Ageing Better:

BIG LOTTERY FUND

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Learning Report No. 2 - Community Connectors

October 2018

Executive summary

Introduction

Ageing Better is a National Lottery funded programme set up by the Big Lottery Fund, the largest funder of community activity in the UK. It aims to develop creative ways for people aged 50 and over to be actively involved in their local communities, helping to combat **social isolation** and **loneliness**. The programme runs from 2015-2021 and is delivered by 14 cross sector **partnerships** across the UK.

This document shares learning about **Community Connector** projects from the 14 Ageing Better partnerships, and is aimed at commissioners and policy makers working in the loneliness, health and social care sectors, and related areas. Ageing Better partnerships define Community Connector projects as:

> "Any mechanism that works to identify isolated people over 50 and then works with them to help them transition from isolated to less isolated through person-centred structured support. This includes community navigators, **social prescribing** and approaches that involve people overcoming a specific barrier, for example, mental health[1]"

Key findings

Some people involved in a Community Connector project experience reduced social isolation and loneliness and positive health and **wellbeing** outcomes. Ageing Better partnerships report that Community Connector approaches can reduce demand for local statutory services responsibly, by empowering people with the skills and self-confidence to live independently for longer and better manage their own health, whilst knowing who to ask for support when they need it.

All the Community Connector models tested by the Ageing Better programme are unique, having been designed in response to local conditions. They are all underpinned by a person-centred approach. The Ageing Better Community Connector approaches are generating a range of positive participant outcomes:

- Reducing social isolation and loneliness;
- Increasing self-confidence, knowledge and understanding about accessing local services and activities;
- Improving health and wellbeing outcomes (including mental and physical health, ability to self-manage health conditions and make healthy lifestyle choices, improve home safety and maintain independence);
- Increasing membership of clubs, organisations and societies, and more involvement in co-production activity;
- Enhancing appropriate service use, by improving targeting, signposting and take-up.

Formal referral partners include Clinical Commissioning Groups (CCGs), General Practitioners (GP Practices), Adult Social Care, mental health teams, and local housing associations and debt advice agencies. Some models are based on community and volunteer networks, providing informal referral pathways to reach people who have very limited contact with local services. In this way, Community Connector approaches are supporting health and social care services to become more agile through improved targeting of available resources and joint working.

Glossary: Words that appear in a **bold blue** format feature in the glossary at the end of this paper.

Crossgates Lunch Club, Leeds

Introduction

About the Ageing Better programme

Ageing Better is a National Lottery funded programme set up by the Big Lottery Fund, the largest funder of community activity in the UK. It aims to develop creative ways for people aged 50 and over to be actively involved in their local communities, helping to combat social isolation and loneliness.

The Ageing Better programme is running from 2015-2021 and aims to enable people aged 50 and over to be:

- Less isolated and lonely;
- Actively involved in their communities, with their views and participation valued more highly;
- More engaged in the design and delivery of services that improve their social connections.

The Ageing Better programme also aims to support:

- Services that improve the planning, co-ordination and delivery of social activities;
- The future design of services by developing better evidence about how to reduce isolation and loneliness for people aged 50 and over.

The programme sets out to achieve this by avoiding imposing top-down models and instead encouraging the development of different local activities and delivery models. Each partnership draws on the skills and experience of people aged 50 and over, making use of the unique nature and assets of each area, to meet locally identified needs. This allows each partnership to develop its own activities and events based on key strengths, resulting different approaches being developed by the 14 cross sector partnerships across England. Partnerships are encouraged to **test and learn** throughout their programme, building on evidence and shared learning so that their work has the most impact possible. This allows them to respond to challenges, honestly reflect and share what has been less successful and capitalise on opportunities to fill gaps in services whilst exploring new approaches.

About this learning paper

This learning paper has been produced by Ecorys, the independent organisation that leads the national evaluation of the Ageing Better programme[2].

This document shares learning about Community Connector projects from the 14 Ageing Better partnerships, and is aimed at commissioners and policy makers working in the loneliness and health and social care sectors, and related areas. Ageing Better partnerships define Community Connector projects as:

> "Any mechanism that works to identify isolated people over 50 and then works with them to help them transition from isolated to less isolated through person-centred structured support. This includes community navigators, social prescribing and approaches that involve people overcoming a specific barrier, for example, mental health[3]"

Ageing Better partnerships are testing a range of Community Connector approaches[4]. Some areas have very established schemes, several have remodelled their approaches using 'test and learn', and others are just starting activity. This paper reflects on recent learning which will be updated as the programme progresses.

This paper:

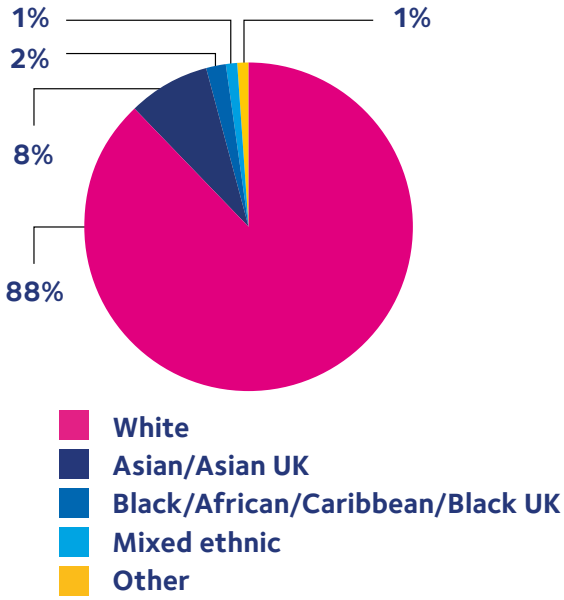
- Situates the Community Connector role within the health and social care policy context;
- Explores the community connecting journey at three key stages;
  - Reaching isolated people by building relationships with potential referrers and establishing informal engagement routes;
  - Support activities and the skills required of Community Connectors;
  - Outcomes for participants: reducing social isolation and loneliness and increasing confidence, wellbeing and engagement in local activities;
- Considers the benefits of Community Connector approaches for the health and social care sector, and the potential legacy of Community Connector activities.

Information used in this paper

- Participant data provided by partnerships about the scale of Community Connector activity so far;
- Participant data on self-reported outcomes for individuals involved in Community Connector projects;
- Qualitative evidence captured by the national evaluation team, from interviews with partnerships[5];
- Emerging local evaluation evidence from individual partnerships reflecting on the successes and challenges of community connecting.

Ageing Better: Community Connector activity

Ethnicity breakdown



Community Connector reach:

At least **4,000** participants[6]

66% Female

34% Male

14
Partnerships

2015 → 2020

Digital Buddies, Cheshire

Community Connector policy context

The UK policy context

Currently, 37% of the UK population are aged 50 and over[7]. Most people will have at least one long-term health condition by the age of 65, and at least two by the age of 75[8]. The Marmot Review (2010) reported that older people are at risk of a variety of complex health needs caused by factors including: financial challenges, poor housing, low self-esteem, isolation, and physical and mental health problems[9]. The complex relationship between social and health needs has increased demand on the National Health Service (NHS), GP Practices and social care. It is estimated that around 20% of patients consult their GP for problems that are primarily social, rather than medical in nature[10].

The need for a Navigator role to support people to navigate their way through health, social care, housing and employment services was identified by researchers[11]. In recent years, this role has been implemented in a variety of ways to help address problems around health and social care services failing to recognise the inter-connected and complex relationship between health and social care. Two main 'navigator' approaches have emerged in recent years:

Improving connections

Approach	Activity
Social prescribing models	Enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services[12].
Community connector models	Enables local (non-medical) organisations and individuals to link others into community activities and non-clinical support services. The sector has yet to agree a definition for 'Community Connectors[13]. Schemes include social activities such as volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and sports.*

*Community Connector models often include social prescribing approaches, referring people via both community and medical routes into community provision.

Reported outcomes from these approaches include: improving resilience, preventing further ill health, increasing self-confidence, reducing isolation, and making savings across the care pathway[14]. Interest in these approaches has expanded recently due to the combined influence of the personalisation agenda in health and social care, the increased interest in public, private, and voluntary sector partnerships; and the increased demand on the NHS[15].

Social prescribing and Community Connector models support a number of NHS policies, including the NHS Five Year Forward View (2014)[16]. Volunteering and social action are identified as key enablers for delivering the new relationship with people and communities, by reducing demand on GP services[17]. Community Connector approaches have emerged in this context, delivered by national charities such as Age UK and the British Red Cross, and a wide range of local organisations.

A review of evidence assessing the impact of social prescribing on healthcare demand and cost implications shows an average 28% reduction in demand for GP services following referral[18]. The study also reports a reduction in the number of Accident and Emergency (A&E) attendances by around 24%[19]. Some of the social prescribing models reviewed include a Community Connector role, and suggest this approach can also reduce costs for the NHS and lead to a range of positive health and wellbeing outcomes (including improvements to quality of life, emotional wellbeing, mental and general wellbeing, and reduced levels of depression and anxiety)[20].

As there is limited evaluation evidence available on the impact of Community Connector models, learning from Ageing Better is enhancing understanding about the benefits of person-centered and asset based approaches, in improving quality of life and informing decisions around efficiencies in health and social care delivery.

Big Lunch - Connect, Hackney

Outcomes – what do Community Connectors achieve?

The Ageing Better National Evaluation has explored the self-reported outcomes reported by people participating in Community Connector projects[21].

Individual improvements

The key aims of Ageing Better Community Connector activity are to increase social contact and confidence and reduce isolation and loneliness for people aged 50 and over[22]. Learning from across the programme demonstrates that the models are starting to achieve this[23]. However, individual capacity building was often required before a participant was ready to engage in community activity.

As part of the national evaluation, partnerships collect participant survey data on entry to a project and at exit from a project[24]. Community Connector participants reported reduced loneliness and social isolation[25] following their participation in the Ageing Better programme. Improvements were greater for Community Connector participants than for Ageing Better participants as a whole. However, Community Connector participants' loneliness and social contact remains below that of participants as a whole, reflecting the high levels of need of this group.

Average scores of loneliness and social contact at entry and follow up[26]

Scale	Average at Entry	Average at Follow-up	Improved by
Loneliness scores for Community Connector participants*	4.0	3.3	0.7
Loneliness scores for all Ageing Better participants*	3.3	3.0	0.3
Social Contact scores for Community Connector participants**	6.3	6.7	0.4
Social Contact scores for all Ageing Better participants**	6.6	6.8	0.2

< Source: National Evaluation participant survey, October 2018 >

*Loneliness scores are based on the De Jong Gierveld loneliness scale, where 6 refers to the most lonely, 0 the least lonely. Community Connector n=1,275, Ageing Better n=4,441.

** Social Contact average is based on contact with non-family members. A score of 6 = contact once or twice a week, and a score of 7 = three or more times a week. Community Connector n=1,197, Ageing Better n=4,909.

Similarly, Middlesbrough participants reported being less lonely and isolated following support, reflecting their lives had improved considerably through regular visits from an outreach worker, enjoying the company and conversation, and feeling more able to go out[27].

> "It rebuilds confidence. I couldn't go to the bus stop because there will be people there. Now, I'll chat to anybody...which is what I've always been like[28]"
>
> (Participant, Middlesbrough)

Community Connectors build trust and rapport with some of the most isolated and lonely people, representing an important social connection in itself. Participants' commonly reported increased self-confidence from this one-to-one contact. For example, one participant described the importance of the direct contact with their Community Connector:

> "It wasn't so much where she took me, but the contact itself, it gave me self-confidence to go out, I didn't go out much by myself. I didn't have no friends, and my family are always very busy...so I felt a bit neglected. All of a sudden, there was somebody taking an interest in me, they gave a boost to my self-confidence to lift up my mood. Then we agreed on visiting this community centre, to see what's available there...The other thing she did for me, which was very useful, was putting me in contact with people who can help me...I am 73 years old, and I need a little bit of help with the cleaning, and shopping. Through her, I met other people...Now I've got friends, I go to the café every day"
>
> (Participant, Camden)

The Community Connector relationship is instrumental in bringing about positive outcomes, particularly for people needing support for a period of time. More intensive Community Connector approaches, including social prescribing elements, indicate positive behaviour change:

- In both Middlesbrough and Bristol, over half of participants consulted had sustained improvements for at least three months after completing a Community Connector project[29].
- The Isle of Wight's Care Navigators project which supports people with higher level need in their own homes, reported significant improvements in participants health status, health confidence, and personal wellbeing[30]. Participants explained that Care Navigator support improved their confidence to self-manage, make healthy lifestyle choices, improve safety in their home, reduce their social isolation and improve their quality of life[31].
- The Leeds partnership reported similarly positive outcomes from home visiting, particularly for the very frail[32]. Monitoring data shows statistically significant improvements in loneliness, higher levels of social contact and higher levels of wellbeing amongst participants[33].

Some participants felt more positive about their mental health after being involved in Community Connector projects:

- Community Connector participants reported greater wellbeing at follow-up than at entry and the change was greater than for participants across the Ageing Better programme as a whole. However, Community Connector participants' wellbeing remains below that of Ageing Better participants as a whole, again reflecting the high levels of need of this group.

Mental wellbeing scores at entry and follow up

Scale	Average at Entry	Average at Follow-up	Improved by
Scores for Community Connector participants*	18.9	21.4	2.5
Scores for all Ageing Better participants*	21.2	22.7	1.5

< Source: National Evaluation participant survey, October 2018>
< Community Connector n=1,266, Ageing Better n = 4,522. >
* Mental wellbeing scores are based on the Short Warwick-Edinburgh Mental-Wellbeing Scale (SWEMWBS). Seven items (I've been feeling optimistic about the future, I've been feeling useful, I've been feeling relaxed, I've been dealing with problems well, I've been thinking clearly, I've been feeling close to other people, I've been able to make up my own mind about things) were each scored out of five as follows: 1. None of the time, 2. Rarely, 3. Some of the time, 4. Often, 5. All of the time, so the highest wellbeing is 35, with a score of 5 being the lowest[34].

Overall health scores of Community Connector participants also improved[35]. Local evaluations also found evidence of health benefits. Participants in Sheffield, who received up to 24 weeks therapeutic counselling support provided by Wellbeing Practitioners, reported more positive feelings. The local evaluation in Sheffield reported a 16% increase in the number of people feeling optimistic, 16% increase in the number of people feeling relaxed and a 12% increase in the number of people feeling useful. The data also reveals a 12% increase in participants reporting they did not feel anxious or depressed and an 11% reduction in people reporting feeling extremely anxious or depressed[36].

Health scores at entry and follow up

Scale	Average at Entry	Average at Follow-up	Improved by
Scores for Community Connector participants	50	58	8
Scores for all Ageing Better participants	60	70	10

< Source: National Evaluation participant survey, October 2018 >
< Community Connector n=588 (Data not available for Leicester's Social Prescribing projects, Bristol's Community Webs, Middlesbrough's Outreach and Thanet's Planning for Later Life project), Ageing Better n=1,849 >

Some participants commented that socialising more has supported their mental and physical health. For example walking to local venues to meet new friends enhances both activity levels and mood as participants engage with others in a similar situation. Participants from several partnerships mentioned new friends accompanying them to hospital visits, providing important support and morale, and increasing their wellbeing (for example Camden and Cheshire)[37]. For example, a participant in Camden stated the following:

> "There is a lady who will come with me to the hospital when my eyes will be done, because I need company, somebody to come with me for the operation. She agreed to that...It's so nice to be in touch with people again, because I felt very lonely and neglected"
>
> (Participant, Camden)

Involvement in community activities

Some participants required light touch support to increase their social contact and community connections. Birmingham's hub network and Camden's outreach and drop in sessions connected people to local activity. Participants across the programme valued making friends and taking up new hobbies, such as knitting or a sport[38].

> "[The Community Connector] introduced me to a knitting group which I've been going to since, and I like it!"
>
> (Participant, Cheshire)

Participants in Community Connector projects increased their membership of different types of clubs, organisations or societies slightly more than participants across the Ageing Better programme as a whole[39]. Middlesbrough's outreach project recorded a good level of take-up of local opportunities, supporting just under 100 people to access 200 community activities[40].

Social participation scores at entry and follow up

Scale	Average at Entry	Average at Follow-up	Improved by
Scores for Community Connector participants	0.6	0.9	0.3
Scores for all Ageing Better participants	1.0	1.2	0.2

< Source: National Evaluation participant survey, October 2018 >
< Community Connector n=1,327, Ageing Better n=4,909 >

Many participants needing more tailored support from an individual Community Connector to (re)build their confidence progressed over time to access community activities and local services independently through a variety of models.

- Participants in Bristol started setting goals and accessing local activities and services independently (including mental health support, social groups, physical activities, and befriending groups), following holistic guided conversations with Community Webs linkworkers

> "Being able to talk to someone, [the linkworker] explored my needs/interests. I was feeling I wasn't good for anything. Now I feel I can take part in cooking/reading/walking groups and engage more[41]"
>
> (Participant, Bristol)

Having enhanced their confidence and wellbeing, many participants continued with these activities independently. Three months after meeting a linkworker, 54% of Bristol's Community Webs clients were attending activities they were supported to access 'very often' or 'quite often'[42]. Similar findings were reported by Cheshire and Thanet.

Some Community Connectors approaches also empower participants to access local services more appropriately following support.

- In Torbay participants estimated their GP visits reduced to three times a year compared to seven times, following their Community Connector support[43].

Community Connectors empower some older people to access services (mainly non-medical services and community activity) who may have been unable to do so before receiving support.

> "[The Community Connectors] are really trying to target people who are most socially isolated. They really had to think about who might have reach with those people. They know that those people aren't easily going to come forward for support. They wanted to work with more men, and that's why they employ more male counsellors to be able to do that"
>
> (Partnership staff member, Sheffield)

Influencing, co-production and volunteering

After involvement in Community Connection projects, more participants agreed that they could influence decisions affecting their local area after their involvement in Ageing Better than before it, although the increase is very slight[44]. Similarly, more Community Connector participants were involved in co-production activities by the end of the project than before it, and the change was greater than for participants across the Ageing Better programme as a whole[45].

Influencing and co-production scores at entry and follow up

Scale	Average at Entry	Average at Follow-up	Improved by
Influencing scores for Community Connector participants*	2.5	2.7	0.2
Influencing scores for all Ageing Better participants*	2.8	3.0	0.2
Co-production scores for Community Connector participants**	0.7	1.5	0.8
Co-production scores for all Ageing Better participants**	0.9	1.3	0.4

< Source: National Evaluation participant survey, October 2018 >

*Influencing - a score of 5 represents a participant definitely agreeing that they can influence decisions affecting their local area, and a score of 1 represents definite disagreement with the same statement (Community Connector n=725, Ageing Better n=2,946)

**Co-production - based on the number of co-production activities participants select (Community Connector n=412, Ageing Better n= 1,695).

> "I referred [an individual] to the project... now he's set up his own group, and now he's linked back to us and we're doing an article with him in the next newsletter"
>
> (Community Connector, Leicester)

These findings demonstrate important characteristics of asset based approaches. While Birmingham and East Lindsey do not have formal Community Connector models, their ABCD[46] approach aims to empower volunteers to set up activities in response to local need, supporting people to build capacity to support others in their community.

> "One of the models that we encourage is just bring an isolated friend along. So everyone who is already coming, if you bring one more person and they bring one more person, you've got a connection function there. It's essentially disseminated right down the structure to the participants"
>
> (Partnership staff member, Birmingham)

Camden's outreach project and Cheshire's social prescribing project also include volunteering opportunities, such as assisting at drop-ins[47].

> "Every drop-in may be different. [They are] quite informal coffee and chat things, there might be an activity, but then have half an hour at the end where [isolated people] can just talk. And they really like that because when they are not talking to people day in and day out, then they want to just talk to people... Volunteers support and help at the drops-ins"
>
> (Community Connector, Cheshire)

National evaluation data demonstrates a slight increase in volunteering activity by Community Connector participants. This increase is the same as for participants across the Ageing Better programme as a whole[48].

Volunteering scores at entry and follow up

Scale	Average at Entry	Average at Follow-up	Improved by
Volunteering scores for Community Connector participants*	0.5	0.6	0.1
Volunteering scores for all Ageing Better participants*	1.1	1.2	0.1

< Source: CMF National Evaluation participant survey, October 2018 >

*Volunteering – refers to the numbers of volunteering activities participants have taken part in (Community Connector n=974, Ageing Better n=3,689)

In Bristol, Community Connectors help participants move forward and increase volunteering activity.

> "[A linkworker]... helped me to realise that if I take things in 'baby steps'... that I can actually do more for myself than I had originally realised. I now feel more motivated and capable than before I met [the linkworker] – they have been great. I like their mind-set and they are easy for me to get along with. I am now thinking that I might try some voluntary work...at a hospice, as I am feeling like the strings holding me back have been cut[49]"
>
> (Participant, Bristol)

Co-production and volunteering approaches within Community Connector models will be explored further in future by the national evaluation team.

Crossgates Lunch Club, Leeds

Community Connector approaches

Types of Community Connector models supported by Ageing Better

Community Connector models developed through the Ageing Better programme are locally designed, testing different models and with different characteristics, captured in the diagram. This variation includes duration and intensity of support provided, how formalised the service is and the type of organisations and individuals involved in referral and delivery[50].

Festival of Ageing, Greater Manchester

Festival of Ageing, Greater Manchester

Community Connector Models

Low intensity

One-off/ out-reach/ pop up events facilitated by staff and volunteers.

ABCD (Asset Based Community Development).
Engagement and group activities organised by local volunteers, with support and guidance from staff.

Medium intensity

Time-bound individual support for up to 2 months

High intensity

Time-bound individual support for up to 3 months

Options for home visiting, and specialist support such as mental health or debt advice. Initially accompanied to activities and/ or appointments if needed. Delivery by staff drawn from a range of disciplines including professional debt counsellors, mental health workers, ex-social workers etc Drop-ins may be delivered by staff and volunteers as a segway into community activities.

Open-ended individual support including options for home visiting, and specialist support such as mental health or debt advice. Accompanying to activities and/ or appointments if needed, and advocacy support available. Delivery by staff drawn from a range of disciplines including professional debt counsellors, mental health workers, ex-social workers etc. Gradually supported to attend activities if appropriate.

Low intensity: establishing community activity and signposting to build social connections

Several partnerships tested Community Connector models linking people into a range of social activities.

Lower intensity support includes outreach, commonly provided as a one-off interaction, to signpost people to community activities. This approach reaches people with limited contact with service providers. For example, Camden's outreach team engaged men in pubs, signposting them to group drop-ins as a first step to meet local people and engage in community activities.

Asset based community development (ABCD) approaches underpin Community Connector projects in Leicester, Birmingham and Torbay, empowering local people to co-produce activities such as very local drop-ins and hobby groups. Supporting volunteers can overcome structural barriers, for example informal groups in Birmingham include car owners providing transport for their peers to attend theatre productions and other events.

Medium intensity: person-centred support, providing advice and connections for up to 2 months

Medium intensity models provide time-bound one-to-one Community Connector support tailored to individuals, identifying activities/ services according to need:

- Bristol's Community Webs linkworkers for example hold holistic guided conversations with individual participants to identify needs and set goals, helping people feel connected and valued. Camden and Cheshire are supporting similar approaches.

> "I was happy that somebody was coming to take an interest in me, what I'm doing, and how they can improve my life. That was exciting for me"
>
> (Participant, Camden)

Home-visiting also features in some medium intensity models, enabling Community Connectors to reach people isolated in their own homes. Community Connectors support participants to build their confidence and awareness of local activities. Community Connectors accompany participants to local activities initially if needed, although many people move onto local activities independently.

> "My Outreach worker came every Thursday to visit and have a cup of tea... We talked about various things. [They were] very easy to speak to and I enjoyed it. She told me [about] places to go to, little sessions and gave me a lot of ideas of what to do in my spare time"
>
> (Participant, Middlesbrough)

Participants from Cheshire and Camden also commented that being accompanied to an initial activity by their Community Connector helped break the ice, and in some instances supported them to start conversations. Community Connectors also text participants to notify and remind them when local activities are taking place, which participants found useful.

Community Connector models with a physical and/or mental health focus provide holistic support, and connections to other services. A mix of staff and/or participants, consulted from partnerships including the Bristol, Sheffield, Isle of Wight (Care Navigators), Cheshire and Leeds partnerships, highlighted the value of holistic support provided by a Community Connector. This provides continuity across time and services, resulting in a less stressful experience for participants and improving efficiencies for staff.

> "[Community Connectors] provide social support and feed very well in with other things; the home independence service, which brings people that turn up at A&E mainly, back into their homes. When you bring them back into their home, they then need more support"
>
> (GP referral partner, Leeds)

High intensity: consistent support, facilitating access to advice and other services

High intensity models provide focused support to people whose isolation is compounded by an event, such as bereavement, retirement, health conditions (including mental health problems), or a combination of factors. Some models are time limited (up to 3 months), whilst others are open-ended. Early learning from Community Connector activity demonstrates the importance of flexible delivery, and therefore whilst some models are 'time limited' in design to ensure they can manage resources to support as many as people as possible, they are also applied flexibly to meet individual needs[51].

- Sheffield's Community Connector model was co-produced with participants and is delivered by Mind. The Community Connectors are trained counsellors, supporting isolated people with complex needs for up to 24 weeks, and are confident in referring participants to the community mental health team when needed. Thanet's Life Planners can also work with participants for up to 24 weeks. The intensity of support varies depending on individual need, from several meetings in the community, to longer-term support at home. Where possible participants are encouraged to meet their Community Connector at Citizens Advice offices rather than in their own homes, to help people feel more connected to their community. Participants expressed gratitude to the Community Connectors for turning their lives around, as the following couple demonstrate:

> "Attendance Allowance...we wouldn't have known anything about that, if it hadn't been for [the Life Planners]... It was unbelievable. That helps us... We are in debt...They've given me more confidence. When I came down to fill in the Attendance Allowance form, I kept saying 'I'm not going to. Don't bother. I'm not going to get this'. I was really negative. I definitely wouldn't have known what to put on the form. We can go out more now. We can put more petrol in the car...It boils down to our lifestyle, our living, all round.... It's a social thing. We can do it now...It makes a difference to just go out and see people"
>
> (Participant, Thanet)

> "I had a quadruple bypass, and we couldn't have been any lower... It's definitely improved my lifestyle. It's completely taken so much pressure. I sleep better. I eat better... it's like an injection of adrenaline"
>
> (Participant, Thanet)

Several Community Connector models incorporating social prescribing approaches provide open-ended support for more vulnerable participants experiencing mental and physical health challenges.

- The Isle of Wight's Care Navigators project, and Torbay's Wellbeing Coordinators project are examples of this approach. Participants consistently valued this level of support, which gave them time to build trust in their Community Connector. As a result, participants felt more comfortable and confident opening up and being honest about their situations. This enables Community Connectors to introduce participants to appropriate activities gradually, increasing their likelihood of sustaining activity, and helps target stretched services at those most in need.

> "It's the ability to talk to people and for them to listen; it's important"
>
> (Participant, Cheshire)

Community Connector workers

Community Connectors' roles vary but are underpinned by a person-centred approach. This focus empowers participants with a greater understanding of the choices available to them, and encourages action. Techniques, skills and qualities Community Connectors found worked well, and which were noted by other stakeholders, include:

- Persevering in building links with organisations in the public, private and community sectors;
- Spotting opportunities and gaps in local activity that could be addressed by volunteers/ peers using asset based approaches;
- Building trust, understanding and mutual respect with each participant;
- Inspiring others through their energetic and consistent approach;
- Introducing people to local activities;
- Maintaining contact and reminding participants about upcoming activities via text messages.

> "The Community Connector is reliable and an enthusiastic person who I can trust"
>
> (Participant, Cheshire)

Volunteers play a central role in delivering low intensity models. Staff employed as Community Connectors by medium and high intensity models included qualified counsellors, advice and guidance professionals, and support workers. Paid staff play an essential role in supporting and managing volunteer activity, such as assisting at drop-ins and supporting individuals with lower level needs[52].

Community Connector challenges

Evidence from both the national evaluation and local evaluation activities highlights important constraints in establishing Community Connector projects:

- Transport represents a key challenge, as participants are often reliant on public transport which can be patchy and costly, limiting access to local activities. Some participants experience mobility problems which reduce their travel options, and safeguarding concerns can compound the problem. These challenges have been tackled in several ways. For example, in Birmingham Community Connectors initiate very local transport collaborations between volunteers and participants. Thanet is collaborating with local taxi services to provide more age-friendly local services. Some partnerships have innovated by taking activities into participants' homes, (including the Isle of Wight, Cheshire, and Sheffield). However this approach is resource intensive and can be challenging to sustain or move on from.
- The complexity of some cases has been challenging, making it difficult for some participants to move on. This has partly been tackled by tapering the support offer – moving from face-to-face to telephone support, and gradually closing a case with reassurance that the participant can re-contact the service if they need.
- Volunteer turnover requires additional time from paid staff to provide training and support, and limits the roles that volunteers can play[53]. Furthermore, national evaluation data revealed that the number of participants intending to volunteer in future actually decreased slightly, from 26% at entry to 25% at follow-up. This probably partly reflects the high levels of need of this group[54].
- Lack of suitable local activities to connect people to was also highlighted as a challenge to setting up Community Connector activity. East Lindsey, for example, established local friendship groups rather than a Community Connector project, given the limited local activities available to people aged 50 and over.

Reaching isolated people

This section explores how Ageing Better's Community Connector projects build relationships with referral partners and engage participants.

Building relationships with potential referrers

Ageing Better partnerships seek referrals from the health and social care sector, mental health teams, local organisations including older people's services and charities, debt advice agencies and housing associations, and self-referrals.

Some of the Community Connector projects include social prescribing approaches; forging referral relationships with GP Practices, to access people presenting non-medical needs to their GP. Support from a local CCG helped establish effective referral routes with GP Practices, (reported by Bristol's Community Webs model). However several partnerships developing direct referral routes from individual GP Practices experienced difficulties generating sufficient referrals. These partnerships broadened their referral network to include mental health teams, adult social care teams and voluntary organisations[55].

Establishing referral routes can be complex and time consuming. Challenges often arise from time pressures experienced by potential referral partners. For example, GP partners highlighted competing demands, short-term provision and uncertainty that a Community Connector approach will meet their patients' needs as reducing the likelihood of a referral[56]. Partnerships delivering social prescribing approaches highlighted the value of a GP 'champion' in securing referrals, but recognised that this

reliance on an individual may negatively impact on the referral route if the GP moves on. Camden originally sought referrals from pharmacies, but found both counter staff and customers were uncomfortable discussing emotional wellbeing.

Most partnerships generated referrals from a mix of public and voluntary sector organisations. The Leicester, Birmingham and Middlesbrough partnerships all developed effective referral routes with voluntary sector partners, and found this helped to build trust with potential participants.

Some organisations leading Community Connector projects receive high levels of referrals from advice services that they have organisational links with. For example, Thanet's Life Planners are based at Citizens Advice and Camden's Community Connectors are Age UK staff. Both organisations regularly refer people requiring more intensive or specialised support than their core services provide.

Some partnerships have also established referral routes between their Community Connector models. For example, Care Navigators on the Isle of Wight refer participants to their Community Navigators, to help them reconnect to local activity.

Inappropriate referral was a common challenge reported by partnerships, often caused by stretched health and social care resources, or during early relationship building between referrers and Community Connector services where referrers needed to better understand what Community Connector services had capability to support. These cases often concern people with higher level needs, such as physical or mental health issues, who need more intensive support than such schemes focused on facilitating social connections can or should provide.

Informal engagement routes

Outreach approaches have informally engaged people in the community (Camden, Leicester, and Bristol have all adopted this approach to some extent).

- In Camden, Age UK staff initiate conversations with potential male participants about local activities in outreach locations including on the street, in pubs and bingo halls. This approach has increased the number of men reached. Camden is also hosting drop-ins at local housing associations to engage isolated residents.

Word-of-mouth and self-referrals also generate informal referrals. Referrals by friends and family were noted in Cheshire and Camden. Thanet's Life Planners estimate that around 50% of their clients are self-referrals, who have been advised by a peer, often a Life Planner client themselves, to contact the service. This organic snowballing approach is empowering, demonstrating that people can signpost their peers to support. This increases the confidence and social contact of both referrer and referee.

Engaging marginalised groups

Some Community Connector activity in Leicester, Greater Manchester and Sheffield focused on engaging BAME individuals, and highlighted the importance of engaging community representatives to link connectors into the local community. Sheffield's Community Connectors engaged more effectively with the BAME community by working with a local BAME charity. Programme data suggests more women are engaged in Community Connector activity then men. Several partnerships are however targeting men (Sheffield, Greater Manchester and Camden). Sheffield recruited more male Community Connectors, and the number of male participants subsequently increased.

Digital Buddies, Cheshire

Benefits for Health and Social Care

This section explores emerging benefits for the health and social care sector from Community Connector approaches, and considers the potential legacy of Ageing Better models[57].

Health and Social Care benefits

Community Connector schemes are helping health and social care providers target their resources more effectively. This does not necessarily result in a net reduction in time spent supporting an individual overall, but helps identify and channel people to appropriate help and support. This is particularly evident for GP Practices.

> "I have found it extremely useful to have a service such as yours to refer to. It has saved time allowing me to focus on clinical aspects of care more[58]"
>
> (GP, Bristol)

Participants report being better able to manage their own health following Community Connector support. In Sheffield for example, around 60% of participants reported seeing their GP less after working with a Community Connector[59], and Torbay reported similar findings[60].

Ageing Better partnerships are also working closely with other statutory organisations such as Adult Social Care teams and local mental health teams. Bristol's Adult Social Care team is exploring how the Community Navigator model, which empowers people to regain their independence, can support people at the tier one threshold[61]. Representatives from local mental health teams attend drop-in sessions run by Cheshire's social prescribing model and also refer clients into the project.

Community Connector initiatives are also joining up services. A public health representative from the Leeds partnership and GPs involved in the Isle of Wight's Care Navigator service highlighted enhanced local service integration. For example, the Isle of Wight's Care Navigators are working alongside the NHS, Social Services, Fire Service and Police. The Care Navigators conduct joint home visits to people with these organisations. This enhances service delivery and enables participants to access help more quickly. The joint approach recorded around 90% achieved visits, whereby services were able to connect with the resident (considerably reducing the number of no-shows reported by public services). It is expected that this approach will enable people to live independently for longer. Community Connector approaches are therefore supporting the system to become more agile.

Legacy of Community Connector activities

Initial indicators from established Community Connector projects suggest sustainability can be achieved. In Birmingham and Leicester, there is already some indication that the ABCD approach empowering volunteers to design and deliver their own activities, are likely to continue after funding has ended. However these approaches will require funding to maintain delivery. Many partnerships work closely with statutory providers and are aligned with health and social care developments. Partnerships are hopeful that this may lead to further funding.

Big Lunch - Connect, Hackney

Festival of Ageing, Greater Manchester

Conclusion

The Ageing Better programme is generating learning about a range of Community Connector models. All the Community Connector models tested by the Ageing Better programme are driven by local conditions and assets, and encourage flexibility to support each individual. These include:

- Low intensity: Support to gently encourage people to (re)connect with their community. One-off outreach activities, pop-up events and volunteer led asset-based initiatives work well.
- Medium intensity: Time-bound individual support for up to 2 months, gently encouraging people to build their confidence before engaging in group activities. This includes options for home visiting, specialist support, and Connectors accompanying participants to activities and/or appointments initially.
- High intensity: Some partnerships provide support for 3-6 months, using similar approaches to the above. Open-ended support is also available for participants with higher level needs (often the most frail or people with medical conditions), using the techniques described above, and also advocating if necessary. Gradually supporting participants to attend activities if appropriate.

All the Community Connector projects establish referral routes. Formal referral partners include CCGs, GP Practices, Adult Social Care, mental health teams, and local organisations including housing associations and debt advice agencies. Some models are based on community and volunteer networks, providing informal referral pathways to reach people who have very limited contact with local services.

Community Connectors' roles vary, but all are underpinned by a person-centred approach which is both helping to connect people and activities, and empowering communities to make the most of their assets. Techniques, skills and qualities Community Connectors found worked well include:

- Persevering in building links with organisations in the public, private and community sectors;
- Spotting opportunities and gaps in local activity that could be addressed by volunteers/ peers using asset based approaches;
- Building trust, understanding and mutual respect with each participant;
- Inspiring others through their energetic and consistent approach;
- Introducing people to local activities;
- Maintaining contact and reminding participants about upcoming activities via text.

The Ageing Better Community Connector approaches are generating a range of positive participant outcomes:

- Reducing social isolation and loneliness;
- Increasing self-confidence, knowledge and understanding about accessing local services and activities;
- Improving health and wellbeing outcomes (including mental and physical health, ability to self-manage health conditions and make healthy lifestyle choices, improve home safety and maintain independence);
- Increasing membership of clubs, organisations and societies, and more involvement in co-production activity;
- Enhancing appropriate service use, by improving targeting, signposting and take-up.

Community Connector approaches are supporting health and social care services to become more agile through improved targeting of available resources and joint working.

The national evaluation will continue to explore learning from Ageing Better's Community Connector approaches during 2019.

Crossgates Lunch Club, Leeds

Crossgates Lunch Club, Leeds

For further details about Ageing Better and our plans for the evaluation, please see **biglotteryfund.org.uk/ageingbetter** or contact us at **ageing.better@ecorys.com**

Partnership websites

Birmingham	**ageingbetterinbirmingham.co.uk**
Bristol	**bristolageingbetter.org.uk**
Camden	**ageingbetterincamden.org.uk**
Cheshire	**brightlifecheshire.org.uk**
East Lindsey	**tedineastlindsey.co.uk**
Greater Manchester	**ambitionforageing.org.uk**
Hackney	**connecthackney.org.uk**
Isle of Wight	**agefriendlyisland.org**
Leeds	**timetoshineleeds.org**
Leicester	**leicesterageingtogether.org.uk**
Middlesbrough	**ageingbettermiddlesbrough.org.uk**
Sheffield	**agebettersheff.co.uk**
Thanet	**agelessthanet.org.uk**
Torbay	**ageingwelltorbay.com**

Glossary

Asset Based Community Development (ABCD)	Asset Based Community Development, (ABCD), is an approach based on the principle of identifying and mobilising individual and community 'assets', rather than focusing on problems and needs (i.e. 'deficits')[62].
Community Connectors	Any mechanism that works to identify isolated people over 50 and then works with them to help them transition from isolated to less isolated through person-centred structured support. This includes community navigators, social prescribing and approaches that involve people overcoming a specific barrier, for example, mental health[63].
Partnership	Partnership refers to the individuals and organisations (partners) that oversee and support the delivery of Ageing Better in each of the 14 programme areas. Each partnership selects a variety of projects that best meet local needs.
Social isolation and loneliness	There is no single agreed definition of social isolation or loneliness. In general, social isolation refers to the number and frequency of contacts with other people that a person has, and loneliness refers to the way that a person views this contact (for example whether it is a fulfilling connection). Social isolation is an objective state, whereas loneliness is subjective.
Social Prescribing	Social Prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services[64].
Test and Learn	Test and learn gives partnerships 'the flexibility to try out a range of approaches. It also means recognising and sharing when things haven't gone as intended, as well as when they have been successful, to create practical learning for others. Using this learning, the programme aims to improve how services and interventions to tackle loneliness are delivered, and ultimately contribute to an evidence base to influence future service development'[65].
Wellbeing	Wellbeing means feeling good, functioning well and being able to respond to challenges in life positively.

Endnotes

1 Definition developed by the partnerships with facilitation from Hall Aitken, the Support and Development contractor for the Ageing Better programme.

2 Ecorys lead the evaluation partnership, which also includes Bryson Purdon Social Research and the College of Health and Life Sciences, Brunel University

3 Definition developed by the partnerships with facilitation from Hall Aitken, the Support and Development contractor for the Ageing Better programme.

4 Process learning from the Ageing Better partnerships was captured via a workshop in March 2018. Key findings are available in Community Connectors, produced by Hall Aitken, publication forthcoming.

5 Lead staff from all partnerships were consulted. Community Connectors, participants, and/ or activity leads participated in interviews and/ or focus groups in 10 areas.

6 These figures are an under-estimate of overall programme activity as they are based on national evaluation survey data, which was not completed by everyone with a Community Connector. Based on participant survey data analysed by the national evaluation team during October 2018.

7 ONS (2017), Population Estimates for UK, England and Wales, Scotland and Northern Ireland: Mid-2017

8 The Kings Fund (2016), Social Care for Older People: Home Truths kingsfund.org.uk/publications/social-care-older-people
A long-term condition is a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies. (Department of Health (2012) Long Term Conditions Compendium of Information Third Edition https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf)

9 Marmot, M (2010), Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010

10 Torjesen, I. (2016), Social Prescribing could help alleviate pressure on GPs. BMJ, 352:i1436

11 Turning Point & IPPR (2004), Meeting Complex Needs, The Future of Social Care.

12 The Kings Fund (date unspecified) What is social prescribing? kingsfund.org.uk/publications/social-prescribing?gclid=EAIaIQobChMIrtm-xra63QIVybztCh215AGJEAAYASAAEgKUBvD_BwE

13 The Ageing Better partnership have developed a working definition of 'Community Connectors', which is provided in section one. 'Connectors' evolved as a key concept in Asset Based Community Development (ABCD) methodologies pioneered in the UK by Nurture Development, led by Cormac Russell. For example, (2014) Community Connectors Asset Based Community Development (ABCD) Pilot Project Report nurturedevelopment.org/wp-content/uploads/2016/01/Croydon-ABCD-full-report.pdf Broadly speaking a 'Community Connector' is 'an individual that is good at discovering what people care about and where their assets can be received' nurturedevelopment.org/blog/abcd-practice/touchstone-one-introducing-connectors-forming-community-building-team/

14 University of Westminster (2018), Making sense of Social Prescribing: http://westminsterresearch.wmin.ac.uk/19629/1/Making-sense-of-social-prescribing%202017.pdf

15 University of Westminster (2018), Making sense of Social Prescribing: http://westminsterresearch.wmin.ac.uk/19629/1/Making-sense-of-social-prescribing%202017.pdf

16 NHS England (2014), Five Year Forward View: england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

17 NHS England (2016), General Practice Forward View england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf People and Communities Board (2017), A new relationship with people and communities: Actions for delivering Chapter 2 of the NHS Five Year Forward View: nationalvoices.org.uk/sites/default/files/public/publications/a_new_relationship_with_people_and_communities_0.pdf

18 Polley M et al (2017), Review of evidence assessing impact of Social Prescribing on healthcare demand and cost implications. Report: westminster.ac.uk/file/107671/download

19 Polley M et al (2017), Review of evidence assessing impact of Social Prescribing on healthcare demand and cost implications. Report: westminster.ac.uk/file/107671/download

20 The Kings Fund (2017), What is social prescribing? kingsfund.org.uk/publications/social-prescribing

21 This paper reflects on both qualitative data from interviews and focus groups with stakeholders and participants and quantitative data, drawing on monitoring information and survey responses. The paper brings together evidence generated by the national evaluation team and local evaluators. Qualitative evidence presented in this section is based on primary research conducted by the national evaluation team, unless otherwise stated.

22 This paper will refer to people aged 50 and over as 'people' or 'participants' to avoid repetition.

23 This includes evaluation data from the following projects: Bristol's Community Webs, Isle of Wight's Care Navigators, Leeds Wellbeing Practitioners, Leicester's social prescribing models, Thanet's Life Planners and Torbay's Wellbeing Co-ordinators and is further supported by the self-reported outcomes emerging from the qualitative research conducted by the national evaluation team.

24 Further information available: biglotteryfund.org.uk/global-content/programmes/england/fulfilling-lives-ageing-better. The national evaluation team produces quarterly reports on participant outcomes. These can be made available upon request.

25 Social isolation is measured in terms of improved social contact.

26 The average time span between entry and follow-up data being collected is six months.

27 Outreach beneficiaries interviews and focus groups (August, 2017).

28 Outreach beneficiaries interviews and focus groups (August, 2017, page 20).

29 Community Webs Final Evaluation Report, (January 2018, p40) and Outreach beneficiaries interviews and focus groups (August, 2017, page 3)

30 Despite these participants tending to be older, taking more medication having higher level need and lower scores at referral than participants in a Wessex social prescribing reference group, they achieved similar levels of improvement. Wessex AHSN, Independent evaluation of Care Navigators on the Isle of Wight, (January 2018, page 4).

31 Wessex AHSN, Independent evaluation of Care Navigators on the Isle of Wight, (January 2018).

32 EQ VAS health scores completed by 93 participants, based on information from baseline and follow-up surveys, show an overall improvement in health scores from 55.17 - 59.73. Reducing loneliness and social isolation through improving wellbeing: A case study of the Supporting Wellbeing project, University of Sheffield and Care Connect (date unspecified, page 6).

33 Reducing loneliness and social isolation through improving wellbeing: A case study of the Supporting Wellbeing project, University of Sheffield and Care Connect (date unspecified, page 4).

34 For further information, see: https://warwick.ac.uk/fac/med/research/platform/wemwbs

35 Health scores are based on the EQ-VAS scale, where participants rate their own health out of a scale from 0 to 100.

36 Age Better in Sheffield: Project 'Deep Dive' Report, Emotional Wellbeing Practitioners Sheffield MIND (date unspecified, page 16).

37 Based on primary research conducted by the national evaluation team.

38 Based on primary research conducted by the national evaluation team.

39 Data analysed by the national evaluation team during October 2018.

40 Middlesbrough Outreach Learning Report, (September 2017, page.3). Note this data should be viewed with caution as comparison data is not available from the start of the project, so the extent to which this represents increased activity is unknown.

41 Community Webs Final Evaluation Report, (January 2018, page 46).

42 Community Webs Final Evaluation Report, (January 2018).

43 Ageing Well Torbay Interim Findings Year Two Technical Report, University of Plymouth (July 2017 page 34).

44 The national evaluation data reported a mean score for influencing improved from 2.5 at entry to 2.7 at follow-up, where a score of 5 represents a participant definitely agreeing that they can influence decisions affecting their local area, and a score of 1 represents definite disagreement with the same statement. This scale, from the Community Life Survey, is an optional outcome measure, and so data is not available for Leicester's Social Prescribing projects, Bristol's Community Webs, Middlesbrough's Outreach and Thanet's Planning for Later Life projects.

45 Data analysed by the national evaluation team during October 2018. Data not available for Leicester's Social Prescribing projects, Camden's Community Connectors and Outreach projects, Bristol's Community Webs, Middlesbrough's Outreach, Torbay's Wellbeing Coordinators and Thanet's Planning for Later Life projects.

46 Asset Based Community Development, (ABCD), is an approach based on the principle of identifying and mobilising individual and community 'assets', rather than focusing on problems and needs (i.e. 'deficits') Frost, S, Learning Network Development Manager, Altogether Better Learning Network, September 2011
Asset Based Community Development (ABCD) Available from: http://www.altogetherbetter.org.uk/Data/Sites/1/5-assetbasedcommunitydevelopment.pdf

47 Based on primary research conducted by the national evaluation team.

48 Data not available for Thanet's Planning for Later Life project.

49 Community Webs Final Evaluation Report, (January 2018, page 47)

50 Qualitative evidence presented in this section is based on primary research conducted by the national evaluation team, unless otherwise stated.

51 Community Connectors – Time Limited Interventions produced by Hall Aitken, publication forthcoming

52 Community Connectors – Time Limited Interventions produced by Hall Aitken, publication forthcoming.

53 Community Connectors – Time Limited Interventions produced by Hall Aitken, publication forthcoming.

54 Data analysed by the national evaluation team during October 2018.

55 The Cheshire and Leicester partnerships offer learning on this approach.

56 This challenge was also identified in the Community Connector process learning document produced by Hall Aitken.

57 Qualitative evidence presented in this section is based on primary research conducted by the national evaluation team, unless otherwise stated.

58 Community Webs Final Evaluation Report, (January 2018, page 49)

59 Sheffield Mind Questionnaire Feedback, (May 2018)

60 Ageing Well Torbay Interim Findings Year Two Technical Report (July 2017)

61 Partnership lead interview, (August 2018)

62 Frost, S, Learning Network Development Manager, Altogether Better Learning Network, September 2011
Asset Based Community Development (ABCD) Available from: altogetherbetter.org.uk/Data/Sites/1/5-assetbasedcommunitydevelopment.pdf

63 Definition developed by Ageing Better partnerships with facilitation from Hall Aitken, the Support and Development contractor for the Ageing Better programme.

64 The Kings Fund (date unspecified) What is social prescribing? kingsfund.org.uk/publications/social-prescribing?gclid=EAIaIQobChMIrtm-xra63QIVybztCh215AGJEAAYASAAEgKUBvD_BwE

65 2018 Knowledge and Learning Programme Briefing, Ageing Better. Big Lottery Fund (May 2018, page 2)

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This report should be referenced as:
Ageing Better: Learning Report No.2 – Community Connectors. October 2018.
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