fractures to improve health outcomes for older people, with evidence of cost and clinical effectiveness. Effective commissioning for falls and fracture prevention will reduce demand and improve quality and outcomes. It can be supported and enabled at all stages of the commissioning cycle and by the governance frameworks that oversee and assure this activity. A collaborative and whole system approach to prevention, response and treatment is recommended for local areas. The following recommendations are of direct relevance to the Healthy Friends project:

    - "*be able to demonstrate the commissioning of services that provide:*

        i. *an appropriate response attending people who have fallen*
        ii. *multifactorial risk assessment and timely and evidence based tailored interventions for those at high risk of falls*
        iii. *evidence based strength and balance programmes and opportunities for those at low to moderate risk of falls*
        iv. *home hazard assessment and improvement programmes;*

    - *ensure that local approaches to improve poor or inappropriate housing address falls prevention and promote healthy ageing."*

- Public Health England's (2018) ***A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community***: this interactive tool can be used to estimate the cost-effectiveness and potential return on investment (ROI) for falls prevention programmes aimed at elderly people based in the community. One out of the four interventions – homes assessment and modification - produces a financial return on investment, through opportunity cost savings (e.g. freeing up hospital beds due to a reduction in inpatient admissions). This supports the practice of the Healthy Friends project in

helping people to access OT assessments leading to aids and adaptations in the home to prevent falls and support independent living.

- **Royal College of Occupational Therapists, (2015)** ***Occupational Therapy in the prevention and management of falls in adults: Practice Guideline:*** this evidence-based resource supports occupational therapists working with adults in the prevention and management of falls. It can also be used to inform service users and carers, together with other health professionals, managers and commissioners working in adult services, about the roles and responsibilities of the occupational therapist in this clinical area. The three recommendation categories reflect key aspects of occupational therapy in the prevention and management of falls in adults and support the practice of the Healthy Friends project. They are:

    i. Keeping safe at home: reducing risk of falls.
    ii. Keeping active: reducing fear of falling.
    iii. Falls management: making it meaningful.

- Public Health England's (2015a) ***Understanding the cost of poor housing to health: BRE briefing papers*** This paper provides an overview of the housing conditions of older people and estimates the cost to the NHS in England of the poor housing occupied by the older population.

- Public Health England's (2015b) ***Local action on health inequalities: Reducing social isolation across the life course*** highlights:

    - social isolation affects physical and mental health and risk of mortality;
    - particular groups or individuals may be more vulnerable to social isolation depending on factors like physical and mental health, income, ethnicity, gender and age or life-stage;
    - there are links between social inequality and social factors that influence social isolation and loneliness operate at the individual level, community level and at the wider societal level;
    - learning from specific interventions already in place in local areas can inform work elsewhere; a recurrent theme is the importance of involving communities in the design and delivery of interventions;
    - interventions will focus on activities that can be shared, bringing people together naturally in a way that is appropriate to their needs;
    - successful interventions to tackle social isolation can reduce the burden on health and social care services and as such are typically cost effective.

- Public Health England's (2015c) ***Local action on health inequalities: improving health literacy*** highlights:

    - In England, 42% of working-age adults are unable to understand and make use of everyday health information, rising to 61% when numeracy skills are also required for comprehension.

- People with low health literacy, compared with the general population:
  - are 1.5-3 times more likely to experience increased hospitalisation or death, and are more likely to have depression;
  - use fewer preventative and health promotion services, such as cancer screening and flu vaccinations, and have less recall and adherence to medical instructions and healthcare regimes;
  - find it more difficult to access appropriate health services, make more use of emergency services and have longer in-patient stays; and
  - have less effective communication with health and social care practitioners and are less likely to engage in active discussions about their health options, potentially leading to their health needs being hidden.
- Population groups at most risk of limited health literacy include:
  - more disadvantaged socioeconomic groups
  - migrants and people from ethnic minorities
  - older people
  - people with long-term health conditions
  - disabled people.

These population groups are also known to have to have the poorest health outcomes. Health literacy therefore has the potential to reduce health inequalities and evidence suggests that improved health literacy can:

- Build resilience
- Reduce disease severity
- Improve mental health
- Increase health knowledge
- Improve adherence to medical instruction
- Promote healthy lifestyle changes
- Improve engagement and involvement in health
- Improve confidence and self-esteem
- Empower people to effectively manage long-term conditions.

*5.6.2 Local policy context*

The Healthy Friends project relates to and seeks to support key **local health policies**. The overall direction of health and wellbeing policy in Birmingham reflects the national policies above and can be summarised as:

- Help people live longer
- Help people live healthier and fulfilling lives
- Close gaps in health inequalities
- Promote healthy lifestyles, neighbourhoods and minds
- Work at a community level, being aware of individual needs.

Specifically, Healthy Friends aligns with and supports the following:

- Birmingham's ***Health & wellbeing strategy*** (updated January 2017): relevant priorities include:
    - improving the independence of adults
    - improving the wellbeing of disadvantaged adults
    - reducing falls
    - tackling loneliness and isolation
    - better management of long-term conditions and
    - promoting personal budgets for health and care.

- ***Birmingham Joint Strategic Needs Assessment: Public health outcomes framework*** (Birmingham City Council 2017a): Indicators which show the poorest performance against all comparators and are getting worse, that are **relevant to the Healthy Friends project,** are:

    - Rates of hospital admission due to falls
    - Social isolation of adult carers
    - Fuel poverty.

- Birmingham's ***Vision & Strategy for Adult Social Care and Health*** (Birmingham City Council, 2017b): the vision is to enable "adults and older people to live independently whenever possible" and the *Strategy* aims to address potential barriers and obstacles and puts in place a framework to make this achievable.

  The *Strategy* contains eight key elements:

    - Information, advice and guidance
    - Community assets
    - Prevention and early intervention
    - Personalised support
    - Use of resources
    - Partnership Working
    - Making safeguarding personal
    - Co-production.

  The Healthy Friends project is well placed to support the implementation of this strategy at a local level and has each of the eight elements built into its work.

- ***Birmingham and Solihull Clinical Commissioning Group (B&S CCG):*** established in April 2018 and the largest clinically-led commissioning organisation in England, B&S CCG covers a population of 1.3 million, tasked with:
    - Delivering the best outcomes
    - Tackling health inequalities
    - Meeting the health and wellbeing needs of a diverse population
    - Improving services [effectiveness, safety, quality and patient experience]

- Working within a financial sustainable system.

(B&S CCG, 2018)

The CCG also commissions with reference to the frameworks of the Health and Wellbeing Boards for Birmingham City Council and Solihull Council and their respective Overview and Scrutiny Committees.

B&S CCG has adopted a ***Collaborative Commissioning Policy: Ethical framework for priority setting and resource allocation*** (Midlands and Lancashire Commissioning Support Unit, 2014), published prior to and in anticipation of the merger of the Birmingham and Solihull CCGs (and the merger of the Black Country CCGs). This framework *"underpins priority setting processes and informs decision making by the Clinical Commissioning Group and its associated committees"* and has 14 principles, two of which particularly relate to the Healthy Friends work in social prescribing and the prevention agenda:

> *"Principle 5: Access to services should be governed, as far as practicable, by the principle of equal access for equal clinical need...There are proven links between social inequalities and inequalities in health, health needs and access to healthcare. In making commissioning decisions, priority may be given to health services targeting health needs in sub-groups of the population who currently have poorer than average health outcomes (including morbidity and mortality) or poorer access to services."*
>
> *"Principle 8: The Clinical Commissioning Group must ensure that the decisions it takes demonstrate value for money and an appropriate use of NHS funding based on the needs of the population it serves."*
>
> (Midlands and Lancashire Commissioning Support Unit, 2014)

The B&S CCG has a Primary Care Commissioning Committee that meets monthly and is open to the public. This is potentially a platform where the benefits of social prescribing should be raised by voluntary sector agencies and NHS referral partners.

- **Birmingham and Solihull Sustainability and Transformation Partnership (STP):** formed in line with government health and social care infrastructure, the B&S STP is

> *"a collaboration of public NHS and council social care commissioners and providers across Birmingham and Solihull working together with partners in the voluntary, community and independent sectors to find the most effective ways to manage the health and care needs of our population within available resources and provide high quality, sustainable care for the future."*

The work of the Healthy Friends clearly has outcomes that relate to both health and social care and as such should seek ways to engage with the B&S STP and highlight its good practice and effectiveness to date.

### 5.7 Summary of the research and policy context

The nature of the Healthy Friends approach is integral to its success. The critical elements of the approach – community-centred and person-centred, supporting independence, building financial resilience and capacity and promoting health literacy – reflect evidence-based practice and are a solid foundation on which to build.

Further, the project aligns itself with and supports the key priorities of the Dept. of Health and Social Care and with Public Health England in tackling health inequalities, reducing emergency admissions, and promoting health and wellbeing by addressing the social determinants of health; and more specifically, the project supports evidence-based practice in relation to falls prevention, fuel poverty and financial resilience among older people to enable them to live independently at home for longer.

It supports the key strategies and priorities of: Birmingham City Council and the Health and Wellbeing Board; Birmingham and Solihull CCG and STP:

- helping people to manage long-term conditions
- reducing loneliness and isolation and
- promoting independence of adults and older people to live well at home whenever possible
- tackling health inequalities.

The Healthy Friends project also incorporates the success factors that have been identified in the emerging evidence on social prescribing and the role of non-clinical interventions in supporting health and wellbeing. The project and its evaluation processes are contributing to that body of evidence.

# 6. Sustainability

Healthy Friends is making an impact on the lives of older people with LTHCs and has achieved impressive outcomes relating to promoting independence at home, reducing isolation and increasing financial resilience. Early evidence indicates to cost effectiveness and suggests that it is saving costs to the public sector in terms of reduced unplanned admissions to hospital, reduced call on primary care services and reduced need for crisis social care. This has been achieved in a difficult economic climate and in one of the most disadvantaged areas of Birmingham. Sustaining this work is not only important, it would leave a big gap if it were not to continue.

Funders and commissioners will want to look at the extent to which the projects' outcomes are sustainable, support independence at home; and reduce the need for services; as well as to improve their own engagement with BAME communities among their wider populations. The evaluation identified the following sustainability factors:

- The project sits with and supports the achievement of national and local health, and social care priorities.
- The project has forged sustainable partnerships with GP practices that have created pathways to support independence at home and to reduce the need for services.
- GPs and other health professionals are very keen for the project to continue and feel strongly that it is yielding positive outcomes for their patients that they could not achieve.
- A 'broad brush' cost benefit analysis indicates that the project represents value for money in the income it secures for its beneficiaries and the outcomes it is achieving.
- People with long-term conditions who have engaged with the project unequivocally support its continuation and feel it responds to a range of unmet needs and improved their independence and quality of life.

In summary, given the project's achievements to date, its clear strategic alignment with national and local health priorities, its established track record on delivery and trusted NHS partnerships, the project is in a position to present a strong case for funding to different potential funders, supported by the findings of this evaluation.

## 6.1 Potential funding streams

The project should explore (and indeed has started to explore some of) the following:

- **Big Lottery Reaching Communities**: Birmingham Age UK has made an application for continuation funding beyond March 2019 to the Lottery's Reaching Communities Programme and is awaiting the outcome. While it is optimistic that funding will be awarded, it is unlikely this will meet the full project costs, as there are competing demands on the Lottery's own budget allocation.

- **Neighbourhood Network Scheme (NNS)** – part of a wider policy programme being rolled out across England, an NNS is a network of *"community based, locally led organisations that enable older people to live independently and pro-actively participate within their own communities by providing services that reduce social isolation, provide opportunities for volunteering, act as a "gateway" to advice/information/services promote health and wellbeing and thus improve the quality of life for the individual".* NNS is more about connecting people and places and part of the new social work 'three conversation' model being rolled out across Birmingham. This includes supporting people by signposting to community-based support to reduce isolation and promote wellbeing and independence. Age UK Birmingham is part of the current pilot scheme and is working in partnership with Disability Resource Centre (the lead partner) to scope local community assets in East Birmingham and feed back to Adult Social services as part of their '3 conversation model'. This is part of the project's exit strategy and would secure part funding if successful.

- **Third sector partnerships**: Building on the above, the project should develop collaborative working and joint funding bids with the DRC and other third sector organisations for other funding streams.

- **Birmingham and Solihull CCG and STP**: Age UK Birmingham, potentially supported by the GPs from local practices working with Healthy Friends, should identify commissioning routes with the Birmingham and Solihull CCG and the STP and begin a dialogue. Starting points might be through the Primary Care Commissioning Committees; and Commissioning Operations team.

- **Charitable trusts and foundations**: there are many charitable trust funds that would support the work and outcomes of the Healthy Friends project, though trust fund applications and appeals take time and resource. Further, being part of a bigger charity will determine which funds can be applied for. Age UK Birmingham should research the relevant trusts and foundations (taking into consideration existing funding for its other work), draw up a schedule based on application deadlines and work alongside the project manager to submit funding applications for the next one to three years. This could be a two-stranded approach: individual applications to the larger trust funds; and a letter of appeal to the smaller local ones. This should be actioned immediately.

- **Ageing Better Birmingham programme**: The city wide contract for Ageing Better Birmingham is jointly led by Age Concern and Age UK Birmingham. The Healthy Friends team has referred community groups to Ageing Better Birmingham and the Community Development Worker will further tap into this fund for Healthy Friends beneficiaries who have formed friendship with other older citizens and support them to sustain relationship by creating social networks and promoting resilience in local communities.

- **National social prescribing networks**: using the findings of this evaluation, the project Manager should actively explore potential partnership resources that may emerge through the national social prescribing networks.

- Some of the above have immediate or imminent timescales and are therefore included in the 'Next Steps' in Section 7. below.

Other areas relating to sustainability that are explored in Section 7. below and which may present opportunities for further funding, include:

- extending the approach to other areas of Birmingham
- developing the strategic role for Healthy Friends to inform social prescribing for older people
- further development of indicators
- strengthening the co-design and co-production approach.

## 6.2 Reviewing outcome indicators/measures

There is an important opportunity for Healthy Friends project to use the findings of this evaluation as a basis to further strengthen and develop its outcomes framework and measures. However, it cannot and should not be expected to develop these measures and research methods alone, especially as it in part involves clinical data. For this reason, Birmingham Age UK should seek the support from the B&S CCG and Birmingham Public Health Department. It should also seek the support of local GP clusters to do this, and to open up the potential for discussions on commissioning of social prescribing as an important prevention programme, that building on its success to date, can have a framework to demonstrate outcomes such as:

- clinical benefits through improved management of long-term conditions, e.g. reducing medication (and prescription costs);

- reducing hospital admissions (including through better management of long-term conditions and reduced falls);

- reduced number of emergency admissions;

- reduced need for or better management of medication;

- reduced rate of and risk of falls and increased mobility;

- improved mental health and wellbeing (that may not be adequately captured by SWEMWBS);

- reduced loneliness and isolation through improved social networks and befriending schemes

- lowering blood pressure and other health indicators, and

- support and improved health outcomes for carers, especially older carers

- tackling health inequalities.

Further areas for Healthy Friends to consider in relation to demonstrating outcomes include:

- scope and methods for tracking longer-term impact;
- ways of measuring improved levels of health literacy for people with long-term conditions
- GP and health professionals time saved
- Improved housing conditions
- Reduction in fuel poverty.

Developing these outcomes and indicators of impact will be vital to the future sustainability of the project.

# 7 Future development and next steps 2018-2019

The evaluation has identified several areas for development and a number of steps to ensure that Healthy Friends builds on its success; and to help build and sustain the future of the Healthy Friends project and the approach it has successfully applied in east Birmingham.

**The key areas for development** are:

- **Continue to seek continued funding for this project** beyond the current project lifetime (see Section 6. above)
- **Retain the focus of the project on prevention support for older people with LTHCs; deliver the project on broadly the same model underpinned by the same evidence-based approaches;** and **review some of the outcomes and indicators** in the light of the evaluation.
- **Develop, monitoring and outcomes frameworks** with health partners, in addition to those required by the Lottery, to demonstrate that non-clinical interventions delivered through social prescribing can have health and wellbeing outcomes; and to demonstrate the cost benefits and value for money. This should incorporate learning from the last three years about indicators that were overestimated, for example referrals to leisure centres.
- **Increase awareness of the project** among black and minority ethnic residents, building on the new Community Development Worker role.
- **Build partnerships with local community** organisations to support provision of social and other activities to refer people to beyond their case work with the Healthy Friends project and to sustain outcomes relating to reducing loneliness and isolation.
- **Continue to raise awareness of the project among local NHS primary care providers** who are not yet referring to it (balanced against staff capacity).
- **Feed back the findings of this evaluation to commissioners and social prescribing networks.**

## 7.1 Strategic next steps

In relation to the **strategic fit and future sustainability** of the Healthy Friends project, the following is recommended in the last quarter of the project:

<u>Strategic fit</u>

- **Healthy Friends and Age UK Birmingham to engage with Birmingham & Solihull Clinical Commissioning Board**, to identify how Healthy Friends can help deliver their strategic priorities and outcomes (with reference to the policy context in Section 5. above and detailed in the Appendix to this report). This dialogue should draw attention to the success of the project to date and seek the support of the GP practices

who currently refer to Healthy Friends in highlighting the strengths and opportunities presented by the project to the current prevention policy agenda.

- Building on this, Age UK Birmingham, the CCG and potential funders should **explore rolling out the Healthy Friends model in other areas of the city**. The social prescribing approach is being understood and grasped as an important way to support older people to live independently at home for longer.

- As part of the above, **Healthy Friends and Age UK Birmingham should seek support from the CCG and Birmingham Public Health or Public Health England West Midlands to develop a 'Healthy Friends Outcomes Framework'** that provides a more effective evaluation tool for measuring impact, costs benefits and value for money. This would for example explore the potential of including additional health impact measures suggested in 6.2 above, such as
  - reduced use of A&E or hospital admissions.
  - more appropriate indicators relating to loneliness and mental wellbeing
  - health literacy levels
  - reduction of/compliance with medication.

The framework should also:
- capture the approach that underpins the success of the project;
- develop indicators to measure progression beyond the immediate activities of the project – for example, self-organisation of health promoting activities; benefits passed on to carers and family members; more appropriate and effective use of health services; and increased independence at home;
- include a mechanism for a more meaningful cost-benefit analysis of the project – against individual outcomes as well as against individual people reached.

The project, along with its health partners, should explore seeking relevant academic guidance in the development of the framework, linking with the national work on social prescribing.

<u>Sustainability</u>

Work is already underway to secure the project's future; the project Manager and Birmingham Age UK should:

- **build on this by exploring the funding streams and opportunities** set out in 6.1 above.

- **seek opportunities to tender to deliver prevention services,** including with partners such as social housing organisations and voluntary and community organisations.

- based on the success of Healthy Friends to date, **Age UK Birmingham should explore extending the model to other disadvantaged communities in the city**, linking with the work of the Ageing Better initiative and Neighbourhood Networks schemes in the city.

- **The Healthy Friends Steering Group membership should be reviewed to ensure it can oversee and support** the effective implementation of the above strategic actions, with representatives from primary care commissioning, public health, primary health and adult social care providers, among others.

### 7.2 Operational next steps

In relation to the future operation of the Healthy Friends project, we recommend the following in the last 18 months of the project:

- **Referrals pathways and criteria:** communicate regularly the referral criteria with GP Practices and other referral agencies ensuring they are understood and adopted, in order to reduce inappropriate referrals of complex needs cases, especially by new referral partners. Review of referral pathways should also take into account the need to engage more BAME residents.
- **Liaise with Adult Social Care** about the response to complex cases referred and the communications issues that have arisen, including with the Carers Emergency Response Service.
- **The Healthy Friends project should seek alternative office accommodation** as the current offices are too small and have no meeting rooms available. This would ideally be provided by a GP Practice, free of charge, but visible to patients; but the base could also be in another community venue if costs allowed.
- **Age UK Birmingham should support Healthy Friends Manager to develop and implement a communications strategy** to raise the profile of the Healthy Friends project, within the local health sector as well as among the wider public, and in the context of the role of social prescribing as a tool to promote health and wellbeing and prevent unplanned admission and call on services.
- **Incorporate staff training into the future project budget,** in relation to higher level of training on common LTHCs such as dementia, diabetes, navigating the health and social care system, etc. whilst seeking support from Age UK Birmingham and partners where possible.
- **The Healthy Friends Steering Group should oversee** the effective implementation of the above actions.

**December 2018**

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