

British Red Cross

*We acknowledge The Cooperative Society, who funds the Community Connector service as a charity partnership with British Red Cross through money raised by colleagues, members and customers.*

Friday 12th April, 2019

**Evaluation of the British Red Cross Community Connectors Programme**

**Final Report**

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# Section 1- Executive Summary

This extended executive summary can be read as standalone document. It includes a summary of the introduction, methodology, key findings, and the conclusions and recommendations arising from the analyses.

**Section 2: Introduction**

Loneliness is increasingly recognised as a public health issue and is considered comparable to obesity and smoking in terms of its detrimental impact on health. It has been linked to a range of negative health outcomes including increased risk of coronary heart disease and stroke, depression, cognitive decline and Alzheimer’s Disease. Social prescribing has had increased recognition within policy and research as a potential way of addressing loneliness and other psychosocial issues. However, there are currently gaps in evidence in relation to the impact of social prescribing, its suitability to address loneliness and interventions more generally to address loneliness.

The research presented within Trapped in a Bubble (Kantar Public, 2016) commissioned by the Co-op and the British Red Cross identified the prevalence of isolation and that certain ‘trigger groups’ were more vulnerable. Consequently, the BRC and Co-op developed the Community Connectors programme, a national scheme but tailored to local areas which sought to provide service users with up to 12 weeks of support to help signpost them to community activities which would help to address their loneliness. The Community Connectors programme is considered as an enhanced social prescribing service as it takes a holistic approach to referrals, has a national coverage, offers support over a longer period than traditional social prescribing services and seeks to address loneliness rather than having a primary objective of decreasing health care utilisation.

Given the lack of evidence on services such as the Community Connector’s programme, the BRC and Co-op commissioned the University of Sheffield to undertake a formative and summative evaluation, to measure how the service impacts on levels of social isolation and loneliness in service users, in order to provide robust evidence to inform BRC decision-making with regard to wider rollout and support advocacy.

**Evaluation questions**

The key questions addressed by this evaluation were: 1) what is the impact of the Community Connectors programme on the service users’ levels of social isolation and loneliness. 2) How does the programme support specific different trigger groups defined as:

* Young parents (aged 18 – 24)
* The recently bereaved (within the last six months to two years)
* Recently divorced or separated (within the last two years)
* Living without children at home (such as ‘empty nesters’ and retirees)
* Experiencing health issues
* With mobility limitations

**Objectives**

* Measure how the service impacts on levels of loneliness in service users
* Understand how the service supports different trigger groups
* Capture the experiences of service users and staff and volunteers involved in delivery
* Capture learning about what works, where and why in the delivery of effective services to support people who are socially isolated and lonely
* Provide robust evidence to inform British Red Cross decision-making with regard to wider rollout and support advocacy (Please note, the Social Return on Investment is reported in a separate document)
* Understand the costs of service delivery and make judgements about its value for money including reductions in the use of acute, secondary and community care that occur as a consequence of the support provided to service users (SROI analysis. Please note, this is reported in a separate document.

**Section 3: Methodology**

The evaluation was guided by a logic model to provide an explanation of how the intervention was expected to work (the programme theory of change). This provided a point of comparison for the evaluation. Tables 1 and 2 below, provide detail on the original and final iterations of the logic model with linkages to the data. The evaluation itself was conducted within three separate but inter related ‘work packages’:

* Quantitative analyses of operational data including a matched comparator analysis (an approach that enables us to identify whether changes in the intervention group are due to the effect of the programme when there is no control group to compare with)
* Qualitative analyses of Community Connector, Volunteer and service user interviews
* A Social Return on Investment (SROI) analysis (which is reported in a separate document)

**Logic model(s) pre and post evaluation and how findings relate to the Theory of Change**

**Table 1: Initial Logic Model for the British Red Cross Community Connectors Programme**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Actions | Outputs | Outcomes | |  | Impact |
|  |  | **Short term** | | **Long term** |  |
| Partnership | * Partnerships established | * Good working relationship | * Increase access to services | * Clients have increased confidence * Increased social connectedness * Decreased social isolation and loneliness * Independence | Improved wellbeing |
| Workforce:   * Project staff   Community connectors   * Volunteers | * Recruited, trained and are based in local communities * Capacity to deliver services | * Knowledge and understanding of existing infrastructure & pre-existing relationships * Good relationship and trust with clients | * Engaging with local community members |
| Service delivery within local communities | * Supports plans developed | * Clients receives emotional support to help build their confidence and independence | * Clients are motivated to engage with workers to set personal goal |
|  | * Workers connecting community members to existing services, resources e.g. social networks, community engagement groups etc. | * Clients receive adequate information support on the available community services/activities, resources and events. | * Clients helping to set own target goals * Clients co-creating their support plans |
|  | * Workers creating relevant links for clients | * Links created are sustained by clients | * Clients feeling empowered |
|  | * Establishing social Networks | * Social networks are functional | * Clients using local resources * Clients interacting well with local community groups |

**Table 2: Logic Model and theory of change – following implementation and evaluation of British Red Cross Community Connectors Programme**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Situation | Main aims of the intervention | Main aims of research/  evaluation | Inputs | Outputs | | Outcomes- Impact  Evaluation will assess extent to which the outcomes/impact are achieved | |
| **The need:**  Prolonged experiences of loneliness are linked to serious mental and physical health conditions, with links to depression, dementia, high blood pressure, anxiety and other forms of mental ill-health  A programme of Community Connectors with support from volunteers seek to develop services which provide practical and emotional support to people who are, or at risk of loneliness  Service users are provided up to 12 weeks’ person centred practical and emotional support, tailored to their specific needs, with the aim of achieving longer term goals beyond the intervention by (re) connecting with their community | **List up to 5 main aims**  1.To increase knowledge of and access to a range of community and universal services for service users  2. To recruit volunteers to provide services and information which will increase uptake in local community activities  3. To improve self-esteem, confidence, health related quality of life among service users  4. To reduce loneliness among service users  5. To prevent the potential need for service users to be dependent on longer term clinical support | **Main evaluation aims**  1. Measure how the service impacts on levels of social isolation and loneliness in service users  2. Understand how the service supports different Trigger groups  3.Capture the experiences of services users, staff, and volunteers  4. Measure any reductions in use of acute, secondary and community care occurring as a consequence of the support to service users  5. Capture learning about what works, where and why  6. Understand the broad costs of service delivery and make judgements on financial and social returns for the investment (in progress)  7. Provide evidence to inform decision making about wider rollout and support advocacy | **What is invested**  Paid staff (Community Connectors) are recruited, trained and based in local communities (85% of support is provided by these)  Volunteers are recruited, trained and based in local communities (15% of support is provided by these)  Collaborators and partners refer to the service (primarily NHS and local authorities)  Collaborators and partners signposting to the service (2/3 are third sector organisations)  Up to 12 weeks support planned with a median of four contacts (telephone and face to face) and 75% have no more than 9 contacts).  Additional support (not direct contact i.e. speaking to family member or referral organisations)  Time taken for  Community Connector to build the network of recruiters, organisations and volunteers  Programme costs (centralised and local administrative costs, set up costs and running) | **Activities/methods (What is done):**  Support plans and goals are co-created with service users (initial review after 6 weeks against goals)  Service users are provided with emotional support (felt listened to)  Service users are provided with practical support  Service users are provided with information on available community services/activities, resources, events  Community members are connected to existing services and resources (e.g. social networks, community engagement groups)  Supporting organisations process and accept referrals in and out of the programme | **Participation**  **Who is reached:**  **2/3 female**  50% older people (over age of 70)    76% White British  14.8% not lonely  85.2% lonely based on UCLA (6-9 being lonely)  ¾ of service users had lower wellbeing than the UK population (n=245, 72.5%) at baseline.    By end of service, half of service users had a level of wellbeing which was equivalent of, or greater than, the UK population  48% were recorded as being in a trigger group as follows:  43% experience a health issue  23% mobility limitations  2% Young parents  2.3% Divorced/separated  7% Recently bereaved  11% Living without children/retirees | **Short-Term results**  **(listed for those reached by measure)**  Personalised, tailored support packages developed  Service users have increased social connections through Community Connectors and volunteers visiting their homes  Service users have increased social connections through access to local groups and activities  Increased signposting to BRC services and therefore more appropriate use of BRC services (5% referrals come from BRC and 10% signpost to BRC services).  Greater self-esteem and confidence identified among service users  Enjoyment of the contact by services users  Volunteers gain a sense of satisfaction and motivation  Volunteers experience increased social connections with service users and other volunteers  People feel they can go back to the service if they need to once they have left  Service users accompanied to medical/health appointments  Provided with wider practical support i.e. get people assessed for specific mobility items of equipment  People signposted to other organisations | **Long-Term results (by measure)**  Decreased loneliness statistically significant change in UCLA scores from services users from baseline to end of programme of 2.5  Significant reduction in loneliness from being lonely to not lonely at end of programme (86% at baseline to 43% at end of programme)  50% not lonely, 50% lonely  16.5% follow up  83.5% follow up  Most lonely - higher levels of improvement  Improved well-being of service users (evidence SWEMBS)  Increased social connections of service users are sustained (% from qualitative)  Over dependence on Volunteer/Community Connector (unintended negative consequence)  Volunteers gained experience of increased employability  Costs of service/value for money/cost effectiveness/SROI (see separate SROI document)  Some very limited evidence from the qualitative analyses that there is a reduction in use of acute, secondary and community care |

**Logic model narrative**

The data presented in the logic model (Table 2) suggests the Community Connectors programme has delivered the planned services and the results suggest that it has led to a significant improvement of service users’ loneliness and wellbeing. As presented, a significant proportion of the service users had lower wellbeing than the UK population at baseline. However, by the end of service, half had a level of wellbeing which was equivalent to, or greater than, the UK population.

**Section 4: The delivery of the Community Connectors Programme**

**Referrals**

The main source of referral is self-referral (n=1858, 32%). Self-referrals increased during the course of the programme and it is thought this is due to a mixture of a growing awareness of the programme, but also of service users re-attending the service. The other main sources of referral are the NHS (n=1279, 22%) and local authority (n=1075, 19%). This indicates that the Community Connectors programme is fulfilling a gap in service provision needed by statutory services.

**Signposts**

Overall, 2607 different signposts were made. It was observed that the service users who were classified as most lonely at baseline received one more contact and were more likely to be signposted. This has implications for service delivery as over 50% of service users were classed as the most lonely at baseline. Signposts were categorised into both primary categories e.g. Local Authority and more specific secondary categories for example social services, libraries and police. The percentage of signposts made for the total sample was 25.1% (n=1402), however this appears lower because of the larger amount of referrals who do not have support data recorded. The signposting rate may be higher in reality as from speaking to Connectors they do tend to under report their signposting activity. Thus there is a need to provide training to ensure Connectors accurately record this.

**Model of service delivery**

Three quarters of service users received less than 13 weeks of support, reflecting the service specification of 12 weeks of support. However, many service users received a considerably shorter length of support with the median being 5 weeks.

For the majority of service users, support provided by the telephone was relatively short, with many calls lasting less than 15 minutes. The interviews identified that for most services users, telephone contacts were used to exchange practical information or used as a way of ‘checking in’. There were some service users who did receive considerable support via the telephone. The interviews highlighted that in these cases service users often had a preference for telephone support. Thus telephone contacts are primarily a practical tool but for some service users are the preferable method of service delivery. It is recommended that the BRC maintain the current model of providing flexible telephone contact depending on the needs of an individual service user.

There was a wider range observed in the number of face to face appointments service users had, from 1 to over 50. However, of these, about half of service users only had one or two face to face appointments. Appointments varied in their length, but the average was 75 minutes. Appointments took place at a variety of locations including at community activities, cafes and appointments based on using public transport indicating that Connectors tailored support to meet service users’ needs. However, there appears more scope to arrange face to face appointments outside of the home.

In terms of telephone and face to face contacts combined, three quarters of service users had 8 contacts or less of support and the median amount of support was less than 3 hours. Just over 10% of service users had more than 12 hours of support.

This indicates that service users received considerably less support than was anticipated in the service specification, albeit there is a small proportion of service users who received more support.

The amount of support delivered by volunteers varied considerably between schemes. In some schemes, no service users received support from volunteers, in other schemes it was over 50% of service users. Overall in the programme, approximately 18% of service users had at least one contact with a volunteer. This figure remained fairly static during 2018. This indicates that in the current configuration, it is not feasible to deliver as much of the support via volunteers as had been initially proposed in the service specification. Indeed, the interview findings reflect this, highlighting how in many local service models, Community Connectors were undertaking the role that was envisaged for the volunteer. This was mainly attributed to difficulties in recruiting and retaining volunteers. However, some of the volunteers who we spoke with felt that they were often under utilised, suggesting a mismatch between expectations and experiences of Connectors and volunteers. It is recommended that BRC reflect on how to increase delivery by volunteers or further increase staff capacity.

Almost half of service users with a specified case closure reason (n=1659, 44.6%) had an early termination of the service. The main reason for early termination was due to the service users’ choice. The large number of early terminations may provide some explanation as to why service users had considerably less support than was anticipated in the service specification. What is not known is whether service users terminated support early because their needs were met or because they were dissatisfied with the service.

**Differences in delivery between trigger groups**

Some trigger groups received greater support than others which has implications for service capacity and delivery (Table 3). In terms of number of contacts and amount of support, individuals with a recorded trigger group had more contacts and a longer period of support than service users not in a trigger group. The difference was an average of two contacts and over 2 hours more of support, which has implications for service capacity. However young parents and service users not recorded as being in a trigger group received less support. For example, service users not in a trigger group received on average 4 and a half hours less of support compared to service users in a trigger group.

Almost twice as many service users in trigger groups were more likely to be signposted than service users not recorded as being in a trigger group. It is not known why there is this difference, for example whether service users in a trigger group have a more identifiable need than those not in a trigger group.

**Table 3: Summary document detailing differences between the 6 trigger groups and for service users with no trigger group recorded**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Living without children at home/retirees** | **Recently bereaved** | **Recently divorced or separated** | **Experiencing health issues** | **Mobility limitations** | **Young parents** | **No trigger group category** |
| **Where they live** | Over half (53%) lived in London  (Based on 653 people with data) | Fairly evenly distributed across the UK  (Based on 377 people with data) | Almost one quarter (23%) lived in Scotland  (Based on 134 people with data) | Almost half (43%) lived in London  (Based on 2511 people with data) | About a quarter live in London (Based on 1319 people with data) | Mostly in South East and NI and the Isles of Man (Based on 89 people with data) | Fairly distributed across the country, with the majority (21%) in London (Based on 3023 people with data) |
| **How they were referred** | Almost half (48%) were referred by statutory health and care services (Based on 653 people with data) | Almost half (49%) were referred by statutory health and care services  (Based on 377 people with data) | One of the groups most likely to self-refer (32%)  (Based on 134 people with data) | More than half (53%) were referred by statutory services and social care (Based on 1100 people with data) | Half (50%) were referred by statutory services and social care  (Based on 661 people with data) | Half were self- referral (50%) (Based on 43 people with data) | Very similar to the participants classified in a trigger group. Majority were more likely to be referred by statutory services and social care. But also a significant proportion (20%) were more likely to self-refer (Based on 3023 people with data) |
| **Living arrangements** | Over three quarters (79%) live alone  (Based on 514 people with data) | Over three quarters (79%) live alone  (Based on 289 people with data) | More likely than most other groups to live with family and friends (29%)  (Based on 91 people with data) | More than half (63%) live alone (Based on 1889 people with data) | Nearly three-quarters (66%) live alone (Based 1006 people with data) | About half (48%) live with family and friends (Based on 27 people with data) | Very similar to the participants classified in a trigger group. About two-thirds (64%) were more likely to live alone (Based on 2230 people with data) |
| **Gender** | More likely to be female (67%) male (33%)  (Based on 603 people with data) | More likely to be female (69%) male (31%)  (Based on 342 people with data) | More likely to be female (66%) male (34%)  (Based on 122 people with data) | More likely to be female (65%) male (34%)  (Based on 122 people with data) | Two-thirds were likely to be female (68%) male (32%)  (Based on 1206 people with data) | Significant majority likely to be female (97%) male (3%)  (Based on 74 people with data) | Very similar to the participants classified in a trigger group. Two thirds were female (66%) male (34%) Based on 2726 people with data) |
| **Age** | Almost two thirds (65%) were over 60 years’ old  (Based on 653 people with data) | Two thirds (68%) were over 60 years’ old  (Based on 298 people with data) | Over half (59%) were over 60 years’ old  (Based on 114 people with data) | Nearly two-thirds (62%) were over 60 years’ old  (Based on 1905 people with data) | Nearly two-thirds (64%) were over 60 years’ old  (Based on 1002 people with data) | All (100%) were below 60 years old (Based on 89 people with data) | Very similar to the participants classified in a trigger group. About two-thirds (63%) were more likely to be over 60 years compared to only 37% under 60 years (Based on 2297 people with data) |
| **Ethnicity** | Three quarters (75%) were white British (English) (Based on 653 people with data) | Three quarters (75%) were white British (English) (Based on 238 people with data) | More than three- quarters (84%) were white British (English) (Based on 83 people with data) | Slightly above three quarters (76%) were white British (English) (Based on 1439 people with data) | Slightly above three quarters (77%) were white British (English) (Based on 745 people with data) | Almost three quarters (72%) were white British (English) (Based on 47 people with data) | Ethnic background very similar to participants classified in a trigger group. Mostly white British/English (77%) (Based on 1742) people with data) |
| **How they were supported** | 32% signposted to other services | 32% signposted to other services | 39% signposted to other services | 37% signposted to other service | 39% signposted to other services | 38% signposted to other services | Similar proportion to participants classified in a trigger group (36%) signposted other services (36%) (Based on 3023 people with data) |
| **Intensity of support provided** | Mean telephone contacts was 9.0 while the average support (in minutes) was 516 (Based on 466 people with data) | Mean telephone contacts was 9.4 while the average support in minutes was 533 (Based on 237 people with data) | Mean telephone contacts was 8.1 while the average support in minutes was 466 (Based on 105 people with data) | Mean telephone contacts was 8.2 while the average support in minutes was 465 (Based on 466 people with data) | Mean telephone contact was 10 while the average support in minutes was 534 (Based on 855 people with data) | Mean telephone contacts was 5.0 whiles the average support in minutes was 442 (Based on 466 people with data) | NO ANALYSIS UNDERTAKEN |
| **Difference the service made** | More likely to experience significant reduction in loneliness than other groups: 87% were lonely at start of support (Based on 449 people with start scores) but this proportion was reduced to 50% at the end of the support (Based on 195 people with end scores) | More likely to be not lonely at the end of our support than other groups (90% were lonely at the start of support (Based on 246 people with start scores) but 59% were not lonely at the end)  (Based 149 end scores) | More than half were more likely to not be lonely after receiving the support than other groups: Loneliness significantly reduced from 93% at the start (Based on 99 people with start scores) to 44% at the end of the support (Based on 45 people with end scores) | More likely to experience a significant reduction in loneliness than other groups: 87% were lonely at start of support (Based on 1342 people with start scores) but this proportion was reduced to 51% at the end of the support (Based on 344 people with end scores) | More likely to experience significant reduction in loneliness than other groups: 84% were lonely at start of support (Based on 736 people with start scores) but this proportion was reduced to 51% at the end of the support (Based on 189 people with end scores) | Loneliness level significantly reduced from 93% at the start (Based on 40 people with start scores) to 50% at the end of the support (Based on 9 people with end scores) | Very similar to the participants classified within a trigger group. More than three quarters (86%) were lonely at start of support (Based on 1577 people with start scores) but this proportion was reduced to 50% at the end of the support (Based on 395 people with end scores) |
| **What differences were made in terms of wellbeing** | About half (50%) were more likely to experience improvement in their wellbeing at the end of the support (Based on 12 people with wellbeing data) | 70% were more likely to experience improvement in their wellbeing at the end of the support (Based on 10 people with wellbeing data) | All (100%) improved their wellbeing at the end of the support (Based on 2 people with wellbeing data) | 73% experienced improvement in their wellbeing at the end of the support (Based on 52 people with wellbeing data) | About 70% were more likely to experience improvement in their wellbeing at the end of the support (Based on 36 people with wellbeing data) | All (100%) improved their wellbeing at the end of the support (Based on 2 people with wellbeing data) | NO ANALYSIS UNDERTAKEN |
| **Proportion achieving their goals** | More than half were likely to achieve their set personal goals. With nearly 60% likely to achieve goal 1 (Based on 255 people with data for goal 1) | More likely to achieve their set personal goals. With more than half 55% likely to achieve goal 1 (Based on 148 people with data for goal 1) | More likely to achieve their set personal goals set. With more than 60% likely to achieve goal 1 (Based on 57 people with data for goal 1) | More likely to achieve their set personal goals. With more than 61% likely to achieve goal 1 (Based on 930 people with data for goal 1) | More likely to achieve their set personal goals set. With a significant majority (60%) likely to achieve goal 1 Based on 493 people with data for goal 1) | Less than half were more likely to achieve their set personal goals set. With about 37% likely to achieve goal 1 Based on 27 people with data for goal 1) | The majority were more likely to achieve their set personal goals. With nearly 90% likely to achieve goal 1 (Based on 236 people with data for goal 1) |

**Section 5: The impact of the Community Connectors Programme**

**Changes in raw loneliness scores and loneliness score groups**

The Community Connectors programme has made a positive difference to service users. Two-thirds of service users with UCLA scores experienced a reduction in their loneliness when accessing the programme. The mean change of UCLA score was a decrease in loneliness of 1.8 (SD: 1.8) points (out of a maximum of 6). When focusing on loneliness groups (UCLA score 3-5 not lonely vs. 6-9 lonely), over a third of service users moved between being classed as lonely to being classed as not lonely after receiving the Community Connector programme.

The matched comparator results indicated that service users included in the analysis (n=100 to 375) had a decrease of 0.7 to 0.9 compared to their matched control group taken from the English Longitudinal Study on Ageing: ELSA (n=100 to 375) indicating that service users had larger improvements in their loneliness scores. Service users were also more likely to have improvements than deteriorations in their loneliness scores compared to ELSA controls. Around 30% of service users moved from being lonely into not being lonely compared to 16 to 20% in ELSA. Around 1 to 2% of service users became lonely at the end of the service compared to 2 to 6% in ELSA. This is an indicator that those who received support from the Community Connectors programme were more likely to be less lonely than the matched control from the general population who started with similar levels of loneliness at baseline.

There were few differences between subgroups in terms of loneliness outcomes. However, service users classified as lonely in their baseline UCLA were more likely to experience improvement in their loneliness than those who were not classified as lonely (but this may be because they had more scope to improve). There also did not appear to be a difference in outcome between service users who experienced an early termination of the programme compared with those who had a planned ending. However, as these analyses were undertaken on a smaller sample of service users who had a reason for case closure and a UCLA change score, the result could have been due to the small sample. Service users who were under 60 also appeared to have a greater level of change than those 60 years and over. Service users not recorded as being in a trigger group were less likely to experience improvement than those assigned to a trigger group.

**Changes in wellbeing scores**

Over two thirds of service users experienced an improvement in their wellbeing whilst in the Community Connector programme. Positive changes were also seen in terms of service users’ life satisfaction, happiness and perceiving what they did was worthwhile. Half of service users also experienced some improvement in how anxious they felt. The qualitative interviews highlighted how many service users spoke about the impact of the programme on the development of self-esteem and confidence, thus more akin to their wellbeing rather than specifically loneliness.

**Sustainability**

There was some loss of improvement in the follow-up period, with almost two thirds of service users becoming lonelier in the period after receiving the programme compared to when they finished in the service. The qualitative interviews highlighted the impact that many Community Connectors had on service users’ lives, thus their withdrawal following the end of the programme was often hard for service users which might account for an initial drop in their loneliness scores. Despite this, almost half of service users did feel less lonely than when they started in the programme, indicating some service users manage to sustain improvements in their loneliness. Note that the follow-up sample was smaller therefore these results are exploratory. Matched comparator analysis could not be undertaken for the follow-up period due to very small sample sizes (n=30 at end-of-service so less than 10 at follow-up).

The follow up qualitative interviews revealed that approximately half of the service users whom we spoke with were maintaining activities that they had begun through the Community Connector programme.

However, there were some clear constraints on the sustained impact of the programme identified via the qualitative interviews. First, it was not always possible to signpost a service user to appropriate support within the 12 weeks of the programme, often due to: a) the service user having more complex needs or; b) services and activities not available in the locality. Second, lack of adequate transportation networks proved to be a major barrier for some service users to continue with their signposted activities and services.

**Differences in intensity of support**

Generally, there was no difference in loneliness outcomes between service users who had between 2 to 19 contacts. This indicates that whilst the number of contacts service users received is less than anticipated in the service specification, this may not have impacted on outcomes. Rather it could be seen as a strength that support is being adapted by Connectors to meet local need. It did appear that service users who received over 20 contacts did have greater improvement in loneliness. However, delivering this amount of support to all service users would create capacity issues (and may not actually be what service users want).

Whether a service user was signposted or received support from volunteers did not impact on their loneliness outcomes. This indicates that it was not detrimental that rates of signposting and support from volunteers was lower than had been anticipated in the service specification.

**Service user satisfaction survey**

In addition to the work described above, at the BRC’s request, we analysed anonymised quantitative and qualitative survey data from 142 surveys received from the BRC relating to service user satisfaction with the programme. The majority of responses were highly positive and highlighted the kindness, help, support and companionship they received. They felt that staff respected, empathised and understood their situation. Many staff members were referred to by name and were spoken very highly of by service users. Service users were provided with practical and social support and felt the programme had built their confidence and sense of purpose, opening them up to new opportunities and helped them to feel more positive about the future. However, they commented upon the need for longer term support with more frequent appointments, but there was an acknowledgement this was restricted due to funding and capacity constraints.

**Section 6: Experiences of service users, staff and volunteers involved in delivery (qualitative findings)**

A key unique selling point of the programme was its **person centred approach**, with service users valuing the relationship they had built with their Community Connector or Volunteer and how the service was personalised and tailored to individual needs.

Some **variation in the content of service delivery** was highlighted and the length of intervention time varied across the different areas with some providing support post the 12-week period which raised issues of service users becoming over attached to the worker and the support they provided.

Although most used the telephone for their initial contact with service users, a small number of Community Connectors offered **telephone support as a replacement to face to face support**. This was usually for clients with physical or mental health problems (such as anxiety), mobility issues or who were ‘embarrassed’ of their living situation.

Most Connectors felt that **referral routes** into the programme had broadened since the beginning of the service. Some areas had high levels of self-referrals, which tended to be more complex cases and required greater consideration of risk. Guidance was required on what constituted an inappropriate referral.

The availability of local resources for onward referral varies across the different areas and it is not always possible to **signpost** to other organisations, due to the high turnover of services and that there are often no services to signpost to (for example befriending services for those with health and mobility issues). A signposting ‘loop’ was also described where individuals would be signposted to the BRC but would have to be signposted back to the referring organisation.

**Volunteers** felt their role was in its early stages and needed time to develop. Some felt their personal experiences had not been utilised appropriately and the amount of training offered for the role varied from ‘no formal training’ to ‘multiple training opportunities’. Connectors described their **engagement with the Co-op** as varied throughout the programme, with most having little or no contact with Co-op representatives in their area.

**Potential challenges associated with service delivery**

* Connectors felt overwhelmed with their workload and targets
* Management structures were not in place during the initial stages of the programme roll out
* Goal setting was not always undertaken by all Community Connectors
* There were mixed feelings regarding the centralised system for Volunteers
* The availability of transport post intervention was an extremely important factor in the success and long term sustainability of the programme

**Lessons learnt for operational delivery**

1. Community Connectors deliver a wide range of interpretations of the programme. This is suitable in the sense that the models can be adapted to reflect local need. However, some Community Connectors appear to be more proactive/successful than others in developing local networks and thus establishing a local model
2. Given the short term nature of the existing model it is vital that longer term sustainability is explored
3. The ending of support can prove to be difficult for both service user/Connector/ Volunteer. Further guidance and training from BRC regarding when to cease contact and how to withdraw from the relationship is needed
4. It would be beneficial to draw on examples of good practice in relation to recruiting young people to the programme
5. More detailed guidance on what constitutes an inappropriate referral needs to be provided by the BRC and cascaded to local teams
6. Guidance concerning re referral into the programme needs to be provided by the BRC and cascaded to local teams
7. Given that management arrangements of local teams appears to be fragmented, it is clear that further attention needs to be given to strengthen this area and ensure that clear communication and guidance is in place

**Section 7: Conclusions and recommendations**

This study is the first to evaluate a national social prescribing intervention to alleviate loneliness. Previous evaluations of social prescribing interventions have generally been small scale, focusing on one locally developed service. Little is also known about the impact of social prescribing interventions to address loneliness, which is the primary objective of this project.

This research frames loneliness as a serious public health issue. Our results demonstrate that loneliness is incredibly complex, requiring a tailored approach adopted to the service user’s individual needs. A number of interpretations of the Community Connector’s service model are being adopted across the UK. Despite this heterogeneity, our results demonstrate that the service is having clear positive impacts on loneliness and general wellbeing. A number of challenges have also emerged including potentially inappropriate referrals which may have resulted in an overrepresentation of those with mobility issues, physical health and mental health problems within the programme. The following section provides an overview of these successes and challenges, along with key overarching findings and recommendations for future practice and service delivery.

**Nationally implemented but locally developed: differences within the service model**

It is clear from both the quantitative and qualitative work that there are differences in how the service model is being developed and implemented across the UK. This is particularly the case in the recording of statistics, the length of the intervention and the acceptance and handling of complex referrals. Although such heterogeneity presents challenges, these differences demonstrate that services are tailoring and personalising support to the individual needs of their population and to fit in with other services in the area. Such tailoring also demonstrates that the broad nature of the service specification is appropriate for the role in practice.

**Duration and content of the programme**

Our qualitative data shows that while some Connectors and volunteers attempt to adhere to the 12-week support period others continue to provide support for their service users over a number of months. The qualitative data suggests that many service users desire longer term support and that Connectors feel the length of intervention should be flexible according to the service user’s needs. Despite this finding, the quantitative analysis indicates that in reality service users are receiving a much shorter amount of support, with the median length of support being about 4 weeks rather than the anticipated 12 weeks. We were unable to explore why people are moving through the service much quicker than anticipated. However, it is clear that the service is having a positive impact on individuals despite it not being delivered as per the service specification. For example, there is no difference in outcomes between those who had 5 contacts compared to 11. Whilst some individuals received longer support than the 12 weeks, this was a relatively small proportion of services users. At the other end of the spectrum, approximately a third of service users only had a single face to face appointment. This requires further exploration as it appears outcomes are better for service users who have more than one contact.

**Service user demographics and trigger groups**

Considerably more females (65%) than males (35%) were referred to the Community Connectors programme. Similar results were observed for the subgroup of “trigger group” users. The gender imbalance does reflect similar schemes, but the BRC may wish to revisit the referral pathways to ensure more male representation. For example, exploring whether male Connectors/volunteers had managed to recruit more males, as appeared the case in one scheme who had developed ‘male’ orientated activities. Almost half of service users were aged over 70 years, with only 13% of service users being under the age of 40 years. The Community Connectors programme had aimed to recruit people across the age spectrum, but the trigger groups themselves are generally more likely to reflect an older demographic, such as those living without children at home/recently retired. The BRC has been proactive in addressing this age difference through linking in with organisations such as Homestart. The success of this approach is being explored by the BRC.

Almost half of service users were recorded as belonging to a trigger group (n=2764, 48%). Of these service users, by far the largest trigger group was individuals experiencing health issues (n=2511, 43.4%). The second largest group is individuals with mobility limitations (n=1319, 22.8%) and this is also reflected in the qualitative work. The other trigger groups are much smaller, comprising less than 10% of service users. This finding indicates that the service is not reaching all the trigger groups as much as it had initially envisioned. However, to address this the BRC is being proactive such as working with Cruse and Homestart to try and reach service users from other trigger groups.

A strong finding from our qualitative work was the difficulty in supporting individuals with mobility limitations and/or health conditions, particularly in terms of sourcing transport and appropriate activities (see Impact and sustainability). These individuals also generally received more service than users not in these trigger groups. **Recommendation: Given the over representation of these individuals within the programme, further guidance may be required to assist Community Connectors to support these individuals.** Our quantitative work shows that those service users without a trigger group recorded appeared to be getting less support than those in a trigger group and were also less likely to have an improvement in their loneliness. Young parents also received less contacts but this did not have a detrimental impact on their loneliness outcomes.

**Impact and sustainability**

Despite challenges there are clear examples of positive impacts from the programme on levels of loneliness and general wellbeing. The quantitative data indicates that a larger proportion of service users experience improvement in their loneliness and wellbeing, and for some the improvement is such that they would no longer be classed as lonely. This was also reflected in the matched comparator work which shows that the service has an impact over and above what would be expected if the service was not available. The impact of the service on the services users we spoke to cannot be underestimated, particularly in terms of the development of confidence and self-esteem. Community Connectors and volunteers were also able to give examples of service users for whom they felt the service has had a very positive impact. It is clear from the qualitative work that service users did not view their contacts with Community Connectors as *appointments* as one may view a medical appointment, but as *social contacts*, demonstrating the value of the programme to its service users.

Findings from the quantitative sustainability work demonstrate that service users experience an improvement at the end of the programme but this improvement dips 3 months’ post service. Almost two thirds of service users experienced some deterioration in their loneliness in the period after finishing in the Community Connectors programme. Findings from the qualitative sustainability work suggest a number of possible barriers to service users sustaining improvement. Sourcing sustainable transport post intervention remains a key factor for the success of the intervention – particularly for those service users who relied on their Community Connector to transport them to activities. Transport is particularly integral for those with mobility limitations which impact on their abilities to engage with community activities outside of the home. Even when sustainable transport was sourced, some service users did not desire signposting or were unable to continue with their activities due to their health conditions. Interestingly, in the quantitative work signposting did not emerge as an important factor in whether someone maintained their improvement. However, this might be due to the fairly small sample size or because the signpost variable only captured if a signpost was actually made, not whether a service user actively engaged with this signpost. Some service users who had initial improvement at their first interview described a dip in their wellbeing 3 months’ post service desired longer term support. This further reinforces the need for a flexible approach to the length of intervention in order to sustain impact post programme.

It is clear from the qualitative work that many service users experiencing health issues and/or mobility limitations often desired longer term support in their home but befriending services for onward referral were not always available. It was suggested that the BRC could add a befriending element to the service to tackle this gap in service provision, although the resource implications of this are acknowledged. Even when transport was sourced, some service users did not desire signposting or were unable to continue with their activities due to their health conditions. This has implications for the sustainability of the intervention given that the service model is based around signposting service users to community activities.

**Volunteers**

The original specification for the service was built around the concept that the majority of the support would be provided by volunteers. Each service would also have approximately 10 volunteers responsible for their own caseloads. This would give Community Connectors capacity to concentrate on other duties such as building relationships with external organisations, sourcing referrals and managing volunteers.

The service being delivered in practice is quite different in that less than 20% of service users have had any of their support delivered by volunteers. However, this varies considerably across schemes, with some schemes not having any service users receiving support from volunteers whereas others had over half of their service users receiving volunteer support. Many Community Connectors discussed the challenge of volunteer recruitment and engagement in the qualitative interviews. The numbers of volunteers engaged with the service across the different areas ranged from 0 to 14, with the majority of services having low numbers of volunteers. Connectors outlined a number of challenges to retaining volunteers, including fitting their role around their everyday lives (such as searching for longer term work) and only wishing to commit small amounts of time. This contravenes the service model of providing 12 consequent weeks of support with the same client – leading some services to provide 12 “sessions” rather than weeks. It was clear that recruiting volunteers was incredibly resource intensive for Connectors who implemented a number of strategies to keep them engaged such as monthly meetings, team building events and presentations from guest speakers. There appeared a tradeoff for Connectors as recruiting, training and supporting volunteers was reported to require a lot of resources, which reduced how much time connectors had to deliver support. Whilst the proportion of service users receiving volunteer support did increase from when the programme started in 2017, the proportion remained fairly static at about 18% throughout 2018, indicating that volunteers may play a minimal role in delivery unless a different approach is taken. **Recommendation**: **future resource may be better allocated to the hiring of more paid staff to deliver the service. Evidence from the BRC Boost Plan suggests that hiring support workers/allocating extra hours to Community Connectors has been extremely useful**.

**Telephone versus face to face support**

The quantitative data suggests that telephone contacts are usually very short, with the majority being less than 15 minutes’ duration. We explored how telephone support is used within the interviews. Most Connectors use the telephone to check the status of a referral, information sharing or to check progress against key milestones – not as formal support. However, some Connectors do offer telephone support in replacement for face to face contact but this is usually for clients who suffer with mental/physical health issues or may be *“embarrassed*” about their living situation.

This would suggest that most contacts through the service take place face to face. However, the quantitative data suggests that half of service users are only having 1 or 2 face to face appointments and three quarters are receiving five or less. This differs to the service specification where it was anticipated that service users may have up to 12 weeks of appointments. However, findings from the quantitative data also differ from the qualitative interviews where a key finding was that service users often desire longer term, face to face support within the programme. We were unable to explore the possible reasons why there tended to be a small amount of face to face contacts, e.g. whether the original referral was inappropriate, whether the support was not appropriate, or whether one appointment was sufficient to meet service user needs. It would also be interesting to explore the origin of referrals to determine who had only one appointment and where they were signposted onto. It is clear from the quantitative data that service users are more likely to experience improvement if they move beyond one face to face appointment. **Recommendation: it is important that the BRC explore the reasons why many service users only have one appointment.**

**Referrals**

It is clear from the quantitative data that referrals are coming into the service from a range of sources but particularly self-referrals (discussed below), NHS (22.1%) and Local Authority (18.6%). The latter two indicate that the Community Connector programmes have a presence in their locality, that the programmes are filling a gap in statutory service provision and meeting the needs of the local area.

Over 90% of referrals were accepted into the service. However, interviews with Community Connectors suggest that there had been an increase in referrals deemed inappropriate or “*too complex*” for the programme, such as those with severe mental and physical health issues. The strategies to manage complex referrals varied across the areas. **Recommendation: further guidance on the acceptance and handling of complex cases would be beneficial. Further networking opportunities between mental health and social services may also be beneficial to improve knowledge of the service’s remit.** Despite a large number of service users being accepted onto the programme, only 3702 (64%) were recorded as having any telephone or face to face contact. It is not clear what has happened to these service users, e.g. whether no contact has been made by the Community Connector or whether they have received support - this has not been formally recorded. **Recommendation: as over a third of service users are not recorded as having any contact this needs further investigation at an operational level.**

**Self-referrals**

Self-referral is becoming an increasingly common source of referral and numbers have increased from 17% described in the interim report (August 2018) to 32.1%**.** This suggests that Community Connectors are widely promoting their services and that schemes are well known in their localities. However, there is some evidence that self-referrals may be people who have already accessed the Community Connector programme and Connectors themselves are unsure about how to manage these. **Recommendation: the BRC needs to consider operationally how to manage service users who want to re access the programme, and provide further guidance to Connectors on this.**

**Signposting**

About a quarter of service users are recorded as being signposted (but it is known that this is under reported). However, it indicates that service users may not be accessing the Community Connectors programme with the intent of being connected with other activities but view the programme itself as the support. The majority of service users who were signposted received one signpost (63%). By far the most common signpost was to the third sector/community activities (66.2%), especially to age specific charities and mental health charities. The trajectory of referrals comes from statutory services but signposts are primarily to third sector/community activities. This indicates that the Community Connectors programme has helped service users to access a wide range of support, which may have enabled service users to access more appropriate support.It is clear from our qualitative work that when signposting has occurred it can have very positive outcomes for service users, but a number of factors can influence their ability to sustain these post service (see Impact and sustainability). **Recommendation: further guidance is needed for Connectors so that they do record signposting activity and more consideration is needed about how to sustain service users access to signposted activities once they are no longer getting support to attend within the programme.**

**Data recording issues: missing data**

There is currently no system in place for quality control of data collection and inputting. This has resulted in a number of problems within the evaluation such as large amounts of routine data (e.g. gender and age) missing, and it is understood that there are paper UCLAs in schemes which have not been entered onto the online system. Some schemes appear better at data entry than others, for example there are some schemes who have no service users with a start and end UCLA recorded. It is clear that a lot of important data is not being captured in the service, which may be due to Community Connectors not prioritising this aspect of the role. There is also evidence that those who do not fall into trigger groups are more likely to have missing data for age, gender and UCLA scores. This makes it difficult to assess outcomes for users in the service and has implications for the generalisability of findings. **Recommendation: BRC need to integrate data recording into the job specification for the Community Connector role, address it in supervision/performance reviews, deliver further training and provide greater feedback about the positive impact of collecting the data. Centrally, there also needs to be streamlining of what data Connectors are asked to collect and consideration of administrative support for Connectors or that more data be inputted centrally.**

**Management**

In general Community Connectors spoke highly of their area managers and the management of the service more widely. However, it was clear that management structures continued to be inconsistent across some areas, leading to key information not being filtered through. **Recommendation: further attention needs to be given to strengthen this area and ensure clear communication and that guidance is in place.**

# Section 2- Introduction

**Addressing loneliness: the policy context**

Loneliness has been increasingly recognised as a public health issue in recent years due to its detrimental impact on health (Steptoe et al, 2013). It has been linked to a range of negative health outcomes (Holt-Lunstad et al, 2015) including increased risk of coronary heart disease and stroke, depression, cognitive decline and Alzheimer’s (Valtorta et al, 2015). Loneliness is considered comparable to obesity and smoking in terms of its detrimental impact on health. Within the UK, 5% of adults in England reported feeling lonely “often” or “always” (Office for National Statistics, 2018). In recognition, the Government set out its vision to address loneliness in its 2018 Loneliness Strategy, advocating interagency working across sectors, locally developed strategies tailored to individual needs, and increased referral to social prescribing schemes (HM Government, 2018).

Social prescribing has had increased recognition within policy and research as a potential way of addressing loneliness and other psychosocial issues (Kilgarriff-Foster, 2015). For example, the Department of Health has recently advocated social prescribing, with the ambition that there will be social prescribing in every locality and over 900,000 people will be referred to social prescribing schemes (NHS Long Term Plan, 2019). There are different models of social prescribing, but the main one currently being advocated in policy is the use of a link worker to signpost people from NHS services to third sector/community sector hobbies, activities and services such as allotments, book groups and volunteering (South & Higgens, 2008). Signposting people who are feeling lonely to activities is considered beneficial because of the positive impact these activities can have on them. For example, recent reviews on loneliness found referral to gardening schemes, physical activity, befriending, friendship clubs, day centres and animal interventions have some evidence they can help tackle loneliness (Gardiner, Geldenhuys & Gott, 2018, Victor et al, 2018).

However, there are currently gaps in evidence in relation to the impact of social prescribing, its suitability to address loneliness and interventions more generally to address loneliness. In relation to social prescribing, there is some qualitative evidence that it helps to address loneliness, and some evidence that it may reduce service demand and increase people’s wellbeing (Bickerdike et al, 2017; Dyson, 2014). However, evaluations to date have tended to be small scale and only focusing on one local service (Pescheny, Pappas & Randhawa, 2018). In addition, no one has used a loneliness measurement tool as the primary outcome measure, and thus there is no statistical evidence on the role of social prescribing in reducing loneliness. Secondly, evidence on interventions to address loneliness also tend to be smaller scale and research has focused on older adults, despite loneliness impacting on people throughout the life course (Victor et al, 2018).

The research presented within Trapped in a Bubble (Kantar Public, 2016) commissioned by the Co-op and the BRC identified the prevalence of isolation and that certain people were more vulnerable including: young new mums (aged 18-24); individuals with mobility limitations; individuals with health issues; individuals who are recently divorced or separated (within the last two years); individuals living without children at home, (‘empty nesters’) and retirees; and the recently bereaved (within the last six months to two years).

**The Community Connectors Programme**

Consequently, the BRC and Co-op developed the Community Connectors programme, a national scheme but tailored to local areas which sought to provide service users with up to 12 weeks of support to help signpost them to community activities which would help to address their loneliness.

Community Connectors and volunteers work across 37 locations in eight areas across the UK with the aim of supporting people who are at risk of or who are experiencing social isolation and loneliness to connect or reconnect with their communities. Community Connectors are paid members of staff (0.6WTE) who are usually the first point of contact with the service user.

It was envisaged that after an initial assessment, Community Connectors would match the service user with a volunteer to support them during the 12-week programme. It was estimated that volunteers would typically give up to 2 hours of their time per week to support the programme and that one Community Connector would be responsible for managing and coordinating a number of volunteers.

The Community Connectors programme is similar to social prescribing schemes as it is based on a model that people receive short-term support with a community worker (be they paid or a volunteer) who helps them identify sources of support and to engage in these. However, the Community Connectors service is considered an enhanced social prescribing service for the following reasons:

* Many social prescribing schemes are based on referrals from primary care, whereas the Connectors programme is taking a holistic approach, accepting referrals from all sources
* Many social prescribing schemes are small scale, covering one geographical area. The Community Connectors programme differs in that it is a national scheme consisting of services spread across the country, who follow a standardised service specification but tailor the delivery to the local context
* Often social prescribing services are limited to a small number of sessions (Kilgarriff-Foster, 2015) whereas the Community Connectors programme offers longer support of up to 12 weeks
* The Community Connectors programme is specifically seeking to address service user loneliness, whereas other social prescribing services have other primary objectives such as decreasing health care utilisation (Dayson et al., 2013)

**The evaluation brief**

Given the lack of evidence on services such as the Community Connector’s programme, the BRC and Co-op commissioned the University of Sheffield to undertake an evaluation to measure how the service impacts on levels of social isolation and loneliness in service users, in order to provide robust evidence to inform British Red Cross decision-making with regard to wider rollout and support advocacy. The nature of the evaluation questions required the use of a mixed method approach, utilising both quantitative and qualitative data collection and analysis. The evaluation also incorporated a Social Return on Investment (SROI) analysis to explore the economic impact of the Community Connectors programme.

**Evaluation questions**

The key questions addressed by this evaluation were: 1) what is the impact of the Community Connectors service on the service users’ levels of social isolation and loneliness. 2) How does the programme supports specific different trigger groups, defined as:

* Young parents (aged 18 – 24)
* The recently bereaved (within the last six months to two years)
* Recently divorced or separated (within the last two years)
* Living without children at home (such as ‘empty nesters’ and retirees)
* Experiencing health issues
* With mobility limitations

**Aims**

To undertake a formative and summative evaluation of the Community Connectors programme on behalf of the British Red Cross and the Co-op.

**Objectives**

* Measure how the service impacts on levels of loneliness in service users
* Understand how the service supports different trigger groups
* Capture the experiences of service users and staff and volunteers involved in delivery
* Capture learning about what works, where and why in the delivery of effective services to support people who are socially isolated and lonely
* Provide robust evidence to inform British Red Cross decision-making with regard to wider rollout and support advocacy (Also see SROI)
* Understand the costs of service delivery and make judgements about its value for money including reductions in the use of acute, secondary and community care that occur as a consequence of the support provided to service users (See SROI)

# Section 3- Methodology

The evaluation was guided by a co-produced logic model to provide an explanation of how the intervention was expected to work (the programme theory of change). This provided a point of comparison for the evaluation. Tables 1 and 2 (Section 1) provide detail on the original and final iterations of the logic model with linkages to the data. The evaluation was undertaken within three distinct, but interrelated ‘work packages’ (qualitative, quantitative and Social Return on Investment) each with an identified lead. The SROI analyses does not form part of this report and will be addressed separately.

**Analysis of qualitative data**

**Service user interviews (on completion of the programme)**

A pragmatic approach to service user recruitment was taken to maximise the number of potential participants. Participants were interviewed at the end of their involvement with the programme. The following processes were utilised:

1. The evaluation team reviewed anonymised operational data to identify interviewees based on certain criteria including scheme location, trigger group, start and end UCLA scores. This was to help reduce any potential bias in the sample of interviewees. The Red Cross evaluation team then contacted the Community Connector who was asked to approach services users to see if they would be willing to be contacted for interview.
2. Community Connectors proactively asked their service users if they would be willing for their details to be shared with members of the evaluation team and to be contacted for an interview. Data for these people was received periodically from the British Red Cross. People were selected for interview using the same criteria as above to ensure key elements of the programme were represented.
3. From October 2018, the British Red Cross telephoned service users who could be classified as young parents, bereaved and recently divorced/separated, to ask if they would be willing to take part in an interview and supplied the evaluation team with the contact details of those service users who were agreeable.

From a large pool of service users that were eligible for interview, a total of 26 interviews were undertaken. Of these, 24 were conducted over the telephone and 2 were face to face. This was determined by participant preference and time constraints.

Whilst a number of the service users could be classified as fitting into more than one trigger group (e.g. health issues and mobility limitations), for the purpose of this evaluation they were broken down into the trigger group they had reported as the primary reason for their referral to the Community Connectors programme.

* Seven service users classed as having mobility limitations
* Two service users were young parents
* Ten service users classed as experiencing health issues
* Six service users classed as recently bereaved
* One service user classed as recently divorced/separated

Whilst the largest group of service users interviewed were classed as experiencing a health issue, it is important to note the variance amongst this group. Two of the ten were aged under 25 years. Two of the ten were in their 50s and the remainder were over the age of 65 years. Some of this group were suffering from physical health issues, however a number were suffering from mental health issues, for example anxiety and depression were commonplace.

**Service user interviews (3 month follow up)**

Follow up interviews were conducted with 12 of the 26 service users 3 months after their initial interview to explore the longer term impacts of the Community Connectors service. Of these, 5 had mobility limitations, 3 were experiencing health issues, 2 were recently bereaved, 1 was divorced and 1 was a young parent.

**Volunteers**

Volunteers were asked to self-identify directly to the evaluation team for an interview through a letter which was distributed to Community Connectors and service managers who were asked to forward this on to their volunteers. A total of 9 volunteers, reflecting the four geographical areas (England, Scotland, Wales and Northern Ireland) and 8 different schemes of the BRC Community Connectors programme, participated in a telephone interview.

The voluntary and professional experience varied across the volunteers from those who had little voluntary experience to those who had been undertaking various roles for over 30 years. Those interviewed came from a variety of backgrounds and personal experiences. Some had personal experience of loneliness or other mental health issues such as depression, which formed part of their desire to become involved in the Community Connectors programme.

**Community Connectors**

An email was sent from the evaluation team to all Community Connectors inviting them to take part in an interview. All those who responded to the email were interviewed. In total, 15 interviews were undertaken with Community Connectors in Year 1 of the evaluation, reflecting the four geographical areas covered by the programme. Community Connectors came to the role from a variety of backgrounds including: community policing, children’s entertaining, probation officer, administration, social work, volunteering and charity work.

In addition to interviews conducted in Year 1, a further 10 Community Connectors were interviewed in Year 2 of the evaluation to explore emerging findings from the quantitative data and any changes relating to the BRC’s Boost Plan. Community Connectors were selected to ensure a geographic spread across the service and to further explore specific service models emerging from the quantitative data (see below). Seven Community Connectors from the previous year were re-interviewed; supplemented with 3 ‘new’ Connectors selected according to the above criteria.

All interviews were audio recorded and transcribed verbatim. Data were analysed using thematic analysis (Ritchie & Spencer, 1994).

**Service user satisfaction survey**

In addition to the work described above, at the BRC’s request we analysed anonymised quantitative and qualitative survey data from 142 surveys received from the BRC relating to service user satisfaction with the programme.

**Pen portraits (service users)**

Interview data from three service users, from different trigger groups, were selected in order to develop pen portraits (stories) that explore the reasons why service users came to the service, their experiences of the service and the impact of the service on their lives. These are provided as standalone documents.

**Service models**

In order to highlight the variation in service delivery and emphasise aspects of good practice, three Community Connector service models were produced drawing on quantitative outcome data and the qualitative interview data. These are provided as standalone documents.

**Analysis of quantitative data using standardised outcome measures.**

**Data collection**

The quantitative component of the evaluation analysed routinely collected data to understand how the service was delivered, the demographic profile of service users and how users’ levels of loneliness and wellbeing were impacted by the service. This consisted of routinely collected data at the start and end of a service user accessing the service. Additional data was collected at 3 months (post intervention follow up) to understand the post intervention impact of the service on service users wellbeing and loneliness. The routine data were collected by the Community Connectors and volunteers using standardised forms and entered on BRM.

**Data analysis**

Data were sent to the evaluation team in an anonymised format. The evaluation team cleaned the data to remove missing information, and it was analysed using SPSS statistical software version 25. Descriptive statistics were extracted to describe the demographic profile of the service users who received the service. This included: age, gender, area of residence and ethnicity. The analysis also explored the goals set and achieved by the service users, their living arrangements, who referred them to the Community Connectors service and from where. We further examined the support that was provided to the service users to explore the impact of this support on the level of loneliness and wellbeing. When looking at frequencies such as number of appointments, we used interquartile ranges and medians, rather than standard means, as a way of addressing some of the outliers which may have been the result of data recording rather than genuine outliers. For example, users who were recorded as having over 100 appointments.

Where appropriate, statistical tests were performed to explore relationships between factors. For example, whether people who were signposted were more likely to experience improvement. Chi Square tests were performed between categorical variables. However, in cases where the sample was smaller, Fisher’s Exact Tests were performed. Where the data was a continuous variable, such as in the case of age, Independent T Tests were performed.

For all of these tests, a *p* value is produced and a score of <.05 indicates that there is a relationship between the variables, for example, whether being signposted was associated with a greater chance of becoming less lonely. As the *p* value relies on decimal places, three decimal places have been used when reporting them as only using one would mean no distinction in regards to significance could be shown.

**Analysis to measure loneliness**

Loneliness was measured using the UCLA (Hughes et al., 2004). This is a standardised and validated measure. The UCLA considers people’s own perceptions of how lonely they feel. Scores range between 3-9 points. The lower the score the less loneliness someone is experiencing. Therefore, if the Community Connectors programme is having an impact, one would expect a lower score at the end of the programme than at the beginning. For example, if a person scored 7 at baseline and 4 at the end of programme this would be judged as reduction in loneliness and that it was having a positive impact. There are established cut offs for the UCLA in that a score of 6-9 is considered lonely and a score of 3-5 is not lonely. These are statistical categorisations, so whilst in the report we refer to someone scoring 3-5 as not feeling lonely, the person may still consider themselves as lonely. So they do not relate to individual experience, but are a useful tool for analysing the data.

**Analysis to measure wellbeing**

In addition to the routine data, an additional Wellbeing Questionnaire was introduced from March 2018, initially to a subset but then to all service users. This collected data on service users’ wellbeing using the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) (Tennant et al., 2007). Unlike the UCLA, there are not established cut offs so instead comparison was undertaken with the UK population mean.

The Office for National Statistics 4 questions (Office for National Statistics, 2018) explored different dimensions of wellbeing. Each of the questions is based on a scale of 0 to 10, with all questions besides the anxiety question being framed that the higher the score, the better - with the final question asking how anxious people feel, a lower score denotes a lower level of anxiety. Furthermore, we used two questions from the Veterans RAND questionnaire to explore the impact of people’s health on their social activities (Hays, Sherbourne & Mazel, 1993).

**Data quality and implication on findings**

Overall, the dataset transferred by the BRC for analysis had a total of 5787 service users who were referred to the Community Connectors programme by the end of December 2018. Statistically this sample is considered a large enough size with good statistical power to detect statistical significance, and to allow for the generalisation of the findings to the wider population. However, due to the large amount of missing information identified during data cleaning, the quality of the data is compromised. For example, 31% had missing data for age (n=1794), 24% had missing data for gender (n=1385), 44% had missing data for ethnicity (n=2538) and 43% had missing data for living arrangement of the service user (n=2502). A large proportion of the service users’ UCLA (n=3756, 65%) and wellbeing scores (n=5445, 94%; NB although these were introduced later[[1]](#footnote-1)) were also not recorded at start of service.

The large amount of missing information meant that there were different sample sizes for different aspects of the analysis. It also has an impact on the generalisability of the findings as those who have data are different from those who do not have data.

**Service user satisfaction survey**

The BRC collected anonymised data on service user experience of the programme. These data were shared with the evaluation team, who undertook a descriptive and qualitative analysis of responses.

**Matched comparator analysis**

In a trial setting, individuals would be randomised to intervention or control group in order to assess whether the intervention works better than what is usually available (usual care or no care). There was no control group for the Community Connectors programme, therefore we cannot observe what would have happened if service users had not used the service[[2]](#footnote-2). Matching aims to try and replicate a trial assessment, where the control group is drawn from another source and compared to the intervention group. It provides an alternative to running a trial in settings such as this where it may not be possible to do so. As the name suggests, matching involves finding individuals with similar characteristics to the service users who would have needed the intervention but who have not received it, in order to assess the impact of the intervention. The English Longitudinal Study of Ageing (ELSA) (Banks et al., 2019) was used to identify individuals who did not receive the Community Connectors intervention.

**Data**

ELSA is a study following the same group of people over time from 2002 (Wave 1) in England. Participants are individuals aged 50 and over as well as some partners. A detailed description of the data is available in the Appendix 1. Data from the two most recent waves, 2014/15 and 2016/17, was used in the matching component. The 2014 data was used as the baseline while the 2016 data was used to match the end of service time point. Data collection is ongoing for the 2018/19 wave therefore this could not be used. Although using different years to the one used in the Community Connectors data may be problematic, due to differences in ongoing national issues that may affect loneliness, it may be beneficial as there is less chance that ELSA members have used Community Connectors.

The intervention group were service users that had used the Community Connectors programme. We focused on those who had UCLA end of service scores irrespective of the reason for a case being closed (n=819). A subset of these service users included in the additional follow up (n=342) also had additional health and wellbeing data. We undertook separate analysis for this group, focusing on baseline to end of service.

In the overall service user data, on average, service users spent approximately 5 weeks in the Community Connectors programme, but there was considerable variation. This shorter length means that time gap between the UCLAs in the service user data is smaller, compared to the gap in the two waves of ELSA data.

The additional follow up may have provided some insights into the impact of this difference, but the small numbers at 3 month follow up (n= 79) mean that we cannot draw any conclusions based on this data.

**Matching analysis**

Matching relies on available information (observable characteristics) to identify suitable matches for the service users e.g. the level of their loneliness should match that of those who are identified from ELSA. ELSA participants had the UCLA (along with two more questions on loneliness flagged as UCLA) and trigger groups were derived from existing information on spousal bereavement, divorce, whether they had children, health conditions and mobility problems (Appendix 1). Due to the age represented in ELSA (50+), a ‘young parent’ trigger group was not created. ELSA participants also completed ONS-4 and a self-rated question on health. Age, gender, and ethnicity were also reported while living arrangements were derived from available information.

We can match on some or all the observable information that is available in both the service users and ELSA data. If we match on all the observable information, then we end up with very small matched samples, although they may be better matches. We therefore chose to match on some of the observable information that we had, which included age, gender, living arrangements, loneliness scores and some trigger groups (health issues and mobility limitations). Details of the 5 different matching criteria are reported in Appendix 1. Different criteria were used as they resulted in different sample sizes and this allowed us to assess the robustness of the results. A process called coarsened exact matching (CEM) was used to undertake the matching (Blackwell et al 2009).

We also undertook matching for the additional follow up based on similar criteria, although not all criteria were used due to small sample size. This still resulted in small samples therefore the analysis of the additional data is exploratory as it cannot be interpreted meaningfully in addressing questions about typical users of the Community Connectors service.

We tested how well the matched samples compared based on age and UCLA scores and other trigger groups not used in the matching. We also tested whether those who were not missing data were different from those missing data (therefore not included in the matching) as this has an impact on generalisability of results.

An underlying assumption of matching is that there are no *unobservable* differences between the service users and control groups once the matching is complete. However, as we are using routine data which has limited information e.g. we know if they have a health issue but not which specific health conditions, then there may be unobservable differences even after matching. These unobservable differences mean we may not be comparing similar samples even after we have matched them e.g. we might have matched someone with a physical health condition to someone with a mental health condition but we have no way of knowing. This matters as needs and subsequent outcomes might be different for those with differences that are not observed.

**Comparison of UCLA scores**

The key assessment is the change in UCLA scores from baseline to end of service when comparing service users to ELSA matches. The difference in UCLA scores at end of service was calculated regardless of how well matching worked. The focus here was on mean differences, controlling for age. We also assessed whether trigger groups made a difference for all groups, apart from being a young parent.

We assessed whether individuals had improvements, no change or deteriorated in their UCLA scores at the end of service. Finally, we assessed whether participants had changed in their loneliness status or not, based on UCLA groups (lonely - UCLA score 6-9; not lonely - UCLA score 3-5). Individuals could be lonely at baseline and not lonely at end of service or still be lonely, and those who were not lonely at baseline could remain the same at end of service or they could become lonely.

**Comparison of other wellbeing and health measures**

The wellbeing questions (ONS-4) and general health were also compared using a similar approach to the UCLA scores i.e. using regressions with start and end of service scores. In order to compare wellbeing changes to loneliness changes, Cohen’s D effect sizes were used, which are standardised differences (Cohen, 1992). Effect sizes have an added advantage over mean differences as they standardise the scores from different measures to allow comparisons e.g. UCLA scores only range from 3 to 9 while ONS-4 questions range from 0 to 10.

All analyses were undertaken using Stata 14.2 (StataCorp 2015).

**Ethical approval**

Ethical approval was obtained from ScHARR’s Research Ethics Committee, University of Sheffield.

# Section 4- The delivery of the Community Connectors Programme

This section of the report focuses on who accessed the Community Connectors programme, the nature of their support and the routes service users were referred into and out of the service (signposting). The section includes findings from the qualitative interviews along with analysis of routinely collected data. The latter was data recorded by Community Connectors and volunteers during their daily work, and which they then uploaded onto BRM (the BRC data management system).

**Who accessed the service?**

5787 service users were referred to the Community Connectors programme. Their demographics are presented in Table 1. Three regions had the largest proportions of referrals: North (18%), Scotland (17%) and Northern Ireland and the Isle of Man (16%). The rest of the regions each had less than 10% of the referrals.

**Considerably more females (65%) than males (35%) were referred to the Community Connectors programme.** Given this gender imbalance there may be a need for the BRC to reflect on the referral pathways into the programme, and why there may be this gender imbalance. However, this gender imbalance does reflect other similar services, with Vandervoort (2012) identifying that whilst men may be more likely to experience social isolation, they also may be more content with their social networks and not see the need to expand them.

In terms of age, almost half of service users were over 70 years old. The others ranged in their ages, with 13% of them being under the age of 40. The Community Connectors programme had aimed to recruit people across the age spectrum, but the trigger groups themselves are generally more likely to be older people, such as those living without children at home/recently retired, so having an older demographic is somewhat understandable. BRC have also taken action to address this age disparity through their work with organisations like Homestart. It is also important to consider age in the wider context; traditionally loneliness services and BRC services generally are aimed at an older population. Consequently, having over half of service users under 70 indicates that the Community Connector programme is managing to engage users across the life course. This is important because of the increasing policy recognition that loneliness does affect people of all ages.

In terms of the ethnicity of the service users referred, about 77% were White British. White others and White Irish (4% each) were the second largest ethnic groups. There were also service users from other ethnic groups such as Black Caribbean (3%). Generally, the ethnic profile of service users was reflective of the UK population as reported in the 2011 UK Census (https://www.ons.gov.uk/census/2011census). This is positive because it indicates that the Community Connectors service is reaching out to service users of different ethnicities and no further action is required beyond this being monitored.

**Table 1: Demographic profile of the Community Connectors service users**

|  |  |  |
| --- | --- | --- |
| Area of residence | N | % |
| North | 1055 | 18.2 |
| London | 870 | 15 |
| South East | 486 | 8.4 |
| Central | 277 | 4.8 |
| South and The Channel Islands | 746 | 12.9 |
| Scotland | 978 | 16.9 |
| Wales | 443 | 7.7 |
| Northern Ireland and the Isle of Man | 932 | 16.1 |
| Total | 5787 | 100 |
| Gender |  |  |
| Male | 1547 | 35.1 |
| Female | 2855 | 64.9 |
| Total | 4402 | 100 |
| Ethnicity |  |  |
| White British | 2492 | 76.7 |
| White Irish | 115 | 3.5 |
| White Scottish | 27 | 0.8 |
| White Welsh | 4 | 0.1 |
| White other | 124 | 3.8 |
| Back African | 74 | 2.3 |
| Black Caribbean | 97 | 3.0 |
| Black other | 41 | 1.3 |
| Asian Pakistani | 45 | 1.4 |
| Asian Indian | 45 | 1.4 |
| Asian Bangladesh | 19 | 0.6 |
| Asian Chinese | 3 | 0.1 |
| Asian Other | 38 | 1.2 |
| Arab | 8 | 0.2 |
| Mixed background | 6 | 0.2 |
| Other ethnic group | 92 | 2.8 |
| Prefer not to say | 20 | 0.6 |
| Total | **3249** | **100.0** |
| Age Category |  |  |
| <30 | 319 | 8.0 |
| 30-39 | 228 | 5.7 |
| 40-49 | 335 | 8.4 |
| 50-59 | 558 | 14.0 |
| 60-69 | 581 | 14.6 |
| 70-79 | 786 | 19.7 |
| 80-89 | 868 | 21.7 |
| 90-99 | 303 | 7.6 |
| 100+ | 15 | 0.4 |
| Total | **3993** | **100.0** |
| Assessment Status |  |  |
| Accepted for support | 5320 | 91.9 |
| Declined | 340 | 5.9 |
| Pending | 117 | 2.0 |
| Failed Referral | 10 | 0.2 |
| Total | 5787 | 100.0 |

**Note:** The total for each demographic varies as each one had differing levels of missing data.

The majority of service users lived alone (64%) (Figure 1). Almost a third of service users lived with family or friends (18%) or with a spouse/partner (11%). A small proportion of service users lived in nursing/care homes (2%) or sheltered accommodation.

**Figure 1: Service users’ living arrangements**

**Programme Trigger Groups**

The service trigger groups included: i) Individuals living without children at home / recently retired, ii) individuals recently bereaved, iii) individuals who were separated or divorced, iv) individuals experiencing health issues, v) individuals with mobility limitations and vi) are young parents aged below 24 years. Almost half of referred service users had a trigger group recorded for loneliness (n=2764, 48%). Of this subgroup of trigger group service users, by far the largest trigger group was the individuals with health issues (n=2511, 43.4%). This group is likely to consist of service users with a wide range of health problems and severities. We could not ascertain what specific health issues they were suffering from, as the service data we analysed did not include such information. The second largest trigger group recorded for loneliness were individuals with mobility issues (n=1319, 22.8 %). The other trigger groups had less than 10% of referrals: living without children at home/retirees (n=653, 11.3%), recently bereaved (n=377, 6.5%), recently separated/divorced (n=134, 2.3%), and young parents (n=89, 1.5%). It is understood that the BRC has taken action such as working with Cruse Bereavement Care as a way to increase the reach of the programme to these triggers groups. A summary table detailing differences between the 6 trigger groups and those with no trigger group recorded is available in the Executive Summary (table 3). One-page summary documents for each trigger group are reported in Appendix 2.

Figure 2 below presents a summary of the proportions of the trigger groups’ service users within the different categories. Of those who were living alone with children at home/retirees, 13% (n=86) were recently bereaved, 6%(n=40) were recently divorced/separated, 77% (n=505) were experiencing health issues, whiles 46% (n=303) had mobility limitations. Of the category who were recently bereaved, 4% (N=15) were also recently divorced, 60% (n=227) were experiencing health issues and about 33% (n=125) had mobility limitations. For the category who were divorced or separated, 63% (n=85) were experiencing health issues, and 33% identified with mobility limitations. For the group who were experiencing health issues, 46% (n=1145) had mobility limitations.

**Figure 2: Comparison within trigger group sample**

***Note****: because of small sample of the category of young parents in the sample, they were not included in the analysis of comparison within groups.*

Statutory services provided more referrals of the trigger groups identified with health issues and having mobility limitations, with the NHS referring the majority (see details of the referral by trigger groups presented in Table 4). About 64%(n=672) of the trigger group subgroup participants compared to a similar proportion of the non-trigger groups participants lived alone at home. About 4% (n=44) of the trigger group participants compared to 5% (n=18) of the non-trigger group participants lived in sheltered accommodation. About 12% (n=123) of the trigger group participants compared to 11% (n=254) of the non-trigger group participants lived with their partners, and only about 1% (n=15) of the trigger group participants compared to 2% (n=42) lived in a nursing home. Thus, overall no significant differences were observed, in terms of the living arrangements, between the trigger group participants when compared to the non-trigger groups. However, there were significant differences between geographical regions in terms of the proportion of service users who were recorded as being part of a trigger group. For instance, there were 21% (n=588) of the trigger group participants compared to 11 %( n=344) of the non-trigger group participants who lived in the Northern Ireland and the Isle of Man. Similarly, about 16% (n=447) of the trigger group participants compared to 10% (n=299) of the non-trigger group participants lived in the South and the Channel Islands. In the London area however, only about 9% (n=242) of the trigger group participants compared to 21% (n=628) of the non-trigger group participants lived there. These observations were statistically significantly (*p*=<.05). There were no differences observed between the trigger-groups versus non-trigger group participants in the other regions (*p*=>.05):

* North: trigger group (n=482, 17%) compared to non-trigger groups (n=573, 19%)
* Southeast: trigger group (n=285, 10%) compared to non-trigger groups (n=201, 7%)
* Central: trigger group (n=142, 5%) compared to non-trigger groups (n=135, 5%)
* Scotland: trigger group (n=398, 14%) compared to non-trigger groups (n=580, 19%)
* Central: trigger group (n=142, 5%) compared to non-trigger groups (n=135, 5%)
* Wales: trigger group (n=180, 7%) compared to non-trigger groups (n=263, 9%)

In terms of ethnic background, about 77% (n=1157) of the trigger group participants compared with a similar proportion for the non-trigger group participants (n=1134, 77%) were white British/English.

**Referral to the Community Connectors programme**

Of the 5787 service users who were referred to the programme t**he majority were accepted into the programme** (n= 5320, 91.9%). **This reflects a finding of the qualitative interviews that connectors will try to support whoever is referred into the programme:**

*“…we’re Red Cross and we support anyone in crisis.”* (CC9)

A small number of service users declined the service (n=340, 6%), were failed referrals (n=10, 0.2%) or were pending (n=117, 2%). The main reason recorded for declining was that the service user did not meet the assessment criteria.

**The most common referral route was statutory services i.e. NHS, local authority (n=2354, 40.7%) (Table 3). The NHS referred more than half of this proportion (n=1279, 22%) and 19% (n=1075) was by local authorities. This is an indication that the Community Connectors programme is fulfilling a need for the statutory services.**

**Self-referral was the second most common referral (n=1858, 32.1%). This is a large proportion indicating that Community Connectors have widely promoted their services and the schemes are well known in their localities.** However, one issue identified through the qualitative interviews is that not all of these self-referrals are new individuals. Some are previous service users who have referred themselves back into the service. Thus the 5787 referrals may not all be different individuals.

A further exploration of the data indicates that there may be 150-200 service users who have accessed the programme more than once. However, numbers varied considerably between schemes, with some schemes having no instances recorded of service users accessing the service more than once and whereas schemes had more than 10 service users who accessed support more than once. It is not known if this variation is due to different needs or connectors taking different approaches to supporting the same service users. **This is salient because the interviews identified that Connectors were unsure about how to manage service users who wanted to re-enter the service and needed clarification from the BRC regarding this:**

*“I would like some more guidance on what we can do at the end if somebody would like to refer themselves back in. Like can people refer themselves…? You know, I’m still quite unclear about… You know, when things come to an end, can people refer back and how long do they have to wait before they refer themselves back into the service.”* (CC3)

A less common source of referral were third sector organisations like charities and community groups (n=766, 13.2%). A number of referrals came from the BRC (n=431, 7.4%) indicating that the Community Connector programme may be filling a gap in service provision needed by other BRC services. Less common routes of referral were family/friends, national government (such as the Job Centre), and the private sector (Table 2).

**Table 2: Referral Primary source**

|  |  |  |
| --- | --- | --- |
|  | Number | Percentage |
| Statutory services (Local authority, NHS) | 2354 | 40.7 |
| Self-referral | 1858 | 32.1 |
| Third/Charity organisations | 766 | 13.2 |
| British Red Cross | 431 | 7.4 |
| Family and friendships | 178 | 3.1 |
| Private sector | 85 | 1.5 |
| Others | 77 | 1.3 |
| Unknown source | 32 | 0.6 |
| National government | 6 | 0.1 |
| Total | **5787** | **100.0** |

When referral was explored in terms of secondary codes, the largest proportion was self-referral (1858, 32%) followed by the NHS (1277, 22%) and Local authority services (1085, 19%). The private sector (85, 1.4%) and national government services (6, 0.1%) recorded the lowest referrals. (Table 3)**.**

**Table 3: Referral Secondary source**

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary source** | **Secondary Sub-code** | **Number referred** | **Proportion (%) referred)** |
| **Self** | **Total: Self-referral** | **1858** | **32.1** |
|  |  |  |  |
| **Local Authority** | Local authority - Police | 22 | 0.4 |
|  | Local authority - Other | 98 | 1.7 |
|  | Local authority - Housing | 134 | 2.3 |
|  | Local authority - Single Point of Access | 44 | 0.8 |
|  | Local authority - Wellbeing | 55 | 1 |
|  | Local authority - Social care | 39 | 0.7 |
|  | Local authority - Unknown | 14 | 0.2 |
|  | Local authority - Leisure, fitness and physical activity | 7 | 0.1 |
|  | Local authority - Fire | 2 | 0 |
|  | Local authority - Learning and education | 22 | 0.4 |
|  | Local authority - Social services | 648 | 11.2 |
|  | **Total** | **1085** | **18.8** |
|  |  |  |  |
| **NHS** | NHS - Community health | 297 | 5.1 |
|  | NHS - Unknown | 34 | 0.6 |
|  | NHS - Mental health | 297 | 5.1 |
|  | NHS - Hospital | 356 | 6.2 |
|  | NHS - Other | 37 | 0.6 |
|  | NHS - GP | 256 | 4.4 |
|  |  | **1277** | **22** |
|  |  |  |  |
| **BRC** | **Total: British Red Cross** | **431** | **7.4** |
|  |  |  |  |
| **Statutory/Third Sector** | Third sector - Physical health condition | 51 | 0.9 |
|  | Other - Integrated care partnership | 62 | 1.1 |
|  | Statutory and third sector partnership | 2 | 0 |
|  | Third sector - Housing/homelessness | 63 | 1.1 |
|  | Third sector - Other | 107 | 1.8 |
|  | Third sector - Religious | 5 | 0.1 |
|  | Third sector - Hobbies/interests/social/cultural | 21 | 0.4 |
|  | Third sector - Age specific | 208 | 3.6 |
|  | Third sector - Disability support | 31 | 0.5 |
|  | Third sector - Mental health condition | 115 | 2 |
|  | Third sector - Bereavement support | 4 | 0.1 |
|  | Third sector - Volunteering and community action | 42 | 0.7 |
|  | Third sector - Family support | 25 | 0.4 |
|  | Third sector - unknown | 23 | 0.4 |
|  | Third sector - Advice and advocacy | 64 | 1.1 |
|  | Third sector - Gender specific | 4 | 0.1 |
|  | Third sector - Ethnicity specific | 3 | 0.1 |
|  | Support from family and friends | 178 | 3.1 |
|  | **Total** | **1008** | **17.5** |
|  |  |  |  |
| **Private sector** | Private sector - Other | 65 | 1.1 |
|  | Private sector - Personal and physical health care | 20 | 0.3 |
|  | **Total** | **85** | **1.4** |
| **National Government** | **Total: National Government - Benefits and welfare** | **6** | **0.1** |
|  |  |  |  |
| **Other/Unknown** | **Total Other/unknown** | **37** | **0.7** |
|  |  |  |  |
| **Overall** | Total | **5787** | **100** |

In terms of referral by trigger groups, the statutory services made the most referrals, with the NHS making the majority of the referrals (n=190, 29%), followed by local authority (n=125, 19%). For instance, the main source of referral for service users who were experiencing health issues was the NHS (n=736, 29.3%). We observed that people who were divorced or separated, and those who were identified as young parents, were more likely to self-refer to the Community Connectors service (Table 4).

**Table 4: Referral source compared by trigger groups**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Living without children at home, N (%) | Recently bereaved  N (%) | Recently divorced or separated, N (%) | Experiencing health issues, N (%) | With mobility limitations, N (%) | Young parents | No Trigger group, N (%) |
| Self-referral | 109 (16.7) | 82 (21.8) | 43 (32.1) | 465 (18.5) | 219 (16.6) | 43 (48.3) | 1233(44.6) |
| Local authority | 125 (19.1) | 80 (21.2) | 24 (17.9) | 558 (23.4) | 325 (24.6) | 14 (15.7) | 383(13.9) |
| NHS | 190 (29.1) | 103 (27.3) | 32 (23.9) | 736 (29.3) | 336 (25.5) | 9 (10.1) | 457(16.5) |
| Third sector | 130 (19.9) | 55 (14.5) | 15 (11.2) | 364 (14.5) | 209 (15.8) | 6 (6.7) | 330(11.9) |
| Others | 10 (1.5) | 7 (1.9) | 1 (0.7) | 35 (1.4) | 28 (2.1) | 0 (0.0) | 28(1.0) |
| BRC | 58 (8.9) | 35 (9.3) | 11 (8.2) | 213 (8.5) | 134 (10.2) | 13 (14.6) | 179(6.5) |
| Family and friends | 24 (3.7) | 13 (3.4) | 7 (5.3) | 84 (3.3) | 47 (3.6) | 4 (4.5) | 64(2.3) |
| Unknown | 3 (0.5) | 0 (0.0) | 0 (0.0) | 9 (0.4) | 7 (0.5) | 0 (0.0) | 12(0.8) |
| Private sector | 2 (0.3) | 1 (0.3) | 0 (0.0) | 2 (0.5) | 12 (0.9) | 0 (0.0) | 21(0.8) |
| National government | 2 (0.3) | 1 (0.3) | 1 (0.7) | 5 (0.2) | 2 (0.2) | 0 (0.0) | 69(2.5) |
| Total referrals | 653(100) | 377(100) | 134(100) | 2511(100) | 1319(100) | 89(100) | **2764(100)** |

**Schemes**

As reported earlier, there were 5787 service users referred to the Community Connector programme, which is less than was initially anticipated when the programme was developed**. However, the number of referrals varied considerably between different Community Connector schemes (Table 5).** The data showed that the Poole, North Belfast, West Belfast, Fife and the Douglas Community Connectors programmes had the greatest number of service users, all above 200 service users. However, many of the schemes had considerably less referrals than these; for example, 8 schemes received less than 100 referrals. It is appreciated that some schemes benefited from the Boost Plan, but there is a need to explore further the reasons for the differences. Possible explanations may be because there is other service provision in an area such as competing similar schemes, problems with referral pathways or staffing problems (see individual service model case studies).

**Table 5: Referral by Community Connector scheme**

|  |  |  |
| --- | --- | --- |
| Schemes | N | % |
| North Belfast | 305 | 5.3 |
| West Belfast | 339 | 5.9 |
| Douglas | 288 | 5.0 |
| Carmarthenshire | 99 | 1.7 |
| Conwy | 143 | 2.5 |
| Torfaen | 133 | 2.3 |
| Newport | 68 | 1.2 |
| Aberdeen | 76 | 1.3 |
| Shetland | 158 | 2.7 |
| Fife | 289 | 5.0 |
| Dundee | 284 | 4.9 |
| Inverness | 171 | 3.0 |
| Reading | 73 | 1.3 |
| Poole | 377 | 6.5 |
| Plymouth | 153 | 2.6 |
| Camborne & Redruth | 143 | 2.5 |
| Nottingham | 154 | 2.7 |
| Great Yarmouth | 29 | 0.5 |
| Corby | 73 | 1.3 |
| Boston | 21 | 0.4 |
| Southampton | 145 | 2.5 |
| Luton | 176 | 3.0 |
| Thanet | 165 | 2.9 |
| Barking & Dagenham | 177 | 3.1 |
| Golborne | 142 | 2.5 |
| Stonebridge & Harlesden | 101 | 1.7 |
| Brixton | 115 | 2.0 |
| Holloway | 131 | 2.3 |
| New Cross | 204 | 3.5 |
| Middlesbrough | 96 | 1.7 |
| Newcastle | 263 | 4.5 |
| Blyth | 169 | 2.9 |
| Oldham | 96 | 1.7 |
| York | 103 | 1.8 |
| Durham | 115 | 2.0 |
| Blackpool | 97 | 1.7 |
| Stockport | 116 | 2.0 |
| Total | **5787** | **100** |

We compared schemes by trigger groups. The results show that =>50% of the trigger group who were living without children at home were more likely to be seen by the Blackpool, Dundee and Blyth schemes. More than 60% of the people who were identified as experiencing health issues, were seen by 19 schemes (Table 6).

**Table 6:** **Distribution of schemes by trigger groups.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Area** | **Schemes** | **Living without children at home** | **Recently bereaved** | **Recently Divorced or**  **Separated** | **Experiencing health issues** | **With mobility limitations** | **Young parents** |
|  |  | Yes | Yes | Yes | Yes | Yes | Yes |
| Scotland | Aberdeen | 5 (4.5) | 6 (5.4) | 1 (0.9) | 72 (67.9) | 50 (45.0) | 1 (0.9) |
| Dundee | 25 (50.0) | 10 (20.0) | 0(0.0) | 31 (62.0) | 13 (26.0) | 1 (2.0) |
| Fife | 0 (0.0) | 4 (8.0) | 3 (6.0) | 17 (34.0) | 14 (28.0) | 0 (0.0) |
| Inverness | 3 (6.0) | 2 (4.0) | 4 (8.0) | 32 (64.0) | 21 (42.0) | 3 (6.0) |
| Shetland | 10 (40.0) | 4 (16.0) | 2 (8.0) | 18 (72.0) | 9 (36.0) | 2 (8.0) |
| Wales | Carmarthenshire | 1 (1.8) | 7 (12.3) | 0 (0.0) | 19 (33.3) | 10 (17.5) | 0 (0.0) |
| Conwy | 2 (10.0) | 0 (0.0) | 3 (15.0) | 17 (85.0) | 13 (65.0) | 0 (0.0) |
| Newport | 16 (30.2) | 4 (7.5) | 3 (5.7) | 40 (75.5) | 23 (43.4) | 0 (0.0) |
| Torfaen | 11 (25.6) | 7 (16.3) | 4 (9.3) | 22 (51.2) | 14 (32.6) | 0 (0.0) |
| NI and the Isle of Man | Douglas | 22 (52.4) | 6 (14.3) | 4 (9.5) | 26 (61.9) | 14 (33.3) | 1 (2.4) |
| North Belfast | 11 (10.0) | 9 (8.2) | 5 (4.5) | 95 (86.4) | 53 (48.2) | 1 (0.9) |
| West Belfast | 20 (33.3) | 6 (10.0) | 5 (8.3) | 51 (85.0) | 28 (46.7) | 5 (8.3) |
| London | Barking and Dagenham | 19 (39.9) | 2 (3.6) | 1 (1.8) | 19 (33.9) | 12 (21.4) | 1 (1.8) |
| Brixton | 1 (2.0) | 4 (7.8) | 2 (3.9) | 30 (58.8) | 26 (51.0) | 0 (0.0) |
| Golborne | 35 (74.5) | 7 (14.9) | 1 (2.1) | 44 (93.6) | 19 (40.4) | 0 (0.0) |
| Holloway | 1 (1.3) | 8 (10.3) | 7 (9.0) | 57 (73.1) | 27 (34.6) | 0 (0.0) |
| New Cross | 2 (4.8) | 0 (0.0) | 0 (0.0) | 5 (11.9) | 3 (7.1) | 0 (0.0) |
| Stonebridge | 0 (0.0) | 1 (4.5) | 0 (0.0) | 15 (68.2) | 7 (31.8) | 0 (0.0) |
| North | Blackpool | 45 (56.3) | 2 (2.5) | 2 (2.5) | 50 (62.5) | 31 (38.8) | 0 (0.0) |
| Blyth | 13 (56.5) | 2 (8.7) | 0 (0.0) | 15 (65.2) | 10 (43.3) | 1 (4.3) |
| Durham | 0 (0.0) | 0 (0.0) | 0( 0.0) | 1 (7.1) | 2 (14.3) | 0 (0.0) |
| Middlesbrough | 19 (20.7) | 9 (9.8) | 6 (6.5) | 70 (76.1) | 11 (12.0) | 1 (1.1) |
| Newcastle | 1 (3.3) | 4 (13.3) | 1 (3.3) | 15 (50.0) | 3 (10.0) | 0 (0.0) |
| Oldham | 26 (48.1) | 3 (5.6) | 0 (0.0) | 27 (50.0) | 14 (25.9) | 0 (0.0) |
| Stockport | 8 (21.6) | 4 (10.8) | 2 (5.4) | 25 (67.6) | 18 (48.6) | 0 (0.0) |
| York | 4 (23.5) | 2 (11.8) | 0 (0.0) | 13 (76.5) | 6 (35.3) | 0 (0.0) |
| Central | Boston | 4 (23.5) | 8 (47.1) | 3 (17.6) | 16 (94.1) | 8 (47.1) | 1 (5.9) |
| Corby | 0 (0.0) | 0 (0.0) | 0 (0.0) | 0 (0.0) | 4 (80.0) | 0 (0.0) |
| Great Yarmouth | 0 (0.0) | 2 (20.0) | 0 (0.0) | 2 (20.0) | 3 (30.0) | 0 (0.0) |
| Nottingham | 2 (7.1) | 4 (14.3) | 0 (0.0) | 12 (42.9) | 9 (32.1) | 1 (3.6) |
| South and the channel islands | Camborne & Redruth | 0 (0.0) | 1 (8.3) | 0 (0.0) | 7 (58.3) | 3 (25.0) | 0 (0.0) |
| Plymouth | 3 (6.4) | 6 (12.8) | 0 (0.0) | 17 (36.2) | 10 (21.3) | 0 (0.0) |
| Poole | 2 (15.4) | 0 (0.0) | 0 (0.0) | 11 (84.6) | 5 (38.5) | 0 (0.0) |
| Reading | 3 (9.7) | 2 (6.5) | 2 (6.5) | 5 (16.1) | 3 (9.7) | 5 (16.1) |
| South East | Luton | 0 (0.0) | 3 (6.3) | 0 (0.0) | 34 (70.8) | 18 (37.5) | 0 (0.0) |
| Southampton | 1 (2.6) | 0 (0.0) | 0 (0.0) | 2 (5.1) | 1 (2.6) | 0 (0.0) |
| **Total** | **315 (20.1)** | **139 (8.9)** | **61 (3.9)** | **932 (59.8)** | **515 (32.9)** | **24 (1.5)** |

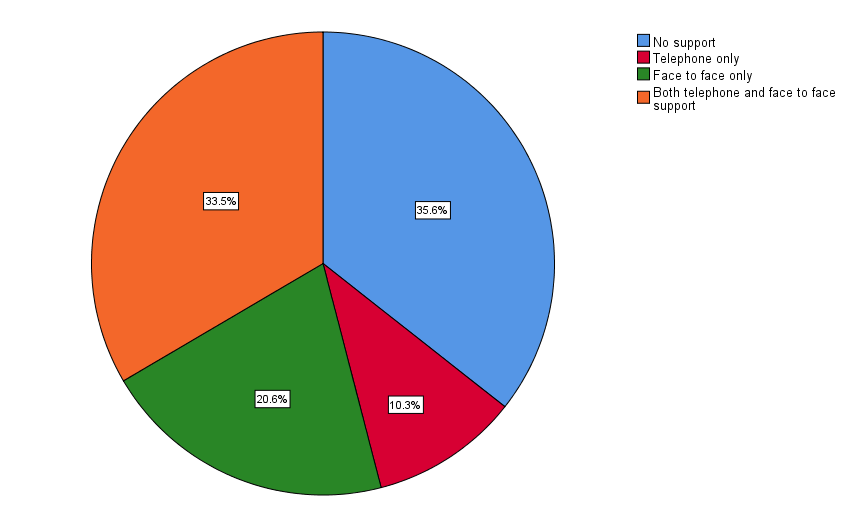
**Delivery of the Community Connectors programme and how this impacts on service delivery**

For the analysis of service delivery, a subset of service users who had been accepted into the service, and had no recorded contact since the 01/12/2018, was created. This was because the open/closed status variable was poorly completed and was problematic to use. The date of 01/12/2018 was selected as it was 6 weeks before the point of analysis, and it was felt that if a service user had not had support in that time then they were unlikely to have any more. We needed to make this distinction because if all service users were included it would have meant that the support provided it would be disproportionately low because it would include service users who were going to receive further support. This subsample consisted of 4543 service users.

**Type of support delivered**

A third of services users received both telephone and face to face support (n=1520, 33.5%) (Figure 3). A fifth of service users received face to face support only (n=935, 20%) and 10% only received telephone support (n=470, 10.3%). However, there were also a third of service users who were not recorded as receiving any support (n=1618, 35.6%).

**Figure 3: The types of support service users received**

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*Sample: 4543. Telephone and face to face support: n= 1520, face to face support: n= 935, telephone support: n= 470, no support: n=1618*

As it appeared to be a large proportion of cases, further exploration was undertaken of the service users who had received no telephone or face to face support. It is difficult to ascertain whether support was actually received because it was not recorded in BRM. However, inconsistencies within the data indicate that that some of these service users may have received support. For example, 229 of the service users were recorded as having received signposting and 2 were recorded as having received support with journeys.

Over a thousand of the service users with no recorded support (n=1024) did have case closure reasons recorded. This does explain why some service users did not receive any contacts. For example, 16 service users were admitted to hospital, 10 died and there was a loss of contact with 8. However, there were also anomalies in the data, such as 242 service users having case closure reason being end of agreed service provision, despite there being no appointments recorded.

This issue appeared to occur throughout the duration of the programme, indicating there is an ongoing problem. However, there were some schemes where there was a greater occurrence of services users having no recorded support and no recorded case closure reason. For example, there were 10 schemes with over 20 service users each having no recorded contact. Therefore, either these schemes had data recording issues or there was a problem with accepted referrals not receiving support. **Given the number of service users without contact recorded, there is a need for BRC to investigate this issue further operationally, by exploration of case notes and discussion with the Connectors themselves.**

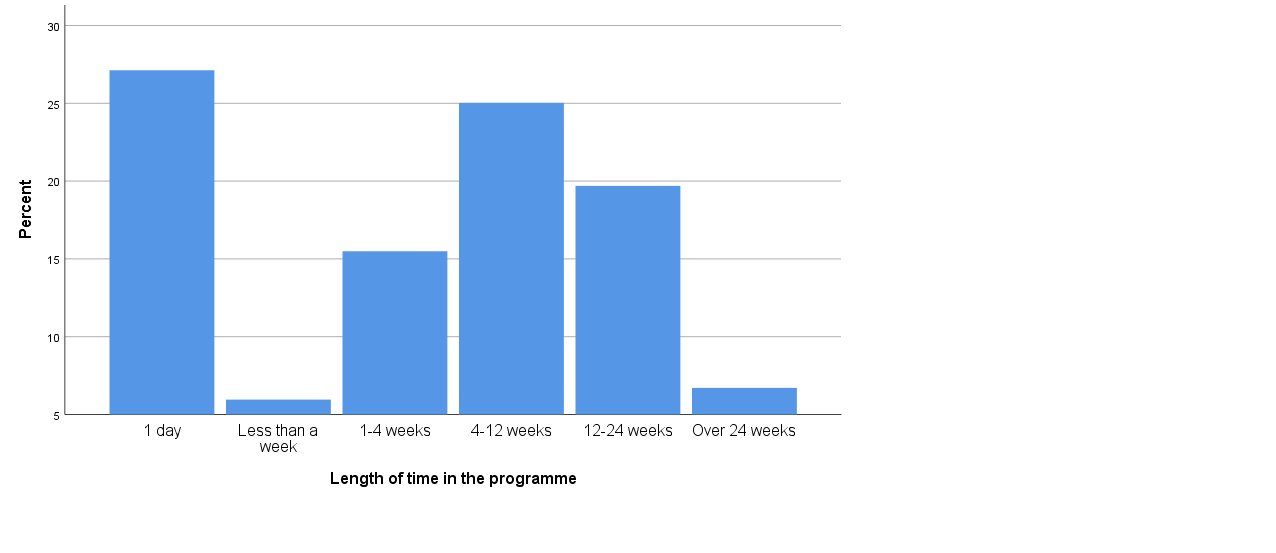
**Length of time in service**

It was difficult to calculate the length of time service users spent in the Community Connector programme because the support start and end date appeared to be completed in relation to administrative processes rather than actual support. For example, the day support ceased did not always match the last recorded date of contact. Therefore, we used the date between the first and last recorded face to face appointment and telephone contact. However, this does not take into account other support service users were provided with such as follow up emails or letters. It also meant that this length could only be calculated for service users with dates recorded (n=2905).

**Three quarters of service-users received 3 weeks or less of support, largely reflecting the service specification of up to 12 weeks of support. The average time in the service was about a month (median: 30 days). However, over a quarter of service users were in the service for just 1 day (n=788, 27.1%) indicating that a high proportion of service users received one contact.**

As days supported ranged considerably between service users, they were grouped into different categories to enable more meaningful analysis (Figure 4). As discussed above, the greatest proportion of service users had one day of support. **However, a similar figure of a quarter (n=727, 25%) had 4-12 weeks of support, reflecting the service specification.** Some service users received a longer period of support. A fifth received support for 12-24 weeks (about 3-6 months) (n=572, 19.7%) and a small proportion of service users received support for more than 6-months (n=195, 6.7%). This latter group is not that many service users across the whole programme. However, consideration is needed operationally about whether this is appropriate, given the intention of the community connectors programme is to give short-term support.

**Figure 4: Length of support**



**Service delivery models**

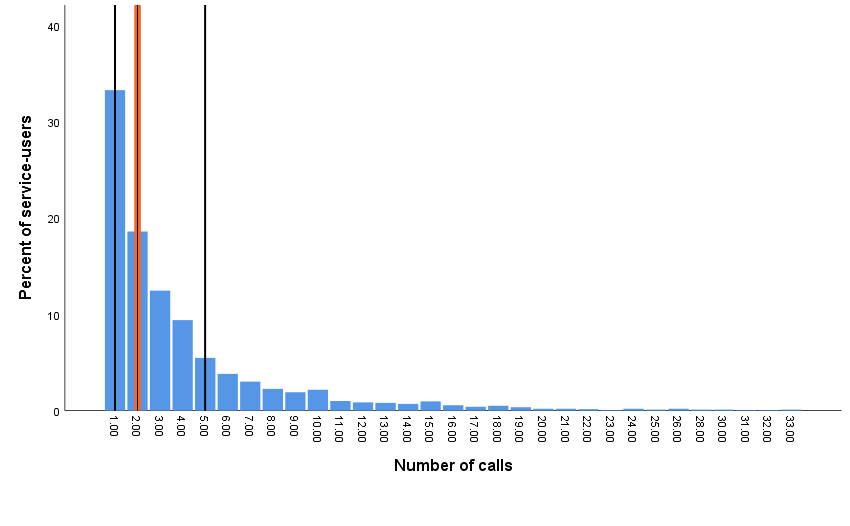
The next sections focus on service delivery models. We explored the telephone and face to face support service users received along with the total amount of contacts. Service users varied considerably in the configuration of this support. For example, some service users received only face to face appointments, some people received mainly face to face support with some telephone support, whereas others experienced a more equal mixture. As the configuration varied for each service user, this was not explored in further detail but is something to be aware of and **highlights that Connectors adapted support to the individual service users’ needs.**

The service delivery work is based on a sample of 2925 service users. These are people who had at least one face to face or telephone contact recorded in BRM and who had received no support since 1St December 2018. This date was used as a cut off so that the analysis was based on people who appeared to of finished in the programme.

**Telephone support**

**Of the service users who had support recorded within BRM, 1990 had at least one telephone call (68%). There was considerable difference in how many calls service users received (Figure 5)**. The average (median) was 2 telephone calls, with a third of service users receiving just one telephone call (n=662, 33.3%). Three quarters of service users received 5 or less calls. However, there were 30 service users who received more than 20 telephone calls each.

**Figure 5: Distribution of telephone calls**

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*Red line denotes median of 2 telephone calls; Interquartile range (the middle 50%) denoted by the two black lines: 1-5 calls telephone calls.*

**In terms of duration, the majority of telephone calls were less than 15 minutes long. This indicates that the purpose of telephone calls maybe to check in with service users or provide practical information. Whilst generally shorter than face to face appointments, these calls were valued by service users and thus an important component of the programme (see section 6).**

Service users ranged in the total amount of support they received over the telephone. The median length was 20 minutes, with an interquartile range[[3]](#footnote-3) of 10-45 minutes. Therefore, 75% of service users received no more than 45 minutes in total of telephone support. Again, this indicates that telephone support may take a different form to face to face support. 53 service users received over three hours of telephone support. For these service users the telephone calls may provide a different function, such as emotional support, or be instead of face to face contacts.

**The vast majority of service users only received telephone calls from Connectors rather than volunteers** (Connectors: n=1782, 89.5 %; volunteers: n=208, 11.5%). This has implications for service planning as indicates that telephone support is a task undertaken by connectors.

**Phone calls to other people**

Alongside providing support directly to service users, Connectors and volunteers also spent time making telephone calls about a service user, such as to people who referred service users, or places they wanted to signpost them to. These are called non-service user phone calls. They were sporadically recorded so it is difficult to know how representative the data is. These calls were recorded for 971 service users (so a third of the sample in this sub analysis). It is anticipated that in reality much more of this activity is conducted than the data indicates. The average (median) number of calls was 2 per service user. Three quarters of the service users had 4 or less calls recorded. However, there were some cases where there was a much larger number of calls undertaken about them. For example, there were 37 telephone calls in relation to one service user. The length of these calls varied, with three quarters of the telephone calls being less than 15 minutes long. However, a few telephone calls were exceptionally long, such as one to the Department for Work and Pensions, which was three hours long. This potentially raises questions about what support activities Connectors should support service users with.

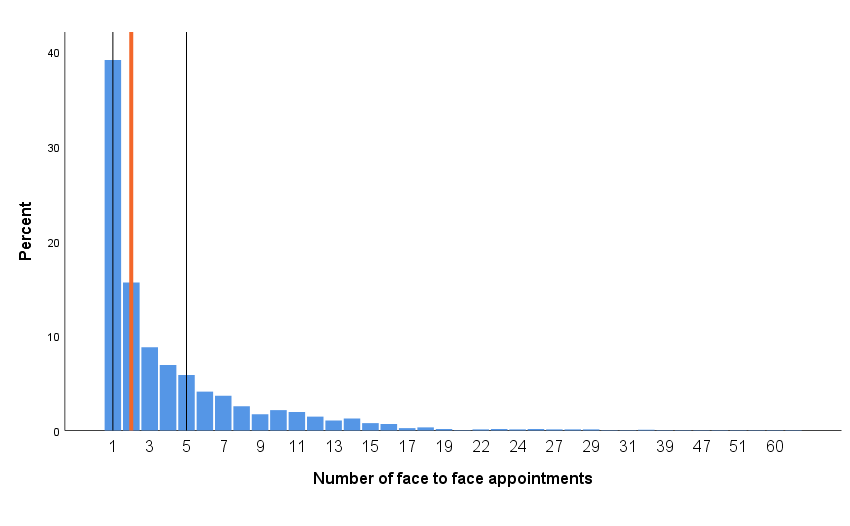
**Whilst this data is poor quality it demonstrates how providing support to service users involves more time than just the direct contact with service users and this needs to be taken into account when considering service capacity.** It may be useful to undertake a detailed case analysis with some Connectors to explore the amount of time they spend on activities related to supporting service users which is not direct contact, to help build a better understanding of this.

**Face to face appointments**

**Over 80% of service users who had contact recorded received face to face support (n=2455, 83.9%).** There was considerable variation in how many face to face sessions service users received, with 1-84 recorded. However, the higher numbers may be due to data quality issues. **Over a third of service users received only one face to face appointment (n=961, 39.1%).** It is not known in these cases whether service users are only having one appointment because the service does not meet their needs, or whether one appointment is sufficient to address their needs.

**On average (median), service users received 2 face to face appointments. Three quarters of service users received 5 appointments or less (Figure 6).** This indicates that whilst in the initial service specification it was anticipated that service users might have up to 12 weeks of appointments, in reality, most service users received a relatively small number of face to face appointments.

**Figure 6: Histogram demonstrating the distribution of the number of face to face appointments service users received**

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*Red line denotes average (median), 2 appointments. The two black lines denote the middle 50% (interquartile range), 1-5 appointments.*

There are a number of key issues arising from the analysis of the face to face appointments. Firstly, Connectors are shaping the amount of support they provide to meet service users’ needs. Secondly, there was a paradox in that service users received a relatively few appointments, but a finding of the qualitative interviews was that service users wanted a greater amount of support (this is discussed subsequently). Thirdly, it indicates that the Community Connectors programme does reflect a social prescribing type model where service users are provided with a relatively small number of appointments.

**The duration of each face to face appointment ranged considerably, with some exceptionally long appointments recorded. The average (median) appointment length was 75 minutes and 50% of appointments lasted between 1-2 hours (the interquartile range).** There were some appointments recorded which were very long, such as a whole working day. Some were the result of data recording issues. However, it is known through the interviewees that some Connectors also occasionally supported service users with activities or appointments that lasted all day. This needs consideration operationally about whether it is appropriate.

In terms of total amount of face to face support, the range was diverse, from 5 minutes of support to 230 hours of support, although the higher amounts may be the product of data quality issues. There were numerous occasions when a service user had a face to face appointment recorded but no length of appointment, so an accurate amount of support could not be calculated. Despite these problems, some exploration of the amount of face to face appointments was undertaken. **The average (median) amount of face to face contact received was 3 hours and three quarters of service users had 7 hours or less of face to face support.**

**Connectors rather than volunteers delivered the vast majority of face to face appointments.** Over 80% of service users had their face to face appointments solely delivered by Connectors (n=2021, 82.3%). However, volunteers were more involved in face to face than telephone support (18% of service users had at least one face to face contact delivered by a volunteer compared to 11.5% in relation to telephone calls).

**Location of appointments**

Face to face appointments took place at a variety of locations including at service users’ homes, attending community activities, visiting cafes and using public transport, to name just a few locations (Table 7). Despite the scope to have appointments at different locations, less than half of service users had any appointments outside of their home (n=1009, 41.1%). The location of appointments did vary between trigger groups, with service users with mobility limitations more likely to have appointments at home. Getting these service users out and about to improve their loneliness was a challenge raised in the interviews (this is discussed later).

Of the 10,218 appointments with a location recorded, over two thirds of appointments took place in the home of services users (n=6980, 68.3%). Community venues and activities were also common places. The ‘other locations outside of the service users’ home’ category covered a range of activities, from visiting the beach to service users being supported to use public transport to increase their independence. There were a small number of appointments which entailed service users being supported to attend health appointments, such as the hospital (120 service users) and personal affairs appointments including Citizens Advice Bureaux (46 service users). The heterogeneity of locations demonstrates that connectors are tailoring the support they provide to the needs of their service users. The multiple service user appointments relate to one scheme arranging for meet ups between a number of service users. The number of appointments recorded as related to this is questionable, however, it demonstrates that this model of support could be something other schemes replicate. This is partly because it provides services users with social networks. It also addresses service capacity issues as several service users can be seen at once.

**Table 7: Location of appointments**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Location | Number of appointments at the specific location | Percentage of total number of appointments at that location (based on n= 10218) | Number of service users with appointments at the location | Percentage of service users who had appointments at a venue (based on n= 2455) |
| Appointment in the service users’ home | 6980 | 68.3% | 2056 | 83.7% |
| Community venue | 764 | 7.5% | 394 | 16.0% |
| Other locations outside of the service-users’ home e.g., using public transport | 625 | 6.1% | 222 | 9.0% |
| Community activity | 461 | 4.5% | 209 | 8.5% |
| Café/Pub/Restaurant | 416 | 4.1% | 178 | 7.3% |
| Library | 299 | 2.9% | 142 | 5.8% |
| Accompanied to health appointments | 181 | 1.8% | 120 | 4.9% |
| BRC office | 102 | 1.0% | 56 | 2.3% |
| Shopping | 94 | 0.9% | 61 | 2.5% |
| Multiple service user appointments | 92 | 0.9% | 3 | 0.1% |
| Gym/leisure centre | 67 | 0.7% | 30 | 1.2% |
| Accompanied to personal affairs appointment e.g. Job Centre | 54 | 0.5% | 46 | 1.9% |
| Social visit to family/friends’ houses | 16 | 0.2% | 13 | 0.5% |

Community Connectors spoke of engaging service users in a range of activities depending on their individual needs and interests, and this ties well with the quantitative data. However, there was a sense that many service users preferred company or someone to accompany them on a daily trip, for example to a café, food shopping, the library or a garden centre, rather than a specific referral out to a community service or organised activity. For example:

*“I think the goals are very simple. It has been building independence things like, well, I’d like to get out of the house or I’d like to go to the garden centre and they’re things that we can easily achieve.”* (CC10)

*“I think it’s just, they either want, basically, they want befriending. So that basically what I’ve found is they just want someone to go around and chat with them for an hour, or two hours and that’s it. They’re not really interested in socialising…But they tend to make excuses like, ‘Oh I don’t really, oh no, that’s not really, that group’s not really for them.”* (CC12)

*“They don’t particularly want to go out and do lots of community activities. They just want a simple outing with a support worker.”* (CC10)

**Journey support**

**Some service users were provided with support for journeys, so a Connector or volunteer took them ‘out and about’. There were considerable differences between schemes with respect to the recording of journeys.** 16 schemes had no support with journeys recorded, some schemes only had support recorded for 1 or 2 service users, and other schemes had journey data recorded for a considerable number of service users, such as 29. **Thus, it is difficult to know whether this variation was accurate or because of inconsistences in how journeys were being recorded. Based on the data recorded, 10.6% of service users received support with journeys (n=214).** Given this issue with the data quality, further exploration of journeys, such as between trigger groups, was not undertaken as it would not have provided meaningful information. However, there is evidence from the qualitative work that some Community Connectors transport service users to activities using Connectors’ own vehicles, although there appears to be inconsistencies in terms of whether Connectors felt this was within their remit. Transport remains a key component to the sustainable impact of the intervention and is also explored further in Section 5.

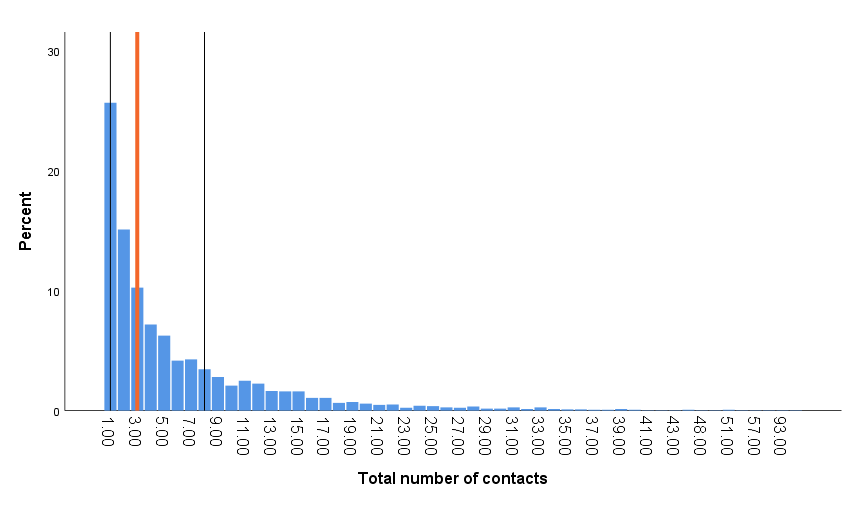
**Total amount of support received by service users**

**The average (median) number of contacts service users had was 3. This was a combination of any telephone and face to face appointments a service user received. Three quarters of service users received 8 or less contacts (Figure 7).** As discussed previously, the precise ratio of telephone to face to face appointments varied depending on the needs of an individual service user. A quarter of service users only had 1 contact recorded (n=751, 25.7%).

At the other end of the spectrum, 5% of service users received more than 20 contacts (n=148).  **However, this is a relatively small proportion of service users when one considers the programme as a whole.**

The 148 service users who received more than 20 contacts were from 24 difference schemes. It is not known if the other schemes did not have service users who required this amount of support or whether they limited the number of contacts they gave to service users. Half of the 24 schemes supported 5 or more service users who had this greater amount of contact. The BRC may want to reflect about how to manage service users who require more contacts in relation to both the aims of the service and the relative capacity of each scheme. For example, if a scheme has a lot of volunteers but a small amount of referrals they have capacity to provide more support to service users than schemes where there are few volunteers and lots of referrals coming in.

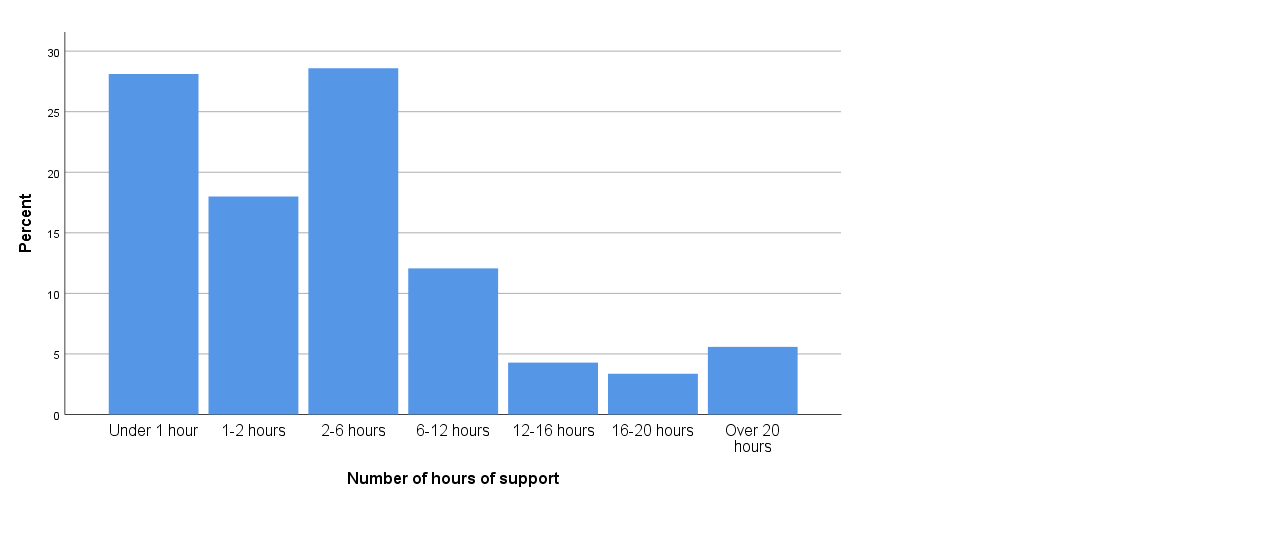
**Figure 7: Histogram showing the distribution of total contacts per service user**

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*Red line denotes the average number of contacts, 3. Two black lines denotes Interquartile range (middle 50%), 1-8 contacts.*

In terms of total duration of support, the average (median) was 145 minutes (2 hours 25 minutes) with half of service users (interquartile range) receiving between 60 minutes and 6 hours of support. As there was a diverse range of precise amount of contact, service users were grouped into different categories (Figure 8). As can be seen, over a quarter of service users received one hour or less of support in total (n=820, 28.1%). Only a small number of service users received 6-12 hours support (n= 352, 12.1%). This is interesting as, based on the service specification, this may have been the most likely amount of support service users received. There were some service users who received a much greater amount of support, with 13.2% of service users receiving over 12 hours of support (n=386). However, some of this data may be the result of data quality issues.

**Figure 8: Distribution of the amount of contact service users received**

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There was an association in that service users experiencing the longer periods of support also had more contacts (*p*=.000); for the most part the same service users who received more than 12 hours of support also had more than 20 contacts (n=121). All but one scheme provided more than 12 hours of support to at least one client, although some schemes supported considerably more service users for more than 12 hours. For example, 16 schemes each provided more than 12 hours of support to at least 10 service users. As with number of contacts, there needs to be further reflection on capacity issues within each scheme to manage these service users. However, there also needs to be reflection operationally about whether providing a greater amount of service reflects the ethos of the programme.

**In terms of the frequency of support, three quarters of service users had no more than 1 contact per week.** There were a small number of service users who had a greater frequency of support; for example, one service user had five contacts per week. Whilst these are only small numbers, further reflection is required about how to support these service users within the confines of service capacity and the purpose of the service. However, it must be noted that the frequency of support was difficult to calculate as it was based on the dates between the first and last recorded contact, which does not take into account other support someone may receive, such as email support. It is also based on the average amount of support a service user received during their time in the Connectors programme. It may be that the frequency of support varies during the period someone is in the programme as is often the case with these types of schemes. Nothing was raised in the interviews about the frequency of support.

**Amount of support delivered by volunteers**

Less than a fifth of service users who had recorded contacts received support from volunteers (n=482, 16.5%). However, there was considerable heterogeneity between schemes. There were 5 schemes which had no support from volunteers recorded, but also 4 schemes where over 50% of service users received some support from volunteers. A breakdown of proportion of volunteer support by scheme is provided in Appendix 3.

We did not explore how volunteer support differed between trigger groups because this would produce spurious results. This is because the main influencing factor appeared to be scheme, so it would be misleading to explore differences in trigger groups.

It takes time to recruit volunteers so it was analysed whether the amount of support provided by volunteers increased over time. We explored whether a service user had any support from a volunteer, using the last recorded face to face appointment date to categorise the data. During the first part of the project in 2017, 10% of service users had some support delivered by a volunteer (n=33 out of 330 service users). This did increase for service users, whose last appointment was recorded in 2018, to about 18%. For those whose last recorded appointment was between 01/01/2018 and 30/06/2018, 18.9% of service users received some support from volunteers (n=132 out of 699 service users). This proportion plateaued, as there was a similar figure of 18.1% for service users who had their last face to face appointment between 01/07/2018 and 31/12/2018 (n=392 out of 2090 service users). These findings are surprising because the number of volunteers and volunteer hours increased during 2018 and thus it would be anticipated that this should have been accompanied by a continuing increase in the proportion of service users who received support from volunteers (as it did between 2017 and 2018). This needs further exploration on an operational level about why this may be occurring, for example whether there are data recording issues or volunteers are providing other support functions. **As the rate of service users who were provided with volunteer support remained stable during 2018, it may indicate that at most, about 20% of service users will have support delivered by volunteers, which needs to be factored in when considering delivery models.**

**Proportion of support provided by volunteers**

We also explored the proportion of support provided by volunteers. Volunteers were recorded as delivering 15.6% of total contacts (3452 out of a total of 22175 contacts). As above this was based on service users who received at least one face to face contact and could only be undertaken where it was recorded who had provided the support. We explored whether this proportion changed over time to reflect the increase of volunteers and service users into the programme. Amongst service users whose last face to face contact was in 2017, volunteers delivered 11.5% of these (290 contacts by volunteers out of 2526 contacts). For service users whose last face to face contact was between 01/01/2018 and 30/06/2018, volunteers delivered 10.5% of these (619 contacts by volunteers out of 5878 contacts). However, this proportion had increased to 18.5% for service users whose last face to face contact was between 01/07/2018 and 31/12/2018 (2543 contacts by volunteers out of 13771 contacts). This indicates that the proportion of contacts delivered by volunteers is increasing over time, even if the proportion of service users being supported by volunteers had plateaued. **It is recommended that BRC continue to monitor these rates to understand further about how much of the direct contact time is being delivered by volunteers because of the impact this has on service capacity.**

Interviews with Community Connectors during year 1 of the project highlighted difficulties encountered in recruiting and retaining volunteers, with many Connectors feeling that they were still undertaking the role of Connector and volunteer during the follow up interviews in year two. However, a number of the volunteers that we spoke to in year 1 of the project felt that their experience and expertise was not adequately utilised, suggesting a potential mismatch between Connector and volunteer views (see section 6). As no follow up interviews were undertaken with volunteers in year two of the project we cannot ascertain whether volunteers continued to feel under-utilised.

**Signposts**

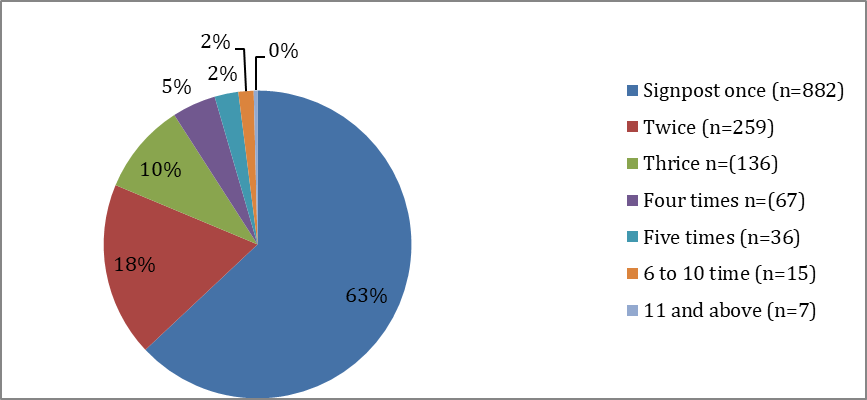
For the signposting data, all service users were included. This is because some service users received signposting despite not having any telephone or face to face contacts recorded in BRM and service users may be signposted at any point of their support so the December cut off was not required. By signposting, what is meant is that service users were told about and/or supported to access other activities, organisations or opportunities. The specific nature of the signpost varied considerably, tailored by need of the service user and what was available in the local area.

**In total 2607 different signposts were made to a range of organisations and activities**. The specific nature of the signpost was categorised into both primary categories, e.g. local authority, and more specific secondary categories, for example social services, libraries and police.  **A quarter of service users received signposting (n=1402, 25.1%). However, this proportion is likely to be higher for two reasons. Firstly, there was a large proportion of service users not recorded as having contact, and whilst some of these did receive signposting many did not, because they were not supported in the scheme. Secondly, Connectors have indicated that they underreport signposting because some are unclear about what is classed as signposting and needs to be recorded.** **Thus, there is a need for greater training to connectors regarding recording signposting.**

Differences in signposting rates, and how this impacts on outcomes, are described below and in section 5.

Amongst service who were signposted (n=1402), almost two thirds received one signpost (n=882, 63%) (Figure 9). Just over a quarter of service users received 2 or 3 signposts (n=395, 27.9%). Under 10% of service users received more than 3 signposts. A small number of these service users received a large number, for example, 7 service users received over 11 signposts each.

**Figure 9: Frequency of signposts**



The next two figures focus on the types of organisations/activities that service users were signposted to. Figure 10 shows the main categories of organisations/activities and Table 8 looks in more detail at the specific types of organisations/activities service users are signposted to.

**Figure 10: Frequencies of signposts by main type of organisation/activity**

**Table 8: Frequency of the secondary coding of signposts**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Primary code | Secondary code | Number of signposts | Percentage within primary code | Percentage within overall sample |
| Third Sector Organisation/ Community Group | Age specific | 427 | 24.7% | 16.4% |
| Mental Health Condition | 148 | 8.6% | 5.7% |
| Physical Health Condition | 145 | 8.4% | 5.6% |
| Community centre/hub | 133 | 7.7% | 5.1% |
| Volunteering and Community action | 126 | 7.3% | 4.8% |
| Hobbies/interests/social/cultural | 95 | 5.5% | 3.6% |
| Befriending | 94 | 5.4% | 3.6% |
| Advice and advocacy | 75 | 4.2% | 2.9% |
| Religious | 57 | 3.3% | 2.2% |
| Education and Employment support | 52 | 3% | 2% |
| Family support | 48 | 2.8% | 1.8% |
| Gender specific | 45 | 2.6% | 1.7% |
| Health and wellbeing | 45 | 2.6% | 1.7% |
| Bereavement support | 41 | 2.4% | 1.6% |
| Transport and mobility | 37 | 2.1% | 1.4% |
| Housing and homelessness | 34 | 2% | 1.3% |
| Food bank | 19 | 1.1% | 0.7% |
| Refugee/Asylum seeker/Migrant support | 18 | 1.1% | 0.7% |
| Lunch clubs/ coffee mornings | 17 | 1.0% | 0.7% |
| Disability | 15 | 0.9% | 0.6% |
| Other/unknown | 58 | 3.3% | 2.1% |
| **Third Sector Organisation/Community Group- Total** | **1729** | **100%** | **66.2%** |
|  |  |  |  |  |
| Local Authority | Library | 61 | 21.5% | 2.3% |
| Social services/social care | 46 | 16.3% | 1.8% |
| Local authority - learning, education and employment | 38 | 13.4% | 1.5% |
| Single Point of Access | 34 | 12% | 1.3% |
| Leisure, fitness and physical activities | 18 | 6.4% | 0.7% |
| Health and wellbeing | 16 | 5.7% | 0.6% |
| Transport | 10 | 3.5% | 0.4% |
| Housing | 9 | 3.2% | 0.3% |
| Police | 5 | 1.8% | 0.2% |
| Fire | 5 | 1.8% | 0.2% |
| Other/unknown | 41 | 14.4% | 1.6% |
| **Local Authority - Total** | **283** | **100%** | **10.9%** |
|  |  |  |  |  |
| BRC | **BRC – Total** | **262** | **100%** | **10%** |
|  |  |  |  |  |
| NHS | Mental Health services | 48 | 54.5% | 1.8% |
| Community services | 33 | 37.5% | 1.3% |
| Other/unknown | 7 | 8% | 0.3% |
| **NHS- Total** | **88** | **100%** | **3.4%** |
|  |  |  |  |  |
| Private Sector | Transport | 22 | 28.6% | 0.8% |
| Care/support at home | 20 | 26% | 0.8% |
| Health | 13 | 16.9% | 0.5% |
| Home maintenance | 5 | 6.5% | 0.2% |
| Other/unknown | 17 | 22.1% | 0.7% |
| **Private Sector - Total** | **77** | **100%** | **3%** |
|  |  |  |  |  |
| Community Directory | **Community Directory** | **22** | **100%** | **0.8%** |
|  |  |  |  |  |
| National Government | Benefits and Welfare | 11 | 78.6% | 0.4% |
| Other/unknown | 3 | 21.4% | 0.1% |
| **National Government - Total** | **14** | **100%** | **0.5%** |
|  |  |  |  |  |
| Other/unknown | **Other/unknown - Total** | **132** | **100%** | **5%** |

There was wide range of organisations that service users were signposted to. By far the greatest proportion of signposts were to third sector organisations and community activities (n=1729, 66.2**%). This is seen as a positive shift of need given one of the main sources of referral was from the statutory sector. Therefore, service users are having unmet need identified by the statutory service, which is then picked up by more appropriate support delivered by the third sector.** Another common signpost was to local authorities (n=282, 10.9%). Whilst this may seem like it is signposting back to statutory services, many of these signposts were for activities such as the library, leisure centre or education opportunities rather than for social service type support. Another frequent signpost was to other BRC services (n=262, 10%). Given the BRC has featured as both a source of referral and a source of signpost, it demonstrates that the community connectors programme is providing added value to other BRC services. There were a small number of referrals to other sectors like the national government, usually the Department for Work and Pensions, and to the private sector, such as for transport or cleaning services.

In terms of secondary codes, **by far the most common signpost was to age specific third sector organisations/community groups (n=427,16.4%).** Whilst the majority of these were to older age charities such as Age UK or Silverline, some were to organisations aimed at younger people like the Princes Trust. Mental health and physical health condition charities each had almost 6% of the signposts. These were charities such as Mind or British Heart Foundation. About 3.6% of signposts were to hobbies/interest/social/cultural activities, for example museums or book groups.

**The wide range of signposts indicates that Connectors already have or have developed a lot of local knowledge and are able to use this to signpost service users depending on their specific needs.**

On first accessing the service, service users identify personal goals that they would like to achieve during their time with the service. These goals then feed directly into the types of activities and signposts that the Community Connector suggests for the service user. When we spoke with service users, a number of different goals were identified and a key issue in relation to service users’ satisfaction with the service was a sense of personalisation – feeling that the Community Connector/volunteer really got a sense of what the service user wanted, rather than making assumptions.

A common goal was building confidence and self-esteem. For example, this related to service users’ confidence to leave their house, to be mobile following an injury, to attend a group, go shopping, make a telephone call and/or use public transport:

*“Well, I’ve had a fall, right, my confidence hit rock bottom. I just wanted basically to get mobile again and be around people again.”* (SU20)

Craft, sports and exercise groups and specialist hobbies (e.g. fishing, bird watching) were also popular goals amongst the service users. For example, service user 6 spoke of how her community connector had connected her to a local bowls group, whilst service user 12 discussed the impact of engaging in his chosen hobby – bird watching. Service user 7 had become part of a local card making group:

*Interviewer: So you said the card making was perfect for you, so what is it about that class?*

*Service user: I am quite creative, so I like the creativity of it. I like the fact that you can please yourself, there is no ‘today we are going to make a sunflower’ you know? You just get on with it.*

*Interviewer: Okay, and is it sociable?*

*Service user: Yes, I will have a cup of tea and a raffle and a bit of chit chat. And I mean you can get up and walk around and talk and ‘oh, what are you doing today?’ I sit on the end so when they are coming backwards and forwards I have quite a few chats.”* (SU7)

Three service users suggested that undertaking volunteering roles was their primary goal. For example, service user 19 became a volunteer in a museum and service user 24 was found a role in a charity shop. Exploring the role of service users in volunteering positions may present new insights in relation to developing self-sustaining communities. For example, Community Connector 15 discussed how he encouraged former service users to become future volunteers within the Community Connector programme. Perhaps this is an angle that the British Red Cross might consider exploring in further detail.

A few service users identified training and education as their primary goals. For example, one service user (a young parent), highlighted how the time that she had spent as part of the Community Connector programme had helped her to undertake some qualifications, which had developed her confidence towards returning to higher education:

*“All the stuff like the diploma, the qualifications and things like that, that’s given me a massive confidence boost towards going back to college as well. Because although I’d been accepted, I was still umming and ahhing a bit about it. But the fact that she’d showed me that there are so many qualifications that I can go and get, that are free and that will help me with my college, it was just, it’s so helpful. Ridiculously helpful.”* (SU5)

A small number of service users required help with administrative tasks, for example claiming benefits, sorting out their housing and/or filling out forms for new equipment such as wheelchairs, stair lifts or laptops:

*“Well he’s given me a bit more confidence in how to handle my bills and to make phone calls and write letters if need be.”* (SU14)

Whilst assisting with administrative tasks may not at first glance appear to be a key aspect of the Community Connector remit, for the service users who identified these issues as goals, resolving them was necessary for them to feel that they could move on to working out activities to integrate themselves into the community (see pen portrait case studies). It is also important to note that for one service user, the Community Connector initially helped with administrative issues and then eventually found someone to assist the service user in the longer term.

One goal that was mentioned by many of the service users was the need to have company. Many of these service users often required someone who could come to their house to sit and talk with them, rather than someone who would help them to integrate and get out into the community:

*“Just a bit of company, that’s all I wanted because I don’t get any company whatsoever…Well someone who could come in, sit down. I could go and make a cup of tea and a biscuit and we have a chat and put the telly…watch a film, a DVD or something like that or just sit and chat or whatever. Just a bit of company basically.*” (SU3)

*“Well basically company to be honest. They posted all sorts of things to me. But you know, basically company.*” (SU18)

For these service users the primary goal was for people to come to them, rather than for them to go out into the community. For some of the service users this was due to mobility issues. Thus, whilst the service users reported positively in terms of the benefit of seeing a Community Connector or volunteer over the 12 weeks of the programme, the sustainability of such work is questionable. We did not find any service users who had been referred onto longer term befriending schemes, although it is unknown whether these types of services were available in their local area.

For a very small number of service users, suitable activities/signposting had not been found. Sometimes it was because of the area in which the service user lived, meaning that there were limited activities available. At other times transportation issues prevented service accessing available activities. For some service users, activities may not have been suitable due to the complexity of their cases (see suitability of programme). One service user felt let down by unsuitable activities being suggested by their volunteer:

*“But she’s asking about going to various, excuse me, food clubs, snooker clubs. I mean what’s the point of me playing snooker when I’m partially sighted?”* (SU3)

However, we are unable to clarify if this service user was located in an area in which there were limited opportunities.

One possible option that the British Red Cross might want to explore is the model currently proposed by Community Connector 15, whereby service users set up groups and activities of interest and then open these groups out to other service users. Thus, they become self-sustaining groups and fill gaps in provision, if no formal groups of interest exist for service users.

**Ending service provision - reasons for case closure**

There were 3716 service users who had a reason recorded for their service provision ending - called case closure reason. This is more than the number of service users who were recorded as having their case closed. Nonetheless, everyone with a reason recorded for closing the case was included in this analysis because there were issues with the open/closed variable generally.

The most frequent reason for service provision ending was early termination (n=1659, 44.6%) (Table 9). About a third of service users had a planned ending (n=1228, 33%). There were 22.3% of people (n=829) whose case closure reason was other, meaning it is not known whether they had an early termination or not.

For service users who had an early termination, the most common reason was that it was the service user’s choice (n=1216, 32.7%). Less than 1% were closed because of losing contact with the service user (n=28). Other reasons related to service users needing greater support, going into hospital or dying. The latter reasons are issues that will inevitably occur for a service of this nature. However, even though some may have been dissatisfied with the service and it did not meet their needs, meaning they chose to terminate their support early, for many, it did meet their needs in a relatively short period of time. **Given it is not known why service users may terminate their support early, it would be useful for BRC to collect further information on this.**

The high proportion of service users having an early termination provides some explanation as to why the median amount of contacts was relatively small, at 3 contacts. What is not known is whether this is a positive outcome, in that service users’ needs have been addressed, or negative, in that the programme does not meet their needs.

**Table 9: Reasons for case closure**

|  |  |  |  |
| --- | --- | --- | --- |
| Early termination or Planned | Specific Reason | Number (n=3716) | Percentages |
| Early termination | Service user need intensified | 257 | 6.9 |
| Service user choice | 1216 | 32.7 |
| Lost contact | 28 | 0.75 |
| Death of service user | 39 | 1.0 |
| Went into hospital | 119 | 3.3 |
| Planned ending | End of agreed service provision | 1228 | 33.0 |
| Unknown | Other reason (not specified) | 829 | 22.4 |

**There was no difference in outcome between service users who experienced an early termination compared with those who had a planned ending.** However, there were issues with the sample so this finding should be treated with caution.

**Differences in service delivery between trigger groups**

Differences in the Community Connectors delivery model between the different trigger groups (Table 10) were explored. As discussed previously, differences between support by volunteers was not analysed because of variation between schemes.

**Table 10: Differences in delivery model between those indicated as falling in a trigger group compared to those who do not**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Trigger group | Amount of contacts | Minutes of support? | Home-based appointments? | More signposting? |
| Living without children at home (n=466) | More | More | 🗶 | More |
| Recently bereaved (n=237) | More | More | 🗶 | More |
| Recently divorced or separated (n=105) | 🗶 | 🗶 | 🗶 | 🗶 |
| Experiencing health issues (n=1550) | More | More | 🗶 | More |
| With mobility limitations (n=855) | More | More | More | More |
| Young parents (n=52) | Less | 🗶 | Less | 🗶 |
| No trigger group (n=585) (compared to those in any trigger group) | Less | Less | More | Less |

*Note: 🗶 denotes no statistically significant difference between those with or without the trigger group. Where significant differences identified p=<.05*

**There are some differences between trigger groups in relation to service delivery.** In terms of number of contacts and amount of support, individuals living without children at home, individuals experiencing health issues, individuals recently bereaved and those with mobility limitations had more contacts, and a longer period of support, than service users not in these trigger groups. These differences were statistically significant. The difference was an average of two contacts and over 2 hours more of support. This is a considerable greater proportion of support when compared to the mean amount of support received by the sample as a whole. For example, the mean amount of support was 6.5 hours of support, so service users in these trigger group received approximately 30.3% more support than the sample as a whole. They also received approximately 28.6% more sessions than the mean of the sample (n=7).

At the other end of the spectrum, young parents and service users not recorded as being in trigger groups had less contacts compared to other service users and again this was statistically significant. Those not in a trigger group received on average 4 and a half hours less of support compared to service users in a trigger group and this was statistically significant (*p*.=000). **These differences have implications for service delivery because it means greater service capacity is required for service users from most of the trigger groups than those not in the trigger groups.** It also raises questions about why there is this variation, for example whether these service users do have greater need or the programme is better tailored to them.

In terms of location of appointments, unsurprisingly, service users with mobility issues were more likely to have home only appointments. Young parents were less likely to have home only appointments but service users without a trigger group were more likely to. This implies that the service delivery model is different depending on the trigger group.

**There were also differences in signposting, with service users in trigger groups more likely to be signposted than those not in trigger groups.** For all of the trigger groups, over 40% of service users were signposted, but for service users not in trigger group the signposting rate was less than 20%. For many of these trigger groups this difference was statistically significant. It is not known why there is this difference, for example, whether service users in a trigger group have a more identifiable need than those not in trigger groups.

**It is apparent that generally, service users in trigger groups are receiving a greater amount of service (except young parents) and those not recorded as being in a trigger group are receiving less support, and this also applies to signposting. This has important implications for service delivery** because it indicates that service capacity will be impacted by the proportions of service users who belong to trigger groups or not. For example, if a scheme has a greater proportion of service users from trigger groups this will require more service capacity than if they had the same number of service users not from trigger groups.

**The service delivered to the most lonely (those scoring 8 or 9 on baseline UCLA)**

To analyse the amount of service received by those most lonely, service users only needed to have a baseline UCLA score, not necessarily an end score. Thus when analysing those most lonely in relation to the service they received, it was a slightly different sample to the sample of service users who had received some support and not had any support since 1st December 2018, a sample of 1561 had a baseline UCLA. Of these, over half of service users were classed as most lonely (n= 831, 53.2%) (This is a comparable proportion to the overall population of people accessing the Community Connectors programme).

**It was found that those who were most lonely received more service and were more likely to be signposted.** In terms of number of contacts, those most lonely did have more contacts and this was statistically significant. Most lonely service users had a mean of 9.3 contacts, whereas other service users had a mean number of contacts of 8.3 contacts. This difference was statistically significant (*p*=.002).  **This indicates that service users who are most lonely have more contacts than other service users. This has implications for service delivery as over 50% of service users were classed as most lonely at baseline and thus may utilise more service capacity.**

In terms of contact with a volunteer there was little difference between the most lonely and other service users (most lonely: n=165, 19.9%, other service users: n=148, 20.3%). However, it was found that service users who were most lonely at baseline were more likely to be signposted than other service users (most lonely: n=370, 44.5%, other service users: n= 282, 38.6%). This difference was statistically significant (*p*= .018), meaning that it was a genuine difference and not due to chance.

# Section 5 – The impact of the Community Connectors Programme

In this section we present the findings of the impact of the Community Connector programme on service users as well as analysis exploring differences in outcome. Qualitative findings of the evaluation are used to provide explanations to the quantitative findings where appropriate. The findings of the matched comparator analyses that compared the users of the Community Connector’s programme with a matched sample are also presented.

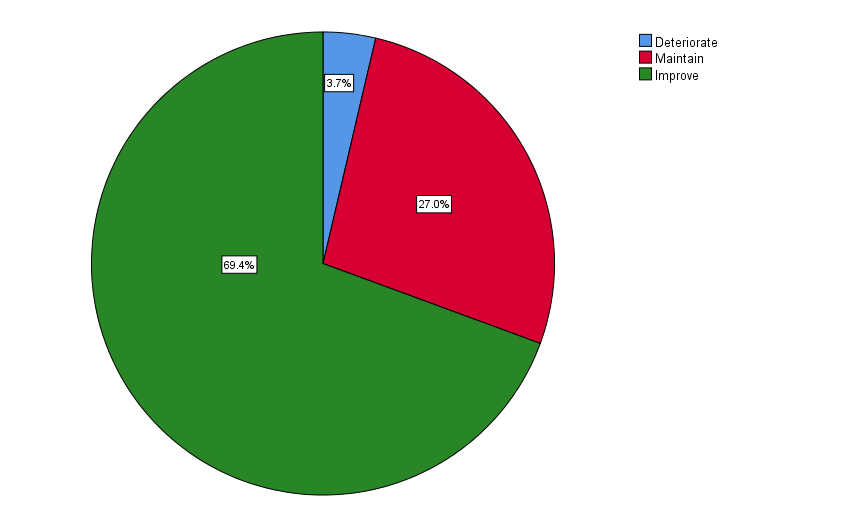
As noted, some service users’ data were missing data (age, gender, UCLA scores) and only a small subset had wellbeing scores. Conversely, information on trigger groups was not missing[[4]](#footnote-4). Any analysis of loneliness and wellbeing is only based on those who had data. The service users with start and end UCLA data were more likely to be in one of the trigger groups (e.g. 76% with UCLA data had health issues) and were also less likely to be missing age and gender information compared to those who were missing data (e.g. only 25% of those missing UCLA data had health issues) (*p*<0.001). This may indicate that data was more likely to be completed if service users identified as being in a trigger group of interest although it could also be the reverse, those who are lonely whose data is completed and they also happen to be in one or more trigger groups. Without further qualitative information on how data was recorded, it is not possible to verify what is driving the pattern we observe. Individuals in some trigger groups were more likely to be lonely (health issues, bereaved, divorced, *p*<0.05).

As we are interested in change, it was also important to consider how those with end of service data compared to those without, based on their start UCLA scores, and there was evidence that those with data were less likely to be lonely (82%) at the start compared to those without UCLA data at end-of-service (87%, *p*<0.01). This indicates that the results may not be generalisable to everyone who used the service as available UCLA data primarily focuses on those in trigger groups, some of whom may be more lonely than the service users who have missing UCLA information. There are also problems in making conclusions that can be applied across all users based on the available data. For example, finding that those in trigger groups were more lonely may be a real finding or a result of missing data, but there is no way to verify this.

**Has the Community Connectors’ programme resulted in improvement of level of loneliness and social isolation of the service users?**

**Two thirds of service users became less lonely between starting and finishing in the Community Connectors programme (n=569, 69.4%) (Figure 1). A further quarter of service users maintained, so did not become more lonely in this period (n= 221, 26.9%). Only a small proportion of service users became more lonely when they were accessing the programme (n= 30, 3.7%).** These figures are derived from changes between the baseline and end of service UCLAs for 820 service users.

**Figure 1: Changes in loneliness following receipt of the Community Connectors programme**

**

*Based on a sample of n=820 - Improved: n=569, Maintained: n=221 and Deteriorated: n=30*

**There were some differences between trigger groups in the proportion of service users who experienced improvement in their loneliness** (Table 1). Amongst young parents and individuals recently divorced/separated, over 80% of service users experienced some improvement in their loneliness compared to 69.4% in the whole sample. However, these differences were not statistically significant indicating that this higher rate may be because of the sample rather than a meaningful difference. Service users not recorded as being in a trigger group were less likely to experience improvement. Just over half of these service users experienced improvement (n=23, 52.1%) compared to those with a trigger group recorded (n=546, 70.4%). This was a statistically significant difference (*p*=.01). However, it must be noted that this group is service users with no trigger group recorded, which could be because the data is missing rather than because someone is not part of a trigger group. Therefore, it is questionable how meaningful this finding is.

Service users could belong to more than one trigger group, indeed of the 820 that there are start and end UCLA scores for, over half (n=472, 57.6%) belonged to two or more subgroups. Therefore, we undertook further analysis on service users who only belonged to one or no trigger groups (n=348). This had similar results in that people recently divorced/separated (n=10, 90.9%) and young parents (n=5, 100%) were more likely to experience improvement in their loneliness and those not in a trigger group were less likely (n=23, 52.3%). However, none of these differences were statistically significant. The issue of only including service users from one trigger group means that there is a smaller sample size, making the analysis less robust. As undertaking this further analysis did not produce different results, it was decided that all other analysis on trigger groups will include any service users regardless of how many individual trigger groups they are part of.

**Table 1: Differences in improvements in loneliness between trigger groups**

|  |  |  |
| --- | --- | --- |
| Trigger group (number of service users in the trigger group) | Number in trigger group experiencing improvement (%) | Statistically significant difference in proportion of improvement compared to service users not in the specific trigger group? (*p* Value) |
| Individuals living without children at home/recently retired (n=194) | 138 (71.1%) | No difference (.546) |
| Individuals recently bereaved (n=109) | 72 (66.1%) | No difference ( .417) |
| Individuals recently divorced/separated (n=45) | 37 (82.2%) | No difference (.055) |
| Individuals experiencing health issues (n=667) | 470 (69.4%) | No difference (.163) |
| Individuals with mobility limitations (n=382) | 271 (70.9%) | No difference (.368) |
| Young parents (n=18) | 16 (88.9%) | No difference (.07) |
| People with no trigger group recorded (n=44) | 23 (52.1%) | Service users not in a trigger group are less likely to experience an improvement (.01) |

***Note:*** *The sample size refers to service users with a baseline and end UCLA rather than the number who have accessed the Community Connectors service generally (n=820).*

**How much of an improvement have the service users experienced?**

**The mean change of UCLA score was a decrease in loneliness of 1.8 points (95% CI[[5]](#footnote-5): 1.7-1.9) points (out of a maximum of 6). However, there were some differences between trigger groups.** Young parents and individuals recently divorced/separated did have a slightly greater level of improvement at 2.2 points (Table 2). Those without a trigger group had a smaller amount of change of 1.3. However, these differences may be due to issues with the sample because they were not statistically significant. **Thus at this stage the findings indicate that there may be some difference in the level of improvement between trigger groups, however any differences are fairly small.**

**Table 2: Differences in the amount of improvement between trigger groups**

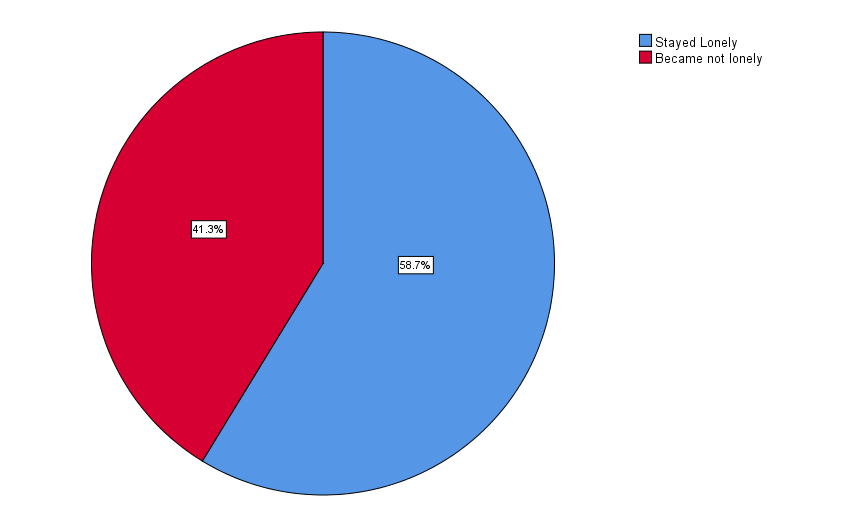
|  |  |  |
| --- | --- | --- |
| Trigger group (number of service users in the trigger group) | Mean increase in loneliness in trigger group: | Statistically significant difference in amount of improvement compared to service users not in the specific trigger group (*p* Value) |
| Individuals living without children at home/recently retired (n=194) | 1.9 | No difference (.271) |
| Individuals recently bereaved (n=109) | 1.8 | No difference (.683) |
| Individuals recently divorced/separated (n=45) | 2.2 | No difference (.102) |
| Individuals experiencing health issues (n=667) | 1.8 | No difference (.127) |
| Individuals with mobility limitations (n=382) | 1.7 | No difference (.563) |
| Young parents (n=18) | 2.2 | No difference (.285) |
| People with no trigger group recorded (n=44) | 1.3 | No difference (.077) |

Note: The sample size refers to service users with a baseline and end UCLA rather than the number who have accessed the Community Connectors service generally.

**What proportion of the service users became not lonely after the programme?**

**Of the service users classed as lonely at the start (n=676; 82%), almost half of these service users had an improvement in their UCLA score which meant they became not lonely whilst receiving the Community Connectors programme (41%, n=279) (Figure 2).** This is based on the UCLA classification of anyone scoring 6 or more being classed as lonely.

**Figure 2: Changes in proportions of service users classed as lonely when receiving the Community Connectors programme**

****

*Sample: n=676. Became not lonely: n=279, stayed lonely: n=397*

The results presented in Table 3 compare the UCLA scores amongst the trigger groups. As seen, there were significant reductions in loneliness status across all the trigger groups – from baseline to end of the service, e.g. of the people who were experiencing issues, 87% (n=1342) were recorded as lonely at baseline, but at the end of the service only 51% remained lonely. Similar results were observed across all the remaining trigger groups except young parents, where no change was seen. However, this could be attributed to the small numbers of young parents in the trigger group sample.

**Table 3: Loneliness/social isolation compared by trigger groups**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Trigger groups |  | UCLA loneliness scores | | | |
| **Status** | **Not Lonely (baseline)** | **Lonely (baseline)** | **Not lonely (end)** | **Lonely (end)** |
| N(%) | N(%) | N(%) | N(%) |
| Living without children at home | Yes | 60 (13.4) | 389 (86.6) | 97 (49.7) | 195 (50.3) |
| Recently bereaved | Yes | 25 (10.2) | 221 (89.8) | 45 (41.3) | 64 (58.7) |
| Recently divorced/separated | Yes | 7 (7.1) | 92 (92.9) | 25 (55.6) | 20 (44.4) |
| Experiencing health issues | Yes | 2010 (13.5) | 1342 (86.5) | 328 (48.8) | 344 (51.2) |
| With mobility limitations | Yes | 135 (15.7) | 736 (84.2) | 189 (49.3) | 194 (50.7) |
| Young parents | Yes | 3 (7.0) | 40 (93.0) | 9 (50.0) | 9 (50.0) |

**Differences in changes in loneliness amongst different demographic groups**

Analysis was undertaken of differences in improvements of loneliness between service users. To enable this, demographics were recoded as dichotomous variables, for example ethnicity became White British or not (Table 4).

**Table 4: Differences between demographics in relation to changes in loneliness**

|  |  |  |
| --- | --- | --- |
| Variable | Statistically significant difference between demographic groups in whether someone is likely to experience improvement (*p* value) | Statistically significant difference between demographic groups in terms of how much change is experienced (*p* value) |
| Gender - male or female | No difference ( .236) | No difference (.942) |
| Ethnicity - White British or not | No difference (.634) | No difference (.627) |
| Age -  Over 60 or under 60 | No difference (0.23) | Evidence that service users under 60 had greater amount of improvement than service users aged 60 or older (.001) |
| Living alone or not | No difference (.289) | No difference (.880) |
| Lonely or not | Evidence that service users who were lonely at baseline were more likely to experience improvement than those not lonely at baseline (.000) | Evidence that service users who were lonely at baseline had a greater amount of improvement in their loneliness score (.000) |

**A key finding is that service users classified as lonely in their baseline UCLA were more likely to experience improvement than those who were not classified as lonely** (lonely: n=517, 75.5%, not lonely: n=52, 36.1%) (*p*=.000). They also had a greater change (lonely: 2, compared to not lonely: .28). This difference is statistically significant, indicating a genuine difference (*p*=.000). The difference is fairly large at 1.5 points on the UCLA, which is a notable change for a service user. However, some of this difference may be explained because those scoring as lonely at baseline have greater potential to improve their UCLA (this is called ‘regression to the mean’).

**Service users who were under 60 also appeared to have a greater level of change than those 60 years and over** (under 60s: 2 points, over 60s: 1.5 points). This difference was statistically significant, indicating a genuine difference (*p*= .001). However, there was no difference between the age categories in terms of how likely it was that a service user would experience any improvement. This indicates that the likelihood of experiencing improvement is similar at any age, but younger people are likely to experience greater improvement in their loneliness.

There was no statistical difference in loneliness outcomes (either likelihood of improving or amount of improvement) in terms of gender, ethnicity or living arrangements**. This indicates that service users who differed in their demographics will have similar changes in loneliness when accessing the Community Connectors programme.**

**The Impact of the Community Connectors programme on the most lonely**

The access criteria to the Community Connectors programme are fairly universal, with service users not having to meet a specific level of loneliness to be accepted. Consequently, the impact of the service on the most lonely (those scoring 8 or 9 on the baseline UCLA) was explored.

Amongst the service users that completed a baseline UCLA (n=2031), over half were classified as most lonely (n=1097, 54%). **This indicates that the Community Connectors programme is supporting people who are experiencing the greatest levels of loneliness.**

**It was found that** **those who were most lonely were both more likely to experience an improvement in their UCLA changes score, but also a larger improvement than other service users.** Of the 820 service users with a baseline and end UCLA score, there were 437 (53.2%) service users classed as most lonely; compared to 383 (46.7%) service users who were not. A greater proportion of the most lonely experienced improvement in their loneliness (n=347, 79.4%) compared to other service users (n=222, 58%). This difference was statistically significant (*p*= .000). The most lonely had a greater improvement in their UCLA score than other service users (most lonely: mean change=2.4; other service users: mean change=1.1). This difference of over a point change was found to be statistically significant (*p*=.000). However, it should be noted that these improved outcomes may be because the most lonely group have greater potential to improve (regression to the mean).

**Differences in outcomes by different service delivery models**

One issue identified as important by the stakeholders was differences in impact for service users who received the support, as per the service specification, compared to those did not.

The original service specification was fairly flexible and consisted of a number of elements:

1. Service users would have up to 12 weeks of support, but this would be tailored to individual need and there was some flexibility for slightly longer support if need be
2. Service users would be signposted to other activities
3. Support would be delivered by volunteers as well as Connectors

An additional feature identified subsequently was a service user receiving at least one session of face to face support.

The different components of service provision were explored individually to understand whether they were related to differences in outcome.

**Amount of support service users received**

The service specification included information on the length of time people would be in the service rather than the amount of support they may receive. However, this length of time information was not accurately collected through the BRM. Consequently, rather than exploring the length of time in the service, we explored the number of contacts service users had (so face to face appointments and telephone support).

This also reflects other work in the field which generally reports by number of contacts rather than length in the service.Support with journeys was not included as they support face to face appointments only. It was explored whether the number of contacts was associated with differences in UCLA change score (Table 5). This could only be done for those with a start and end UCLA score and have had at least one contact but no support since 01/12/2018 (n= 742).

Firstly, there are a small number of service users (n=21) who had telephone contact and no face to face who also completed UCLA.

This must be treated with caution because it is a small sample, but it appears that if service users are given only one telephone call then this does not result in an improvement in loneliness (0% improved). However, if more than one telephone contact was delivered this could result in an improvement in loneliness (64.7% service users improved).

Similarly,service users who only received one face to face appointment and no other contact were less likely to experience improvement in their loneliness score than those who had more contacts (44.6% of service users experienced improvement compared to 70% for those who had more than 1 contact). This difference was statistically significant (*p*=.008). However, there was only a small sample of service-users who had received one face to face contact (n=15). Having less improvement amongst service users who had one face to face appointment is important because a third of all service users in the connectors programme only received one face to face appointment. **For some service users it appears that one face-to-face appointment can be sufficient to improve their loneliness, but it is not enough for most service users.** **Therefore, the BRC needs to focus on getting Connectors to engage service users in at least one more contact beyond the first appointment.** However, it is noted that this data is questionable because it is not known how both a start and end UCLA could be collected for a service user whose only recorded contact is a single face to face appointment. Therefore, it is recommended that the focus on collecting outcomes should be on service users who have a more significant amount of contact.

For service users who received between 2-12 contacts (these will be different combinations of telephone/face to face appointments and length of appointments), the findings were fairly consistent in that the mean amount of UCLA change was almost 2 points, and over 70% of service users experienced some improvement in their loneliness. Interestingly, the level of change decreased for service users who had 13-20 contacts.

**Table 5: Number of contacts in comparison with UCLA change score**

|  |  |  |  |
| --- | --- | --- | --- |
| Number of contacts | Number of service users (n=742) | Mean change in UCLA score (mean 1.8) | Percentage of service users who experienced some improvement on their UCLA score (mean 70.2%) |
| 1 Telephone support only | 4 | 0 | 0% |
| 2+ telephone calls (but calls only) | 17 | 2.0 | 64.7% |
| 1 face to face appointment | 15 | 1.0 | 44.6% |
| 2-7 contacts (face to face and some telephone) | 265 | 1.8 | 70.2% |
| 8-12 contacts (face to face and some telephone) | 180 | 1.9 | 70.6% |
| 13-20 contacts (face to face and some telephone) | 143 | 1.5 | 69.9% |
| Over 20 contacts | 118 | 2.0 | 77.1% |

**Figure 3: Proportion of improvement based on number of contacts**

Given there appears little difference in outcomes between someone having 12 or having 3 contacts it could be argued that the numbers of contacts could be reduced. However, because Connectors shape the support they provide to the needs to the service users, the same results may not have occurred if a service user had received less contacts. Whilst it appears that service users with more than 20 contacts had better outcomes, this was not a statistically significant difference (Figure 3). This may be because of the sample, rather than greater support leading to more users experiencing improvement (*p=*.221). **Thus, it is recommended that Connectors continue to be able to provide this greater level of contacts if they identify a need to but that it does not need to become standard.**

In the initial service specification, it was anticipated that service users would have around 12 weeks of contact, thus we explored any differences in outcome between service users who had between 8-16 contacts, including at least one face to face appointment, and those who did not (this included both service users who may have had only a smaller number of contacts or a larger number of contacts). Of service users with a UCLA change score, there were 282 service users who had the service specification level of support ‘on spec’ (38%), compared to who were ‘not on spec’ (n=460, 62%). **However, there was found to be no significant difference in whether service users experienced improvement in their UCLA scores because of receiving a specific amount of contact (*p=*.865).** This again indicates that rather than the BRC focusing on how many contacts a service user receives, it is more important that connectors tailor the support to the needs of the service user.

Alongside number of contacts, we also explored whether the number of face to face appointments impacted on outcome (Table 6, Figure 4). This could only be undertaken with service users who had at least one face to face appointment and had a baseline and end of service UCLA (n=721). There was a similar pattern to the number of contacts in that service users who only receive one face to face appointment have smaller amount of improvement (1 point compared to 1.8) and 44.6% improvement compared to the average of 70.7%. Levels of improvement do not vary between those with 2 and 20 face to face appointments, with just over 70% of service users experience improvement and a mean change score of around 1.8.

**Therefore, it indicates that the number of face to face appointments does not impact on outcome and Connectors should continue to tailor these to meet the needs of service users.** However, those with over 20 face to face appointments appeared to experience greater improvements in their loneliness, of over 2.6 points, with 88% of these service users experiencing improvement. However, this difference was not statistically significant (*p*=.066), indicating that this difference may be due to chance rather than more appointments being associated with greater improvement. If these service users had received less appointments it is not known whether they would still have experienced improvement, or whether they needed this larger amount of appointments to enable any improvement in their loneliness. **As there is not an infinite amount of service capacity there may need to be a trade-off between the amount of support provided to service users who need more support, compared to the benefits it brings to the individual.**

**Table 6: Impact of outcome of the number of face to face appointments**

|  |  |  |  |
| --- | --- | --- | --- |
| Number of contacts | Number of service users (n=721) | Mean change in UCLA score (mean 1.81) | Percentage of people who experienced some improvement on their UCLA score (mean 70.7%) |
| 1 face to face appointment | 74 | 1 | 44.6% |
| 2-5 face to face appointments | 280 | 1.8 | 71.4% |
| 5-12 face to face appointments | 263 | 1.9 | 74.9% |
| 13-20 face to face appointments | 79 | 1.8 | 73.4% |
| Over 20 face to face appointments | 25 | 2.6 | 88% |

**Figure 4: Proportions of improvement based on number of face to face appointments**

In terms of receiving signposting, there was no difference in outcomes between service users who were signposted or not *(p*=.132). Analysis was not undertaken of how the number of signposts may impact on outcome because it had been established that signposting per se was not associated with this. There was also no difference in outcomes between those with support from a volunteer or not (*p*=.083).

**This indicates that whilst the proportions of service users who received signposting, or support from a volunteer, is lower than anticipated in the initial service specification, it does not appear to be having an impact on outcomes.**

**Differences between sizes of schemes**

We explored whether there were differences in outcome based on the size of scheme (calculated by whether a scheme received less or more than 150 referrals). **There does not appear to be any difference between the proportions of service users who experienced an improvement in their loneliness between the larger or smaller scheme, indicating that the size of scheme does not affect outcomes**.

**Changes in Wellbeing**

A number of wellbeing measures including the Short Warwick Edinburgh Mental Health Wellbeing Scale (SWEMWBS) and the Office for National Statistics Wellbeing Questions (ONS-4) were collected to explore whether service users experienced a change in wellbeing when receiving the Community Connectors programme.

Not all service users completed the wellbeing questions at both the start and end time points so we analysed both the change within the population (so amongst everyone in the sample, how much change is experienced). However, we also analysed the specific change individuals experienced (so whether an individual’s wellbeing had increased). The average population change is presented first for each question followed by individual change.

The subsample of service users who completed wellbeing measures were compared with all service users to explore how representative the wellbeing findings may be (Appendix 4).

There were some differences between the wellbeing sample and all service users, notably in regards to gender and ethnicity (Appendix 4). In the wellbeing sample, three quarters of the service users were female (75.4%) compared to 64.9% in the overall sample. With regard to ethnicity, almost 90% of the wellbeing sample was White British (88.3%) whereas in the main sample the proportion of White British service users was smaller at 76.7%. In regards to living arrangements and age, the wellbeing sample and all service users were similar. **Whilst there are some differences between the wellbeing subsample and the wider sample, the specific demographics where there are differences were not related to changes in loneliness. Thus it is unlikely to be an issue for the generalisability of the wellbeing data to the wider population of service users.**

A considerably greater proportion of the wellbeing sample were members of trigger groups compared to the overall sample (Appendix 5). For example, 77.6% of the wellbeing sample was recorded as having health issues compared to 43.4% amongst all service users. This pattern was the case for all of the trigger groups. However, given there was no differences in changes in wellbeing between trigger groups (discussed further below) this is not considered to be an issue for the generalisability of the wellbeing findings.

The wellbeing sample also received a considerably greater amount of support than other service users. For example, the median amount of contacts was 13, whereas in the overall sample it was 3, and 45.5% had contact with a volunteer compared to less than 20% in the overall sample. These differences could be explained because Connectors were asked to collect the wellbeing measures as an additional questionnaire so may have been more inclined to administer it to the service users who they had more contact with. However, in relation to loneliness outcomes, there was no difference between those who had 3 compared to 13 contacts, so again this may not impact on the generalisability of the wellbeing data.

**Improvements in wellbeing between starting and finishing in the Community Connectors programme**

**Service users experienced an improvement in their wellbeing score when receiving the Community Connectors programme.** The mean baseline SWEMWBS score was 18.9 (n=338) (95% CI 18.2-19.5) (Figure 5). This was a lower average than the UK population, where the national average is 25.2 (Office for National Statistics, 2019). At the point of finishing in the programme, the mean end score had increased to 22.3 (95% CI: 21.3-23.2) (n=111). Although, despite this improvement, average wellbeing levels were still below the national average.

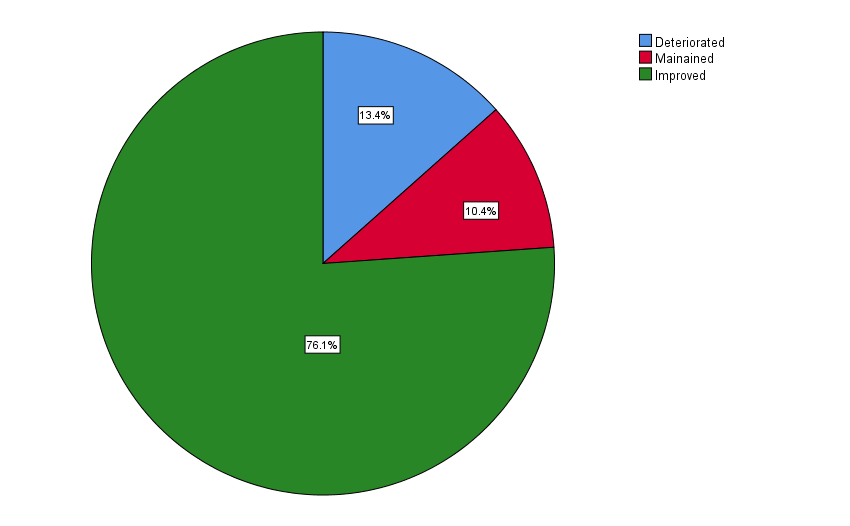
Whilst the mean was still below the national UK average, there was improvement in the numbers of individuals having the UK average level of wellbeing. **Double the proportion of service users had wellbeing equivalent or more than the national UK average at the end of the programme than they had at the beginning** (start: 16.9%; end: 38.8%). This is also reflected an individual level, **with almost a third of service users who had a lower than the UK average wellbeing having equivalent or greater wellbeing at the point of finishing in the service** (n=18 of 56, 32.1%).

**Figure 5: SWEMWBS Scores between baseline and end of programme**

*Note: Baseline SWEMBWS: 18.9, end of service: 22.3, national average (denoted by red line): 25.2*

**When looking at individual change in wellbeing, service users did experience an improvement**, with three quarters of service users having an increase in wellbeing (n= 51, 76.1%) (Figure 6). In terms of amount of change, the average was an improvement of 3.6 points (95% CI: 2.4-4.8).

**Figure 6: Change in wellbeing after receiving the Community Connectors programme**



*Sample: n= 67. Improved: n=51, maintained: n= 7, deteriorated: n= 9*

Some researchers propose that a meaningful change on the SWEMWBS is an improvement of 3 points rather than any increase (Putz et al., 2012).

**Using this more stringent criteria the average change of 3.6 points is above this threshold**. However, the lower end of the confidence interval does fall slightly under it at 2.4 points, so it is not highly certain that the average change is above the meaningful difference cut off. However, on an individual level, the proportion of service users having a meaningful improvement in wellbeing is just over half (n=37, 55.2%). As there is not universal agreement about this meaningful change categorisation, any increase has been classed as an improvement in this evaluation.

Analysis was undertaken of differences in wellbeing improvement between trigger groups. However, because of small numbers in most of the trigger groups the results were meaningless. The exceptions were the trigger groups experiencing health issues and with mobility limitations. As these were larger samples, meaningful analysis could be undertaken (Table 7). **There appeared no difference in wellbeing outcomes between service users who were experiencing health issues or had mobility limitations compared to those who did not.**

**Table 7: Differences between trigger groups in wellbeing score**

|  |  |  |
| --- | --- | --- |
| Trigger group (numbers in trigger group with wellbeing score) | Number in trigger group who experienced an improvement in their wellbeing (%) | Statistically significant difference in whether someone experienced improvement in their wellbeing (*p* value) |
| Experiencing health issues (n=52) | 38 (73.1) | No difference in likelihood of experiencing an improvement in wellbeing between those who experienced health issues and those who did not (p=.492) |
| With mobility limitations (n=36) | 25 (69.4) | No difference in likelihood of experiencing an improvement in wellbeing between those who had mobility limitations or those who did not (p=.167) |

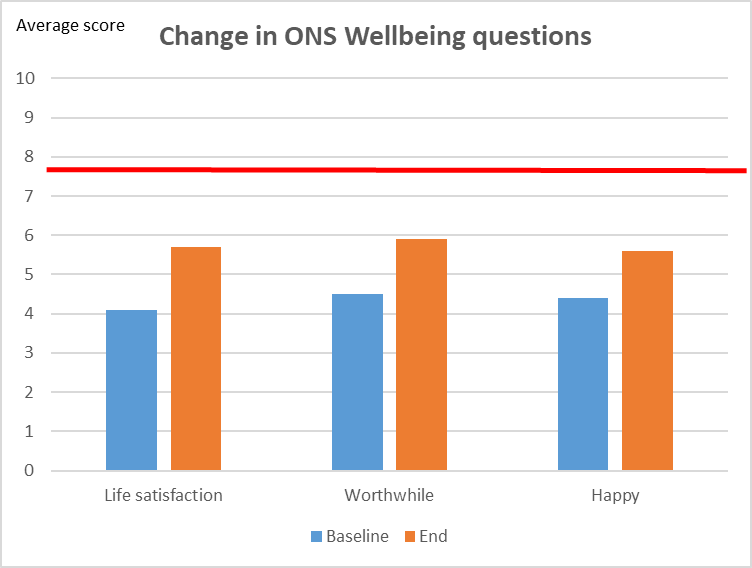
**Generally, the same service users who experienced an improvement in their wellbeing also had an improvement in their loneliness.** Whilst the sample was small (n=55), this correlation was statistically significant (Fishers Exact Test: *p*= .006). So it appears these two benefits go hand in hand.

Subgroup analysis of improvements in wellbeing between different demographic groups was not undertaken for two key reasons. Firstly, few differences had been identified in regards to improvement of loneliness and thus demographics appeared less relevant than other factors on the outcomes of service users. Secondly, the relatively small sample meant that even if differences had been identified, they were likely to have occurred because of the small sample rather than a genuine difference.

**Change in wellbeing based on the ONS-4 questions**

No subgroup analysis was performed on the ONS-4 questions because the sample was relatively small and questions were additional to the main wellbeing outcome, which was measured through the SWEMWBS. Figure 7 visualises the findings of the wellbeing questions (excluding anxiety) between the start and end points of the programme, comparing the findings with the UK average.

**Figure 7: Change in ONS wellbeing questions**

****

*National average approx. 7.7 (ranges between 7.5-7.9 between the questions). Life satisfaction: Baseline 4.1, End: 5.7. Activities Worthwhile: Baseline 4.5, End: 5.9. Happiness: Baseline 4.4, End: 5.6.*

**Life satisfaction**

**The majority of service users experienced an improvement in their life satisfaction when accessing the Community Connectors programme**. The mean life satisfaction score at baseline was 4.1 (n=366). There was an average improvement of 1.6 points, with the mean end score being 5.7 (n=199). However, the mean UK population score is 7.7 indicating that service users in the programme had a lower level of life satisfaction that the UK average (Office for National Statistics, 2018).

Amongst service users who had both a baseline and end of life satisfaction score (n=68), over two thirds experienced an improvement in their life satisfaction (n=45,67.6%). The mean improvement on an individual basis was 1.7 points (95% CI: 1.02-2.4).

**Service users’ perceptions that what they do is worthwhile**

**Over half of service users feel what they do is more worthwhile following receipt of the Community Connectors programme. This is important because an objective of the Community Connectors programme is to support people to connect with meaningful activity.** In terms of overall change, the mean score at baseline was 4.5 (n=360) and this increased to 5.9 (n= 120) at the end of service indicating an overall improvement of 1.4 points. Even with their improvement, service users were still below the UK population average of 7.9 points (Office for National Statistics, 2018).

In terms of individual change (n=71), just over half of service users experienced some improvement in their score (n=39, 54.9%) and there was an overall mean change of 1.4 (95% CI: .8-2.0).

**How happy individuals feel**

**There was improvement in how happy service users felt after receiving the Community Connectors programme.** At baseline, the mean happiness score was 4.4 (n= 362) and this increased to 5.6 (n=121), indicating an improvement of 1.2 points. Despite this improvement, service users still had lower levels of happiness than the general UK population, whose score is 7.5 (Office for National Statistics, 2018).

On an individual service user level (n=71), over half experienced improvements in their happiness (n=43, 60.6%), with a mean improvement of 1.5 (SD: 2.8) (95% CI: .83-2.16).

**How anxious service users feel**

**Service users had mixed experiences in whether they experienced improvement in their anxiety when accessing the Community Connector programme**. At baseline the mean anxiety score was 4.6 (n= 367) and this was the same at the end (n=119). This stagnation is reflected on an individual service-user level (n=72), where the mean change score was fairly static at an improvement of .35 (95% CI: -.51-1.3). Both at baseline and end of service, the level of anxiety amongst service users was higher than those in the general UK population, whose mean is 2.9 (Office for National Statistics, 2018).

Despite it appearing that there was little change in mean score, just over half of individual service users did experience an improvement in their anxiety (n=38, 52.8%). These mixed results indicate that for some service users, their anxiety improved during their time in the programme, whilst others became more anxious. One possible explanation may be because of service users being encouraged to try new activities by the Connectors, which in the short term may make someone feel more anxious. However, it is a fairly small sample and further exploration may be required by the BRC.

**How much someone’s physical or mental health impacted on them being able to engage in social activities**

Service users were asked how much their physical or mental health had interfered with them being able to engage with social activities. **Amongst the sample, it appeared that service users generally felt that their social activities were less negatively impacted by their physical or mental health at the end of the Community Connectors programme**. For example, at baseline, 37.6% (n=136) of service users reported that their social activities were impacted all of the time by health issues whereas this decreased to 14.3% (n=17) at the end of the programme. **Whilst the sample is too small to explore whether it can be attributed to the Community Connectors programme, it indicates that an element of the work Community Connectors do is supporting service users with improving how they manage their health issues so that it has less of a detrimental impact on their ability to engage in social activities.** If this is the case, then it is an important aspect of the programme as it will have a positive impact on someone’s loneliness as it may help them to engage more in activities if they are finding ways to manage their health.

The interviews with Community Connectors and volunteers revealed that a number of difficulties were encountered when supporting people with physical health needs, particularly when these needs resulted in mobility issues which restricted service users’ abilities to access community activities. In these cases, sourcing sustainable transport was key to the success of the intervention but this was not always possible, due to a lack of resources in some areas. In some cases, even when transport was sourced, service users did not want, or were unable, to be signposted to community activities due to their health or mobility conditions:

*“But she does phone now and again to see if I’m going out which I find difficult because of an injury…And being partially sighted as well…But she’s asking about going to various, excuse me, food clubs, snooker clubs. I mean what’s the point of me playing snooker when I’m partially sighted?”* (SU3)

A number of service users also discussed spending periods of time in hospital during their time with the service due to ill health/mobility issues which impacted on their ability to engage with activities.

**Service users meeting their goals**

A good number of the service users set goals and worked towards achieving them. The data suggest that about 60% of those accepted into the programme set goals. Those who did not set goals either could not be contacted (19%) or had declined the service (18%). Nearly half of those who were identified as belonging to a trigger group set goals (n=236, 47%).

In terms of the progress made towards achieving personal goals set, the results show that more than half of the service users who set personal goal 1 achieved it, and made a lot of progress towards achieving the goal; only about a quarter made no progress. Slightly above half of the users have achieved goal 2, and about a quarter made a lot of progress towards achieving this goal. For the users who set personal goal 3, about half have achieved this goal, and about a quarter made a lot of progress. No significant differences are observed across all three goals regarding those who are not making any progress in achieving all three goals (Figure 8).

**Figure 8: Progress made towards achieving goals set**

**Goals achieved compared by trigger groups**

The data presented in Table 8 compares the progress made towards achieving personal goals set by the service trigger groups. More than half of the service users who were identified as recently bereaved, experiencing health issues, with mobility limitations, and those who were recently separated or divorced had achieved their goals, and <40% of young parents achieved their personal goals set.

**Table 8: Progress towards goals set**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Progress made towards achieving goals set (Goal 1) | | | |
| Trigger groups | Achieved | Made a lot of progress | Made some progress | Made no progress |
| Living without children at home | 152 (59.6) | 39 (15.3) | 51 (20.0) | 13 (5.1) |
| Recently bereaved | 82 (55.4) | 28 (18.9) | 29 (19.6) | 9 (6.1) |
| Recently divorced/separated | 35 (61.4) | 12 (21.1) | 10 (17.5) | 0 (0.0) |
| Experiencing health issues | 570 (61.3) | 121 (13.0) | 187 (20.1) | 52 (5.6) |
| With mobility limitations | 294 (59.6) | 61 (12.4) | 106 (21.5) | 32 (6.5) |
| Young parents | 10 (37.0) | 7 (25.9) | 8 (29.6) | 2 (7.4) |
| No trigger group | 682 (62.2) | 144 (13.1) | 207 (18.9) | 63 (5.7) |
|  | Progress made towards achieving goals set (Goal 2) | | | |
| Living without children at home | 117 (54.7) | 39 (18.2) | 43 (20.1) | 15 (7.0) |
| Recently bereaved | 54 (49.8) | 21 (19.3) | 23 (21.1) | 11 (10.1) |
| Recently divorced/separated | 24 (57.1) | 10 (23.8) | 7 (16.7) | 1 (2.4) |
| Experiencing health issues | 331 (50.3) | 111 (16.9) | 151 (22.9) | 65 (9.9) |
| With mobility limitations | 189 (50.7) | 55 (14.9) | 86 (23.3) | 41 (11.1) |
| Young parents | 6 (28.6) | 6 (28.6) | 8 (38.1) | 1 (4.8) |
| No trigger Group | 388 (50.7) | 131 (17.1) | 170 (22.2) | 77 (10.1) |
|  | Progress made towards achieving goals set (Goal 3) | | | |
| Living without children at home | 66 (56.9) | 16 (13.8) | 25 (21.6) | 9 (7.8) |
| Recently bereaved | 38 (53.5) | 12 (16.9) | 16 (22.5) | 5 (7.0) |
| Recently divorced/separated | 13 (54.2) | 5 (20.8) | 3 (12.5) | 3 (12.5) |
| Experiencing health issues | 171 (48.9) | 59 (16.9) | 89 (25.4) | 31 (8.9) |
| With mobility limitations | 103 (28.6) | 30 (14.4) | 52 (25.0) | 23 (11.1) |
| Young parents | 1 (7.1) | 4 (28.6) | 7 (50.0) | 2 (14.3) |
| No trigger group | 210 (50.1) | 67 (16.0) | 102 (24.3) | 40 (9.5) |

**Overall outcome achieved**

The majority of the service users who accessed the Community Connector programme have improved/widened their social networks and made friends. The results also show that a good proportion have increased their awareness of, and access to, further services, and that a significant proportion are now making more meaningful use of their time. There were no significant differences observed in these outcomes achieved across all three goals for each outcome (Figure 8).

**Figure 8: Outcomes achieved**

**Relationship between goals achieved and improvement in UCLA loneliness scores**

We explored the relationship between goals achieved and the improvement in UCLA loneliness scores among trigger group participants, and we compared these with non-trigger group participants. Table 9 summarises the results. Of the 64% people who were experiencing health issues and achieved their goals, 85% (n=153) experienced an improvement in their UCLA loneliness scores, and 79% (n=189) had no change in UCLA loneliness score at the end of the service. 33% (n=1) of people in this category of trigger group experienced a decline in their UCLA loneliness scores. However, results must be interpreted with caution because of the small sample in this category (n=1).

The trigger group sample who were experiencing health issues and achieved their goals (36%, n=321) were less likely to experience a significant improvement in their UCLA scores. **This is an important finding demonstrating that the Community Connectors service has had a significant impact on service users’ loneliness, particularly the trigger groups experiencing health issues** (Table 9).

**Table 9: Achieved goals, trigger groups and UCLA loneliness scores**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Achieved goals (1,2 3)  N(%) | Change in UCLA group 3 | | |
|  | **status** | **No change** | **Improved** | **Declined** |
| Trigger Group |  | N(%) | N(%) | N(%) |
| Individuals living without children at home | Yes | 152 (17.1) | 53 (22.2) | 49 (27.1) | 1 (33.3) |
| No | 739 (82.9) | 186 (77.8) | 132 (72.9) | 2 (66.7) |
| Individuals recently divorced or separated, | Yes | 35 (3.9) | 13 (5.4) | 14 (7.7) | 0 (0.0) |
| No | 856 (96.1) | 226 (94.6) | 167 (92.3) | 3 (100) |
| Individuals recently bereaved | Yes | 82 (9.2) | 29 (12.1) | 22 (12.2) | 0 (0.0) |
| No | 809 (90.8) | 210 (87.9) | 159 (87.8) | 3 (0.0) |
| Individuals experiencing health issues | Yes | 570 (64.0) | 189 (79.1) | 153 (84.5) | 1 (33.3) |
| No | 321 (36.0) | 50 (20.9) | 28 (15.5) | 2 (66.7) |
| Individuals with mobility limitations, | Yes | 294 (33.0) | 112 (46.9) | 85 (47.0) | 3 (100) |
| No | 597 (67.0) | 127 (53.1) | 96 (53.0) | 0 (0.0) |
| Young parents | Yes | 10 (1.1) | 3 (1.3) | 3 (1.7) | 0 (0.0) |
| No | 881 (98.9) | 236 (98.7) | 178 (98.3) | 3 (100) |

**Benefits to service users arising from the interviews**

Whilst the quantitative analysis focused on measurable improvements in loneliness and wellbeing, many of the service users spoke about the impact of the programme on the development of their self-esteem and confidence. It was small changes to service user’s daily lives, such as the confidence to catch public transport or looking forward to a weekly activity that they had started as a result of the Community Connector programme, that could make a big difference to a service user:

*“I feel a lot more productive and confident I would say.”* (SU19)

*“I’m back to where I want to be, you know?”* (SU20)

*“I built up so much energy, I’m getting back to what I like doing and I’m moving forwards going into doing my other volunteer job later in the year. And I am meeting all sorts of new people and it’s great, you know.”* (SU4)

For example, CC1 spoke of a service user who had recently come out of hospital and wanted someone to accompany her on the bus and into town. After four visits she felt that she was confident enough to do it on her own. Similarly, CC4 spoke about a service user who had recently been mugged and had lost his confidence. He wanted someone to accompany him on certain routine outings in order to build that confidence back up. CC7 described how they had taught a housebound service user to use a laptop to help them connect with the world and how this had a profound effect on their mental wellbeing.

One Community Connector felt that their biggest impact was in terms of being an advocate for their service users. They spoke of one case where they were involved in applying for grants for a wheelchair and laptop for a service user with multiple sclerosis (MS):

*“…I’ve got one client who has got multiple sclerosis. And he is completely isolated and lonely; he’s basically given up on dealing with any of his affairs…he rarely goes out. He’s got no friends to speak of, so it’s coordinating the wheelchair service to get a new wheelchair and to push for him to get an electric wheelchair, we’re still trying to push on that one...I’ve managed to get a grant from the MS society for him to buy a laptop. At least he could start managing his own affairs like his bank accounts and utility bills…”* (CC5)

As well as giving specific examples of service users who had benefited from the service, many Community Connectors discussed the impact and value of the service more generally:

*“I think you know, if all connectors are sort of working on that person centred approach and managing expectations, I think you’re kind of opening a door for a person that may be you know, has been wedged shut for a very long time… And when I think that a person’s lost hope and if you’re able to just show them a little bit of light at the end of the tunnel, that’s a huge thing for somebody. Absolutely huge.”* (CCFU7)

*“I think it’s really important because people are lonely…we need someone there to build our resilience and build our confidence. And the programme at the very beginning initial stage is fantastic…We are at the very beginning of befriending but to build someone’s confidence. And I think you can only do that one to one, so I think it’s fantastic. It’s brilliant. And yeah we go in when people are feeling most vulnerable but then we leave when we have built their confidence. It’s like a different person.”* (CCFU17)

**Impact on statutory service use**

**To date the findings have considered the impact of the Community Connectors programme on individuals, however it is also important to consider its impact on statutory services. This is because often schemes like the Connectors programme are commissioned in the hope they will decrease demand on statutory services (Polley et al., 2017).**

A small number of Connectors discussed the impact of the service on statutory services, which most felt were overburdened and overstretched. Most Connectors hoped that the service would impact on statutory service use but were unable to give any examples of this. One Community Connector described a gentleman diagnosed with bipolar disorder who became too busy with activities to visit the doctor:

*“One gentleman who was diagnosed as being bipolar, his doctor says he’s usually there every week and I know for a fact now, I have got him signed up as a comedian. And he’s going around the over 50 clubs as a comedian and he’s also got himself a market stall and he hasn’t got time, he says, to go to the doctor. He’s really doing well.”* (CCFU15)

However, others felt the service was unlikely to have an impact on statutory service use due to the short term nature of the intervention and the saturation of services in certain areas. It was felt that the BRC cannot be a replacement for other services which clients are usually engaged with in the longer term:

*“If I’m honest I don’t think [it is having an impact on service use] because it’s such a short-term service and I think if people are needing to rely on statutory services in the first place, often it’s because they have longer term needs, so I don’t think it’s a replacement for that. I think it can kind of give those statutory services a bit of a break for a bit, but I don’t think in the long term that it makes a huge amount of difference.”* (CC3FU)

*“I don’t think it’s becoming less reliant on statutory services. I think it’s just another service added on to the many other services that are available.”* (CCFU17)

One Connector discussed how the service compliments other services, rather than replaces them. For example, if a client is receiving physiotherapy following a fall the Community Connectors service can work alongside to build up the client’s confidence socially.

Whilst there is no data on reduction of use of statutory services, it is apparent from the quantitative data that the Community Connectors programme is filling a need for services. The most common source of referral was statutory services in terms of the NHS/Local authority (n=2354, 40.7%), and referrers taking part in the SROI spoke highly of the role the Community Connectors programme played in local service provision. For example, in one area the programme filled a gap at the point service users were being discharged from hospital to help them engage in the community. There is also a trajectory that, whilst a common source of referral was from statutory services, two thirds of signposts were to third sector organisations/community activities, which implies some shifting of need from the statutory services. Sources of referrals and signposts are discussed in Section 4.

**Matched comparator analysis**

The previous results have focused on the change in service users without comparing to a control group. Matching aimed to address the question of what additional benefit the Community Connectors programme brought to service users over and above what would have been available if they had not used the service. As noted in the methods, matching used different criteria including age, gender, living arrangements and trigger groups to enable suitable controls to be identified in ELSA for comparison with service users who had closed status at the end of service. Comparison was limited to those **who had data** and there was evidence that for service users, these were individuals who were **more lonely or more likely to be in the trigger groups** while for ELSA, these were individuals who **were less lonely and less likely to be in the trigger groups** (Appendix 1 table 1). Matching results may therefore be systematically biased (i.e. the data is not missing randomly but is associated with whether or not service users were in a trigger group or not) compared to if everyone who used the service also had data. Results may also not be generalisable to other service users who do not have data.

The matching resulted in sample sizes ranging from 750 (n=375 for service users and ELSA data) to 556 (n=278 for service users and ELSA data)[[6]](#footnote-6) (Appendix 1 table 2). As UCLA scores were used, the UCLA scores and proportions who were lonely were similar across the matched samples and differences in other characteristics varied depending on the group, therefore all the matched samples were used in the analysis. This also maximises on the available data as sample sizes vary by up to n>200. Age was not well matched so this was included as a control in the analysis. A sub-sample of service users were contacted 3 months after end-of-service and they completed UCLA and wellbeing measures. For this additional follow up, the matched samples were much smaller (n= 204 and n=200 respectively with half of these being service users and the other half ELSA data). The additional follow ups were more lonely at baseline compared to the overall sample and therefore the matching reflects this (Appendix 1 table 3).

**Matching results: change in raw loneliness (UCLA) scores for service users compared to ELSA**

The change in raw UCLA loneliness scores for service users compared to the ELSA control group, after controlling for age, was -0.7 to -0.9 depending on the matching sample. For groups 1 to 3, the results were the same; mean change in raw UCLA loneliness scores was -0.8 (95% CI: -0.6 to -1.0) with a similar mean change for group 4 but different 95% CI [-0.8 (95% CI: -0.6 to -1.1)]. Group 5 had a larger mean change [-0.9 (95% CI: -0.7 to -1.1)] while in the additional follow-up there was a slightly smaller change [-0.7 (95% CI: -0.3 to -1.1)].

These differences are negative, indicating that **service users had *improvements* and had *lower* raw loneliness scores at end of service compared to the matched ELSA control groups**. For the main analysis, the magnitude of change was the same regardless of the match sample group and the variation in the 95% confidence intervals shows that these were statistically significant differences. The magnitude is slightly smaller in the additional follow up (-0.7) and there is wider variation as change in service users ranges from -0.3 to -1.1 which shows more uncertainty in the outcomes for the additional follow up (a potential problem with smaller samples). Overall however, the similarities in results indicates that the finding is robust.

Including the trigger groups in the analysis did not change the overall outcome in terms of magnitude or variation in the raw scores. We explored whether the trigger groups had an impact on end of service raw UCLA scores and found that only being divorced had a negative impact i.e. lower loneliness scores (we used match group 3 where more of the trigger groups were used for matching to explore this, otherwise any differences could be due to poor matching). The ‘divorced’ group had small numbers, therefore this result may not be generalisable.

We also explored the combination of being in a trigger group along with being a service user compared to not being in a trigger group or a service user using match group 3 (Table 10). As noted in the methods, we can explore all trigger groups (apart from young parents as there are none in ELSA) regardless of whether they have been used in the matching. The results show that **compared to those in ELSA who were not in the trigger groups, service users *benefitted* from the service regardless of whether they were in a trigger group or not**. Those with and without health issues had smaller benefits in terms of changes in raw loneliness scores compared to the other trigger groups. Service users who were divorced had the largest gain, but as noted, this group is small. Although the differences are not statistically significant, ELSA individuals who were in the trigger groups for being divorced or bereaved had an average negative change in raw loneliness scores which may indicate that some in this group will improve without an intervention. This is not unexpected as the impact of getting a divorce or bereavement on loneliness can be expected to reduce naturally with time.

**Table 10: Matched analysis - change in service user raw loneliness scores by trigger group compared to ELSA - group 3**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Health** | **Mobility** | **Divorced** | **Bereaved** | **No children** |
| ELSA in trigger group | 0.2 | 0.0 | -0.3 | -0.2 | 0.3 |
| (95% CI) | (-0.1 to 0.6) | (-0.3 to 0.4) | (-1.9 to 1.3) | (-0.7 to 0.2) | (-0.1 to 0.7) |
| BRC not in trigger group | -0.6\* | -0.9\* | -0.8\* | -0.9\* | -0.8\* |
| (95% CI) | (-1.1 to -0.1) | (-1.2 to -0.6) | (-1.0 to -0.6) | (-1.1 to -0.6) | (-1.1 to -0.6) |
| BRC in trigger group | -0.7\* | -0.8\* | -2.0\* | -0.9\* | -0.7\* |
| (95% CI) | (-1.1 to -0.3) | (-1.1 to -0.4) | (-2.9 to -1.2) | (-1.3 to -0.5) | (-1.0 to -0.3) |

*Note: green – statistically significant reduction in loneliness scores; blue- reduction in loneliness scores, not statistically significant; orange- increase or no change in loneliness score, not statistically significant. \*Statistically significant differences. All groups are compared to ELSA who are not in the trigger group. BRC - British Red Cross Service Users; ELSA - English Longitudinal Study of Ageing*

**Matching results: Changes in loneliness score groups in service users compared to matched ELSA sample**

Table 11 shows the changes in loneliness scores grouped either by improvement, no change or deterioration or based on changes in loneliness the service users and their ELSA matches.

**Improvements, no change and deterioration groups**

When considering changes in loneliness scores in terms of improvement, no change or deterioration, the majority of service users (ranging from 63% to 66 %) who had end of service data had **improved** (Table 11). This increased to 73% and 75% in the additional follow up. In comparison, 40-45% had improvements in UCLA scores for ELSA (46% and 49% additional follow up). This shows that there was a **20% difference between service users and ELSA** that may have been attributable to the Community Connectors programme.

In the service users, a small proportion (3.2 to 5.1%) experienced a **deterioration** (3% in the additional follow-up).

This compared to 17 to 20% for ELSA (15% and 11% in the additional follow-up) indicating **less deterioration in service users compared to ELSA** (Table 11). Finally, around 29% to 32% % of the service users did not report any change in their UCLA scores compared to 36% to 42% in ELSA. Differences were all statistically significant.

**Loneliness groups**

It is important to consider whether change in overall UCLA scores translates into changes in loneliness based on the cut-off scores (3-5 not lonely; 6-9 lonely). The proportion **who were lonely at baseline and who were no longer lonely** at end of service ranged from 29% to 34% for service users compared to 16% to 20% in ELSA, indicating that **using the service was associated with reductions in loneliness when compared to ELSA participants**. On the other hand, **a smaller proportion of service users became lonely compared to ELSA matches** (Table 11).

Across both the service users and ELSA, the largest group were those **who were lonely at baseline and experienced no change** in terms of loneliness at end of service. This ranged from 38% to 42% in the service users (50% in the additional follow up) compared to 51% to 56% in ELSA (60% and 62% for the additional follow-up) (Table 11). Therefore, although the proportion remaining lonely was large in both the service user data and ELSA, the **proportion remaining lonely were smaller for service users compared to ELSA**. Differences were all statistically significant but it should be noted that some cells have very small numbers in them (e.g. those becoming lonely). The proportion who were not lonely at baseline and who experienced no change was similar across the service users and ELSA with some slight difference.

**Table 11: Matching analysis changes in loneliness scores grouped by improvement and loneliness in matched samples**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | |  | | |  | |  | |  | | **Additional data** | | | | |
|  | **Match group 1** | | **Match group 2** | | | **Match group 3** | | **Match group 4** | | **Match group 5** | | **Match group 1** | | | **Match group 2** | |
|  | **BRC** | **ELSA** | **BRC** | **ELSA** | **BRC** | | **ELSA** | **BRC** | **ELSA** | **BRC** | **ELSA** | **BRC** | **ELSA** | **BRC** | | **ELSA** |
| **UCLA Scores** | **%** | **%** | **%** | **%** | **%** | | **%** | **%** | **%** | **%** | **%** | **%** | **%** | **%** | | **%** |
| *N* | *375* | *375* | *352* | *352* | *320* | | *320* | *319* | *319* | *278* | *278* | *102* | *102* | *100* | | *100* |
| Improvement | **66.1** | **45.3** | **63.9** | **43.8** | **63.1** | | 40.0 | **66.1** | **46.1** | **64.4** | **43.9** | **74.5** | **46.1** | **73** | | **49** |
| No change | 29.1 | 37.6 | 31.0 | 36.4 | 31.9 | | **42.2** | 29.8 | 36.7 | 32.4 | 36.0 | 22.6 | 39.2 | 24 | | 40 |
| Deterioration | 4.8 | 17.1 | 5.1 | 19.9 | 5.0 | | 17.8 | 4.1 | 17.2 | 3.2 | 20.1 | 2.9 | 14.7 | 3 | | 11 |
|  |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  |
| **Loneliness** |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  |
| *N* | *375* | *375* | *352* | *352* | *320* | | *320* | *319* | *319* | *278* | *278* | *102* | *102* | *100* | | *100* |
| Became not lonely | 32.0 | 19.5 | 29.3 | 19.0 | 32.2 | | 17.5 | 31.0 | 18.5 | 32.7 | 15.8 | 34.3 | 21.6 | 34 | | 22 |
| No change – not lonely | 24.8 | 23.2 | 26.4 | 22.4 | 27.5 | | 21.9 | 25.7 | 21.3 | 27.3 | 22.3 | 14.7 | 14.7 | 15 | | 16 |
| No change – lonely | **41.3** | **50.9** | **42.3** | **52.3** | **38.4** | | **53.8** | **42.0** | **54.6** | **39.2** | **56.1** | **50.0** | **61.8** | **50** | | **60** |
| Became lonely | 1.9 | 6.4 | 2.0 | 6.3 | 1.9 | | 6.9 | 1.3 | 5.6 | 0.7 | 5.8 | 1.0 | 2.0 | 1 | | 2 |

*Note: largest group in* ***bold***

**Matched results: changes in wellbeing measures (ONS-4) and health from baseline to end of service in service users compared to ELSA (additional follow-up)**

We also explored changes in wellbeing (ONS-4) and the health question which were in both the additional follow up and the ELSA data. Note we did not explore SWEMWBS or the social activity question as these were not available in ELSA. These findings are exploratory as a much smaller sample had the wellbeing measures in the additional sample and matching reduces the sample even further (n=30 service users). We also only matched based on the criteria used for group 1 and 2 due to this small sample size.

**Wellbeing changes**

Mean changes in life satisfaction from baseline to end of service for the service users were positive and larger than their matched ESLA sample and the differences were statistically significant (mean difference ONS satisfied 0.2 (95% CI: 0.1 to 0.2) (n=30)). This indicates that **service users were more satisfied with their lives than their ESLA matches at the end of programme**. Taking into account trigger groups did not make a difference in magnitude or statistical significance.

Mean changes in service users’ perceptions of whether what they did was worthwhile were positive and slightly larger than their matched ELSA sample at end of service and the differences were statistically significant (mean difference ONS worthwhile 0.1 (95% CI: 0.1 to 0.2) group 1and 0.2 (95% CI: 0.1 to 0.3] group 2). **This indicated larger improvements in worthwhile activities for service users compared to the matched ELSA sample**. Taking into account trigger groups only made a difference in group 1 for health issues, which may reflect matching problems as it did not make a difference in group 2 where this was taken into account in the matching.

Mean changes in happiness for the service users from baseline to end of service were positive and slightly larger than their matched ELSA sample but these differences were not statistically significant (mean difference in ONS happy 0.1 (95% CI: -0.0 to 0.2) in group 1 (n=30) and 0.1 (95% CI: -0.0 to 0.1) in group 2 (n=30)). This indicates that service users could have been more or less happy than the matched ELSA sample. Taking into account the trigger groups did not have an impact on the magnitude of difference for ONS happiness but it made the difference between the service users and ELSA statistically significant, when health issues were taken into account for the group 1 match.

There were no differences in changes to how anxious service users felt compared to their matched ELSA controls. (Mean difference ONS anxious 0.0 (95% CI: -0.1 to 0.1) for group 1 (n=29) and 0.0 (95% CI: -0.1 to 0.2) for group 2 (n=29)). This did not change when trigger groups were taken into account. There was some borderline evidence (statistically significance at 10% level) that individuals were more anxious at follow up but this was, in general, rather than due to whether or not they were service users or in ELSA.

**For some aspects of wellbeing, specifically life satisfaction and feeling life is worthwhile, service users had greater improvements, which were statistically significant, compared to the ELSA sample. There were greater improvements for happiness to**, but this was not statistically significant. There were no differences for feeling anxious.

**Comparing loneliness changes to wellbeing changes using effect sizes**

In order to compare the changes to wellbeing with changes to raw loneliness scores, we compared the effect sizes[[7]](#footnote-7) (note that these comparisons use different samples as there are fewer service users with wellbeing measures). When comparing service users to their ELSA matched samples, effect sizes for change were small for (=0.4) and not statistically significant for those who had wellbeing data compared to matched ELSA controls.

Effect sizes ranged from very small and not statistically significant in how anxious service users felt to large (0.8 to 0.9) and statistically significant for how satisfied service users were or whether they did worthwhile activities compared to their matched ELSA controls (Appendix 1). These results suggest that **when change in loneliness scores were compared for those with wellbeing data they did not always improve but some aspects of wellbeing may have improved for service users compared to ELSA**. These results should be interpreted with caution due to the small sample sizes.

**Whether the benefits of the Community Connectors programme were sustained**

**Quantitative follow up work**

This section focuses on exploring whether service users sustain any changes in loneliness during the period after finishing in the Community Connectors service. There is a considerably smaller sample of service users with follow up UCLA data (n=79). Of these, 78 of the service users had baseline UCLAs and 71 had end of service scores which are used to explore changes in loneliness.

The characteristics of the follow-up sample were compared with that of all service users who accessed the Community Connectors programme to explore whether they are reflective of the general population (Appendix 6). This is important in terms of understanding how generalisable the follow up findings are.

Generally, the follow up sample was similar to all service users, for example 68.9% of the follow-up sample was female and amongst all service users it was 64.9%. The main difference was in terms of living arrangements, where 80.6% of the follow up sample lived alone compared to 64% amongst the whole sample. However, living arrangements were not found to have impacted on loneliness outcomes between starting and finishing in the Community Connectors programme so this difference does not limit the generalisability of the findings.

There was considerable variation in the proportion of service users in trigger groups in the follow up sample compared to service users generally (Appendix 7). Service users who had completed follow ups were far more likely to be members of a trigger group than other service users. For example, 45.6% of the follow up sample had mobility issues compared to 22.8% amongst all service users. The only exception was the young parents trigger group where the follow up sample was comparable to all service users. However, as trigger group status did not appear to be related to whether improvements in loneliness were sustained, the difference in sample is not considered to have impacted on the generalisability of the outcomes.

It was also important to explore whether the follow-up sample had similar levels of loneliness for all service users at the start and end of accessing the Community Connectors programme, as this could have implications for how representative the follow up scores may be. When UCLA scores were compared at both baseline and end of service for the two groups, the scores were comparable. In the follow up sample and overall sample, the mean UCLA score at baseline was 7.3. The mean change score amongst the follow up sample was an improvement of 2 points and in the overall sample it was 1.8, meaning that the follow up sample experienced slightly greater improvement. However, this is not to an extent where there appeared a difference.

The follow up sample received ‘more’ service than all service users such as frequency of signposts, journeys and number of contacts. This is understandable as the service users who had received a greater level of support from the Community Connectors programme may feel more attachment to it and thus be more willing to complete the evaluation paperwork. In terms of the service received, a greater proportion of the follow up sample were signposted (n=44, 55.7%) compared to 25% in the overall sample.

In terms of number of contacts, the median number of contacts was 11, compared to 3 contacts amongst the general sample. It was found that the number of contacts and signposting was not related to changes in loneliness between the start and end of service so having this difference may not be an issue.

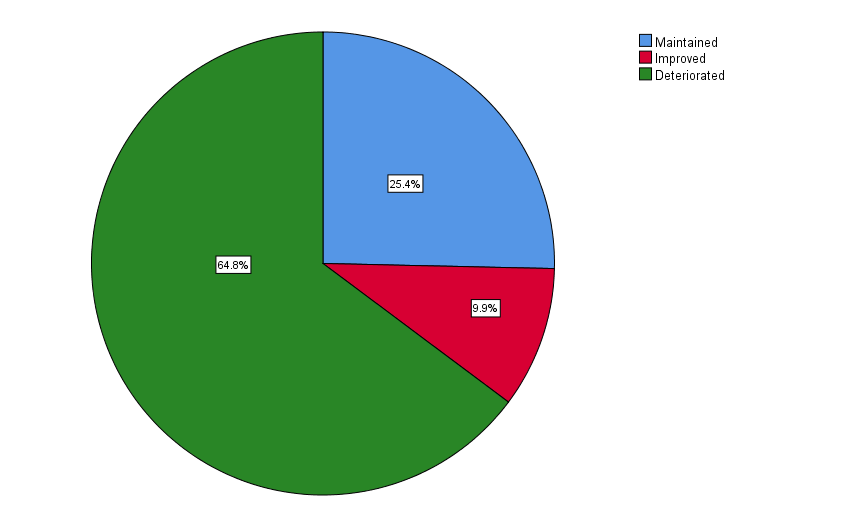
**Levels of loneliness in the period after finishing in the Community Connectors service**

Of the 71 service users who had both end of service and follow up data, the mean change in their UCLA score was a deterioration of 1.6 points (95% CI: .65-1.7). **This meant that service users became lonelier in the period between finishing in the community connectors programme and completing the follow up UCLA.**

Not everyone had an end of service UCLA score, so the follow up sample as a whole (n=79) was analysed to understand how as a group, their loneliness changed between finishing in the programme and the follow up period. The average end UCLA score was 5.2 but the average follow up score was 6.8. **This is a deterioration of 1.6 points on the UCLA, indicating that people’s loneliness got worse during the period after they finished in the programme. This change also meant that as a population, between finishing in the service and the follow up period, service users became classed as ‘lonely’ based on the UCLA threshold.**

On an individual basis, 46 of the 71 service users (64.8%) had a deterioration in their UCLA score, 18 (25.4%) maintained their UCLA score and 7 (9.9%) had an improved score (Figure 9).

**Figure 9: How service users’ UCLAs changed between finishing in the service and follow-up**

*****Sample size: n=71. Deteriorated: n=46, maintained: n=18, improved: n=7*

The percentage of service users feeling lonely at the follow up period was 83.5% (n=66 of 79), this was considerably more than the proportion of service users who felt lonely when they finished in the programme (45%, n=32 of 71). Amongst individual service users, over a third moved from not feeling lonely to feeling lonely during the follow up period (n=28, 39.4%). **This indicates that a notable proportion of services users crossed the loneliness threshold and became lonely in the period after attending the Community Connectors programme.**

**Change in loneliness between baseline and follow up**

The change in service user’s loneliness between starting in the programme and the follow up period was explored to understand the impact of the programme generally (n=78). In terms of individual change, there appeared a slight improvement, with loneliness scores decreasing by .4 points (95% CI: -.75- .04). However, as the confidence interval went over 0, it indicates that in reality there was not a change in the population mean. **This means that as a population, there was not any change in service users’ loneliness between starting in the programme and the follow up period. However, this also means that there was no deterioration in loneliness either, which is still a positive impact as an aim of the Community Connectors programme is to prevent service users from becoming more lonely.**

It was unnecessary to calculate the level of change in terms of the overall population (as was performed between the end and follow up period) because there was only one service user who had a baseline and not a follow up score.

On an individual service user basis, almost half of service users did feel less lonely at the point of follow up than before they received the Community Connector programme (n=33, 42.3%) (Figure 10). A third of service users also managed to maintain their level of loneliness in this period (n=27, 34.6%). However, almost a quarter of service users did become more lonely in this time (n=18, 23.1%).

In terms of the service users who were lonely at baseline (n=64), the majority were still lonely at the follow up period (n=59, 92.1%) **indicating that at follow up, the population of service users would still be considered lonely.**

Whilst there was a substantial number of service users (64.8%) who became lonelier between finishing in the programme and the follow up period, this number is much lower when the change between baseline and follow up is considered (23.1% became lonelier) (Figure 10).**So as a population, service users’ loneliness improved when they received the Community Connectors programme but some service users experienced some worsening of their loneliness in the period after they finished in the programme**. We sought to compare this with other studies to identify if this is a recurring pattern in loneliness interventions. However, it transpires that this is difficult to explore because most evaluations only include a start and end or follow up measure so there is not the three time points to track progress. The interventions with three time points have generally been psychological therapeutic interventions aimed at older people (Gardiner, Geldenhuys, & Gott, M., 2018) and are not comparable to the Community Connectors programme. Of the social prescribing services which have reported more than one time point, such as Grant et al (2000), this loss of benefit did not appear to occur. However, arguably this is because the service users only received a small number of sessions, so by the time of their follow up at 1 month it may have been some time since they had completed their support, so had already experienced some deterioration. This is particularly relevant because Grant et al (2000), reports much smaller levels of improvement than has been identified in the Community Connectors programme. **Therefore, having the three time points within the Community Connectors programme has been innovative for these types of interventions in demonstrating that service users may experience quite a large level of improvement while receiving support, but there are issues with sustaining this improvement, for some service users, once they finish in the programme.**

**Figure 10: Comparison of changes in loneliness between the start and end of the programme with the follow up period**

**Exploration of variables that may contribute to whether people maintain their loneliness in the follow up period**

It was important to explore whether there were any variables which may be related to why some, but not all, service users’ loneliness got worse in the period after finishing in the Community Connectors programme. To undertake this analysis, a dichotomous variable of deterioration or not was created. Anyone who became lonelier between finishing in the programme and the follow up period was classed as deteriorated and service users whose loneliness stayed the same or improved were categorised together. It is important to note that the findings may be affected by the fairly small sample size (n=71). However, this exploratory analysis does provide some useful initial findings.

**Most variables did not appear to have any relationship with whether service users deteriorated or did not between finishing in the service and the follow-up period (Table 12).**

**Table 12: Significance of variables in relation to follow up**

|  |  |  |
| --- | --- | --- |
|  | Variable | Whether there was a statistically significant difference in whether service users experienced deterioration or not (*p* value) |
| Demographics | Gender | No difference (.351) |
|  | Ethnicity - White British or other | No difference (.696) |
|  | Age | No difference (.416) |
|  | Age - over 60 or under 60 years old | No difference (.582) |
|  | Living arrangements - living alone or not | No difference (.773) |
|  |  |  |
| Trigger groups | Experiencing health issues | No difference (.760) |
|  | With mobility limitations | No difference (.712) |
|  | Living without children at home/recently retired | No difference (.378) |
|  | Young parents | No difference (.352) |
|  | Recently bereaved | No difference (.733) |
|  | Recently divorced/separated | No difference (.414) |
|  | People with no trigger group recorded | No difference (609) |
|  |  |  |
| UCLA Score | Baseline - lonely or not | No difference (.361) |
|  | End - lonely or not | If a service user is not lonely at the end of the programme they were more likely to experience deterioration (.018) |
|  |  |  |
| Service received | Whether the service user was signposted | No difference (.387) |
|  | Whether the service user received support with journeys | No difference (.646) |
|  | Whether the service user received support from volunteers | If a service user received support from a volunteer they were more likely to experience deterioration (.029) |
|  | Whether appointments only took place in the home | No difference (.723) |
|  | More than 8 contacts | No difference (.157) |
|  |  |  |

*Footnote: Chi Squares were undertaken to explore associations. However, when the sample was smaller a Fisher’s Exact Test was performed instead. For continuous variables such as age, T-Tests rather than Chi Squares were performed*

**As can be seen from Table 12, there did not appear to be any difference between demographics or between trigger groups in regards to whether people experienced deterioration or not in the follow up period**. Service users classed as not lonely when finishing their support were more likely to experience deterioration at the follow up period *(p*=.018). However, this finding should be treated with caution as it may be because these service users had greater scope to deteriorate than service users who felt lonely (regression to the mean).

**There appeared little difference in follow up outcome based on the service people received, although having support from a volunteer was relevant. It appeared that if a service user received support from a volunteer then they were more likely to experience deterioration in the follow up period (*p*=.029).** This finding is problematic given the basis of the service specification is for service users to receive support from volunteers. However, it must be noted that this may be because of the relatively small sample size. If this does hold true, one explanation could be because a service user has received greater support or formed a bond with a volunteer and they miss that in the period after finishing in the service, as was reported in the qualitative interviews. This issue may need further reflection because of the core role volunteers play in the delivery of the Community Connectors programme such as how to manage endings.

A small number of service users completed the SWEMWBS in the follow up period (n= 34). As a population, the mean follow-up score was 20.9. Whilst this was a decrease from the end of service score (22.3), it was still higher than the average baseline score of 18.9. **Thus some improvement in wellbeing is sustained in the period after attending the Community Connectors programme.** Individual levels of change and further subgroup analysis of this was not feasible because of the small sample size.

**Impact and sustainability: qualitative findings**

We followed up service users 3 months after we had initially spoken with them to explore the longer term impacts of the Community Connector service. Within these interviews, several themes arose which helped to explain the quantitative data that showed improvements in loneliness were not always sustained.

11 out of the 12 service users we conducted follow up interviews with reflected positively on their time with the Community Connectors service, speaking highly of the Community Connector who had supported them. Approximately half of these service users were continuing with the activities that they had been introduced to during the Community Connectors service. These included; fitness activities, craft clubs, lunch clubs and volunteer roles. One of the service users (SU20) who described how they had been in a “*very bad mental state*” at the start of the programme continued to be speak very positively about their experience, directly attributing improved mood to the support of the programme. During support this participant was taken on shopping trips, on long walks and to coffee shops to build up confidence. Three months after the end of support they continued to take part in these activities alone, had started *“mingling with people*”, and felt happier than they did before the programme. They no longer needed any support and credit the BRC Community Connector programme with their progress:

*Interviewer: “So you wouldn’t have been able to do these things that you are doing now, without the help of the British Red Cross. Is that that what you’re saying?”*

*“I wouldn’t have. Certainly not. It was at that critical time in my life, you know.”* (SU20)

Another participant (SU16), who received assistance with their housing benefit and discussed their desire to be referred to further services at their initial interview, was still waiting to engage with further support.

Despite finishing the programme 3 months previously they were still receiving phone calls and ad hoc support from their Community Connector. The Community Connector had been in touch with various external agencies including DWP for support with the participant’s mobility issues but the agencies have been “*slow*” to get in touch. Although this had been difficult they remained positive about the support they had received and their relationship with their Community Connector. They were hopeful that they would receive the further support as required in the future:

*“Well there has been progress. It is a bit slow because [name of community connector] has like been in touch with you know different agencies. But it’s not [name of community connector’s] fault. It’s the agencies that you put me in touch with, it’s about them you know escalating stuff but things are a bit slow at the moment… But now things are happening but it’s you know I know there’s other people in the system need help you know, some more than others. So it does take time. So yeah. I am just patiently waiting for some good news.”* (SU16)

However, interviewees faced a number of constraints to sustaining impact, including the health of the service user, whether they have been successfully signposted, their willingness to continue progress post intervention, and the availability of transport. The length of the intervention was also an issue when service users had not been successfully signposted (appropriate activities had not been sourced and/or the service user had been unable to attend them).

An overarching theme impacting all of these is the complex and multifaceted nature of chronic loneliness which often requires longer term, intensive support. Some Connectors felt that this was not possible to do within a 12-week period, particularly for immobile individuals who had not been connected to activities in their communities:

*“You know, it’s a good service, I’m not knocking it as a community service. You know, it serves a purpose for lots of people, this kind of short-term intervention. But, the resounding thing that comes out of it is, unless you do manage to in that 12 weeks, build somebody’s confidence sufficiently, get them connected to a group that they happen to really enjoy and like…which in so many cases, is just not possible…by the end they just want you to keep coming to like provide company and have that chat that you’re having with them week in and week out. We can’t do that because that’s not what this service is about.”* (CC3FU)

*“…for people who have been so lonely and isolated for many years, for them it is major work trying to go out there and socialise. And this is why this service, I think, it is a good service. I believe in the value of what I’m doing. I believe that. However, I think that the service will not really meet the problem of loneliness as such and so, the problem will still be there. Yes, we can reduce it for some but not for everybody.”* (CC5FU)

Community Connectors did believe successful signposting was a key feature of sustaining improvements in service users:

“*She’s a lady who was hoarding in her home. She’s doing really well because she put on loads of extra weight. And she’s been going to the gym and you know she’s been keeping really happy, socially. Because her house was in an awful state and because we put provisions in place, we managed to get social services to get in a company which deal with people who you know have got access when they need a lot of stuff that needs clearing. We managed to get the service in and clean her house out for her. And then going forward she’s doing brilliantly. Still going to the gym, losing more weight.”* (CCFU17)

For example, one young participant (SU19) suffering with anxiety discussed feeling “*more lonely”* 3 months after the Community Connectors service than they did at the beginning of the programme. They were positive about the support that they had received and discussed feeling more confident at the time of their first interview. However, although they were positive they did wish for the support to continue after the 12 weeks so they could carry on building their confidence:

*“I think if it was a bit longer but maybe not every week. Maybe like once a month or something.”* (SU19)

They also discussed missing the company of their Community Connector:

*“I was sad [when it ended] because I really liked her*.” (SU19)

Due to their rural location they had struggled to locate appropriate activities they could attend after work. 3 months on they had still not attended any activities and were still struggling to meet new people. They no longer feel as confident as they did at the start of the programme. Although they noticed a “*big difference*” in their mood whilst being supported, this change in mood was only temporary:

“*It did [help] temporarily… (Pause) It wasn’t a long-lasting thing.”* (SU19)

…and began to deteriorate soon after the programme had finished:

*“When I was seeing the Community Connector I felt more confident and like reassured in a way. I’m not sure what the right word is…Sort of motivated to do things. Afterwards I felt like less sure of myself…. I noticed my mood, what’s the word, deteriorating?”* (SU19)

Similarly, SU24 had enjoyed the company of their Community Connector, but had not been successfully signposted into any activity. As a result, once the Community Connector visits ended, they were still feeling socially isolated and lonely and missed the contact of their Community Connector.

For both of these service users it seems that the lack of suitable activities and agencies for onward referral, in part due to their rural locations, presents a potential barrier for long term impact. Furthermore, it would seem that they came to rely on the regular contact that they had with their Community Connectors and perhaps this raises questions about their suitability for the programme. A further participant (SU12) described being sad when the support had finished and it feeling like “*losing a friend”.* Despite wanting to be referred to a befriending service at the end of the programme, they were still seeking this support 3 months on. Although they enjoyed their time with the Community Connector programme unfortunately they did not feel that this had a lasting impact, attributing this to a lack of finances and time:

*“I think they were very good but unfortunately they obviously don’t have the finance or the time to extend it further you know. They (Pause) a bit like the doctor gives you a box of thirty tablets, says take these and you’ll be alright you know. But that was when you finished the box isn’t it?”* (SU12)

One young parent who was seeking support with their mental health, employment/skills and home relocation continued to be unsatisfied with the support they had received 3 months’ post programme. Despite being happy with the social support from their volunteer, they felt that little progress had been made towards achieving their goals:

*“I was talking with them, you know, because it was nice to talk with somebody that was asking me how I was and to help me understand where I need to go, how to go about my issues, really. And, how to overcome the issues and actually getting the support in getting things done wasn’t there, you see. So, I’m happy with it to a point, but then I was obviously let down by the fact that I wasn’t given any support in getting anything done, you know.”* (SU30)

However, as the type of support this service user was hoping to receive was related to their health and practical skills, and not related to social groups, their appropriateness for the programme could be questioned:

*“If I remember, I think they suggested… Somebody suggested for me to take part in a group of some sort. But, there is nothing. For me, to be honest, I’m not the kind of person anyway, that can just go to a group and make friends. That’s just not me.”* (SU30)

Despite emerging as an important factor for success in the qualitative interviews, signposting was not found to be related to whether improvements were sustained in the quantitative work. But this may be because the quantitative data recorded signposts made, rather than take up or engagement in signposts with the organisations/support they were signposted to.

Despite the aim to support service users to engage in other activities, 6 out of 12 service users discussed how it was not possible to continue attending them once they finished in the Community Connector programme. This was often due to ill health/transport & mobility issues such as two elderly participants who were unable to continue their activities due to periods of time in hospital. Transportation issues - no access to public transport or expensive public transport – was a key factor in the longer term success of the intervention. Difficulties here were particularly evident if the Community Connector/volunteer had been the person who had transported the service user to activities and outings. Whilst this is beneficial in the short term, in the long term it is unsustainable and may result in service users feeling worse than they previously did. This result is significant given the largest trigger group being supported by the service is individuals with health issues (n=2511, 43.4%), and the second largest group is individuals with mobility issues (n=1319, 22.8%). It is clear that sourcing sustainable transport is key for these individuals.

*“But anyhow, as I say the problem is transport, really, is my problem. But that’s the only way that you meet people.”* (SU8)

*“And then the expense as well because I’ve had to get rid of my car and now I’m having to use taxis.”* (SU3)

*“I won’t be able to afford to keep paying for cabs you know?”* (SU22)

Service User 24 identified transport as one of the key reasons as to why her time with the Community Connectors service was not a lasting success:

*“…living in [a rural location] there isn’t and you see, I don’t drive, so it makes it so much harder. I mean she [the Community Connector] was limited to where she could take me, because if she wasn’t with me, I’d have to walk or get the bus or something…”* (SU24)

For Service User 22, a local volunteer driver had been arranged through their Community Connector. This meant that they could continue to attend activities two days a week. However, in contrast SU8 had no transport following completion of the Community Connectors service and had since not been able to continue with their chosen activity.

This suggests that Community Connectors and volunteers need to consider sustainability issues when they look for suggested activities, or it may raise questions about the suitability of the referrals if they do not have the means to be able to get to community groups/clubs/activities on their own accord once they are introduced to them by their Community Connector.

It also appeared that longer term impact requires innovative strategies and sustained effort from the Community Connector. For example, one Community Connector set up interest groups for their service users, such as a walking and fishing club, which have become self-sustaining post programme (see service model case studies).

# Section 6 – Experiences of service users, staff and volunteers involved in delivery (qualitative findings)

In this section we draw on qualitative findings from interviews with the service users, volunteers and Community Connectors to explore aspects of service delivery that might be considered as good practice and also aspects that have presented as challenges with a view to inform service development.

**Person centred approach**

All of the Community Connectors that we spoke with felt that there was a real need for the programme, could identify cases where they felt that they had made an impact and saw the future potential of the programme. Specifically, the person centred approach was seen as being a key unique selling point of the programme:

*“…I think putting the onus onto people and saying, well you know, this is about you. Support is for you. It’s what you want to achieve from it. It’s probably a brilliant refreshing concept, but I think it’s quite new to the members of the public.”* (CC10)

The importance of a person centred approach was also reflected in the interviews with service users. With the exception of two service users, all spoke extremely positively about the relationship that they had with either their Community Connector or volunteer. Positive attributes included being empathetic, having the time to dedicate to the service user, not making assumptions about people’s requirements and ensuring that the service was personalised and tailored to individual needs. For example, one service user commented:

“…*she actually listened to what I wanted personally. Rather than; these are the baby groups you can do. These are for children and these are for mums. It was more; what do you want to do? What do you want to get out of things? And then she came back with loads of stuff. Absolutely tons of stuff.”* (SU5)

For many service users, the relationship that they had forged with their Community Connector or volunteer had been a highlight of the service for them:

*“Well the best part of the programme was being with her because she’s lovely and it was nice to go for a coffee with her.”* (SU24)

*“I couldn’t expect anyone better to help me get back to the real world after 15 years of being depressed after a marriage breakdown...When she found out about my background, she said she would come and see me at home. And she was really very calm and really wanted to know how she can help me. And I think anyone who works for the Red Cross, I’ve found they are very interactive. But she went extra miles visiting me at home and sitting with me, making a plan how we could go forward.”* (SU23)

However, for the two service users who reported not having had a good relationship with their Community Connector/volunteer, the primary reason appeared to be a lack of empathy on the part of the Community Connector/volunteer towards the service user’s individual circumstances, thus not taking a person centred approach:

*“…I found her very pushy so that on the days that I didn’t want to actually meet up, because my mood was just really lousy, she would be quite forceful in saying, come on, you’ll be okay, once you get here you’ll be fine.*

*But I think some of the things I will actually flag up, I hope it’s taken in a constructive way, is that to be mindful and to be sensitive about the people that you’re dealing with. Because people are not always on top form and if they are actually saying to you that they don’t feel up to it you need to actually leave them actually just be and then they’ll contact you when they’re ready.”* (SU32)

**Variation in service delivery**

It is clear that there are variations in the ways that the aims and remit of the programme have been interpreted and delivered by Community Connectors across the United Kingdom.

For some it was clear cut:

*“… the aim of the service is for you to connect people to things in their community. And then it’s their responsibility to take up those offers. I mean you can’t hold their hand through the whole process.”* (CC2)

Whilst for others there were inconsistencies. This was particularly the case in the acceptance and handling of inappropriate referrals, the length of the intervention and the recording of activities with service users due to the difficulty of systems (particularly the recording of appointments):

*“It is being done very differently. I know that when I did a training when I met other Connectors in [the region], we’d all been sort of told different things about what we could do and couldn’t do. It was quite shocking actually. Oh my god, we’re not you know, all singing from the same hymn sheet at all*.” (CC4)

Community Connectors discussed spending extensive periods of time making links with local organisations. Many of them were well positioned to do this due to their previous working roles (for example, third sector work, community policing) and it seems that those Community Connectors who have been particularly successful have taken pragmatic approaches to actively engage with the community (see separate service models). The Community Connectors spoke of the importance of considering the long term practicality and sustainably of activities that they were referring service users into. Service user mobility and the local transport infrastructure figured highly in these considerations.

Alongside traditional activities approximately four of the Community Connectors we spoke with gave examples of innovative activities which aimed to bring together their service users. Examples included a café group and a choir for young service users which was also used to boost recruitment. One particularly successful service has created groups for their service users developed around their common interests. These groups have now become self-sustaining with the support of the Community Connector, service users and pockets of funding from local organisations (see separate service models).

A small number of Community Connectors had also assisted service users with benefit claims and housing forms, appearing to go above and beyond the traditional remit of the role. However, it was clear that for these service users, administrative tasks took priority over specific social activities and the service users were not able to move onto activities associated with addressing their social isolation until they had addressed pressing administrative concerns.

The length of intervention varied across the different areas, with most Community Connectors attempting to adhere to the 12-week period. Others provided support post 12 weeks on an ad hoc basis, whilst others continued to provide longer term support over a number of months. Some Connectors commented that the complicated nature of isolation and loneliness often requires longer term support, suggesting that the length of intervention be flexible according to the service user’s needs. The length of intervention is often influenced by unforeseeable circumstances, such as a service user who was doing “*really well”* before suffering a bereavement at 11 weeks which meant she required ongoing telephone support. Support length is also influenced by volunteer/Community Connector capacity, with two areas providing 12 “sessions” rather than weeks due to volunteers not wanting to commit to consecutive weeks of support. Due to workload and administrative duties it was not always possible for connectors to visit clients weekly.

*“Yes it’s working out what, matter of fact, that you can do. Every case is individual, every case is different and if you try to go in with a one fit fits all, it just doesn’t work. And I’ve had a discussion over the time limits before and I’ve said, look I can spend 12 weeks with somebody, like I am supposed to, and they can just be on the cusp of making a change. Do I walk away and then watch them grow back over?”* (CC15)

*“So, there’s loads of new studies and things that are being done all the time about loneliness but I read something that my manager gave me that said that really approaches need to be on a longer scale moving forward. Really, we need to start looking at maybe it’s going to be for a longer, a period of time…. And so you know, putting that person at the centre, again. Not trying to find a programme that’s going to fit everybody but you know, looking at what’s helpful to that person. And I really agree with that, because I think loneliness is so complex and because you’ve got the influences of what it can do to your physical and your mental health. I don’t really think that 12 weeks is long enough for some people.”* (CC7)

Although it was acknowledged that the service provided longer support than similar programmes, some Connectors felt that the length of intervention did not “*recognise the complexities chronic loneliness brings”.* This was particularly the case for those service users who had not successfully been connected into their community (e.g. due to mobility limitations/health issues) and had not been signposted to further provision. One volunteer felt that 12 weeks was not sufficient to have an impact on isolation and loneliness and could potentially do “more harm than good”. For this volunteer the length of support provided enough time to get to know a client and assess their needs before you “dump them straight on the ground, so they are back to square one again”. The length of the intervention is also constrained by the availability of the volunteer, holidays and other commitments. It was suggested that the length of intervention should be flexible depending on the client’s goals and needs, and that there should be scope to increase support if required:

*“The programme, it only runs for twelve weeks…. You just nicely make contact with somebody. Find out their needs and then you just dump them straight on the ground, so they are back to square one again. You achieve nothing by it (Pause) in truthfulness.” (V4)*

Two Community Connectors suggested that adding a befriending element to the service could help tackle this unmet need, although the resource implications of this were acknowledged:

*“Although I know it would open a whole new can of worms in terms of the resources that we would need to feed in to the service, because if we were offering a longer-term service then obviously we wouldn’t have such a high turnover of cases on a regular basis, if that makes sense. So, we would definitely need to be more resource heavy. But I feel like it would be putting the service users first by being able to provide that slightly longer-term support for people where there is a gap in befriending services lately.”* (CC3)

However, a small number of Connectors felt that the length of intervention was appropriate, particularly in order to avoid attachment from service users which some Connectors suggested would be emotionally difficult for them.

Yet, one volunteer discussed how the length of intervention can sometimes be problematic as “you do get attached to people” – describing how an elderly lady had cried at the end of her 12 weeks which they had found “very sad”. Strongly related to this, it was suggested more official guidance on managing exit strategies would be useful:

*“I think the hardest thing is the separation at the end of twelve weeks.”* (CC1)

“*At the very beginning we were taking service users up to eleven to twelve weeks I will be honest… And what I noticed was the relationship was getting a bit too close for comfort. In terms of it becomes kind of an attachment then you know. Service users want to cling on… But I find now what we’ve done is we are kind of quite strict on how we go in.”* (CC18)

Other volunteers discussed the challenge of becoming attached or “drawn in” with certain clients, meaning they provided a service that is “over and above” what is expected. One volunteer discussed how they had visited one of their elderly clients every day in hospital whilst they were unwell and upset. They then visited them in their home, staying with them for long periods of time, making their bed as well as making their lunch and dinner on one occasion. The volunteer and their Community Connector were aware this is beyond the remit of the service but the volunteer felt obliged to provide this support whilst the client was feeling particularly vulnerable, stating that *“you can’t treat everything like a business… there is a human element to it”.*

This difficulty concerning the ending of support through the programme was also raised by some of the service users that we spoke to:

*“I felt grateful that I’d had it. I was sad that it was ending.”* (SU19)

*“…I miss her. I wish she could keep doing it.”* (SU24)

*“I mean it’s quite sad saying goodbye to her. Really weird.”* (SU29)

However, it was clear that some service users kept in touch with their volunteer/Community Connector, albeit sporadically:

*“She said she would keep in touch with me...”* (SU8)

*“If anything, I am not sure about anything and I feel you know stress about anything and I’m not sure. If I give him a call, he will find out for me and get back to me.  You know find out from wherever he can and then get back to me and see if he can get it sorted.  So yeah it’s not regular like before.”* (SU16)

This raises questions for the programme about how to build the independence of service users during the programme and the potential capacity of the programme to provide a ‘back-up’ service for service users should they re-enter further difficult periods in their lives.

**Telephone versus face to face support**

The way in which Community Connectors use telephone and face to face support varies across the service. Most Community Connectors use the telephone for the initial contact with service users, to follow up on the initial referral, information sharing or checking progress at key milestones rather than for providing formal support sessions. The first face to face meeting would then usually take place in the service user’s home (unless there were issues with safety) before gradually encouraging them to leave the house over a number of weeks. A small number of Community Connectors offer telephone support as a replacement for face to face support (although face to face is usually preferred).

When formalised telephone support is used (e.g. blocking out an hour’s appointment for a phone call) this is usually for clients who suffer with physical or mental health problems (such as anxiety), mobility issues, or are *“embarrassed”* by their living situation:

*“I’ve noticed a few different things, I suppose. I’d say where a person’s dignity has been affected a little bit by their health conditions. So, if they’re incontinent for example, they might be a bit more embarrassed about having people round at their home.*” (CC7)

*“I could have two service users that I speak to on a weekly basis via telephone… say somebody would like our help to get somewhere but can’t because of mobility issues or because they’ve spent time in a hospital. Or because of anxiety as well you know which is stopping them getting out of the house.*” (CC14)

Despite the remit of the service being based around connecting people back into their communities, many Community Connectors stated that service users still wished for longer term support in the home. One Connector discussed how the willingness of clients to leave the house is affected by their level of loneliness and whether this could be classed as chronic or has recently developed. Encouraging those who suffer with long term, chronic loneliness, where the reasons are complex and multifaceted, can be resource intensive:

“*I think again it’s because it’s such a complex issue, loneliness and isolation. Because it can bring a barrage of other things, like anxiety, depression, so many things it can impact. And I think for a person it’s not just as easy as getting Mrs Smith to a bus to a group, and then she’ll meet you know, Mrs Jones and they’ll get on fantastically well. I think when you’re bringing anxiety in, I mean anxiety itself, people will try to avoid it. You know, avoid their feelings, avoid the panic feelings and the sweaty palms and things like that…. And when you think about it, as much as a person doesn’t like their circumstances and doesn’t like feeling alone and isolated, it’s what they know, and what’s safe in a way. So, taking the time to build and go to a group session, people can take a long, long time…. Because if [loneliness] is more chronic, it’s a lot harder to get them out the door. For want of a better phrase.”* (CC7)

**Referrals**

Most Community Connectors felt that the referral routes into their service had broadened since the beginning of the service, although continued effort is required to sustain referral pathways, which again links back to the pragmatism of the Connector to establish and maintain links. Referrals tended to come from health and social care, with GPs, mental health services, social services and support workers being the primary referrers. Referrals also came from occupational therapists, health and wellbeing coordinators, physiotherapists, community nurses, local councils, family support groups and other Red Cross programmes. Some areas had high levels of self-referrals which tended to present as more complex cases, requiring a greater consideration of risk:

*“I find if it’s a self-referral the risk assessment needs to be a bit more…. As opposed to someone coming along and that’s been supported by say a health professional or someone in [this area]. And, they’ve known the history and things like that. So, with self-referrals I tend to try and meet them in the community rather than in their house...Because there’s a lone working risk.”* (CC18)

Some Connectors discussed the potential for service users to be re-referred into the service following an original period of time in the service. It was apparent that more guidance on re-referrals would be beneficial.

**Inappropriate referrals and complex cases**

Complex cases were often discussed by Community Connectors and volunteers, however, definitions of ‘complex case’ varied, as did perceptions on how complex cases should be dealt with:

*“I’d say a complex case again is where there’s influences and multiple issues, multiple preventing needs. You know, that maybe the loneliness has starting as one thing and has morphed into another and another. And you know, I think especially when mental health issue start becoming a part of it… they’ve got multiple barriers, they’ve got multiple influences that are impacting their lives. And also, their world is so shrunken by all those things. You know, it almost becomes like a little room, you know.”* (CC7FU)

Some Community Connectors felt that a number of inappropriate referrals led to a small number of service users being too “complex” for the programme. In most cases this was due to severe mental health issues and/or physical limitations, which had an impact on service delivery:

*“…I did highlight that, actually, although mental health isn’t something that comes under one of our target areas, and we are not mental health specialists and we’re not to take on mental health, you know where one in three people suffer from mental health it is a bit of a statement to kind of say we don’t support people with mental health because we’re Red Cross and we support anyone in crisis…and actually I would also probably say that loneliness actually is a mental health illness in itself.”* (CC9)

Despite reiterating the service remit to referral providers, a number of connectors felt that referrals from mental health services, social services and self-referrals were sometimes inappropriate or too complex:

*“Well I just think to myself that social services are sometimes a bit naughty…. We want to help as much as we can you know. And even if it means just sorting out a wheelchair for someone. And if it helps social services and if we have the capacity we will do but then they would have to go back into that anyway because there is only so much we can do… despite me constantly going back to them saying this is what we do, this is what we don’t do. You know they still keep asking the same questions. They still sometimes send inappropriate referrals.”* (CC4FU)

However, some Community Connectors felt it was their duty of care to accept complex cases into the programme, although signposting onto further provision (such as mental health services) was common. Others did not accept complex cases and stuck more rigidly to the trigger groups. It was clear that more official guidance on the levels of need acceptable for referral as well as the handling of these cases would be beneficial. Further mental health training and networking opportunities between the BRC and other services may also be useful in order to better understand each services remit:

*“…on the one hand I think, you know, I’ve had a few referrals which are inappropriate but then, on the other hand, I think to myself these people are socially isolated, you know.”* (CC6)

One Community Connector discussed how they had seen an increase in referrals from individuals with multiple complex needs such as learning difficulties or autism who had been “failed” by statutory services. Due to the challenging nature of these cases they are usually signposted back into statutory services in order to locate longer term support:

*“…a bigger problem that I’m struggling with recently is because we’ve had more complex cases with people with more complex needs, and by this, I mean people who have learning difficulties, people like those who are on the autism spectrum, so what they really need is a long-term support worker who would also be their advocate…Even if the person had the money to pay, there’s sometimes not any available services to support those with that very high level of need – not high enough where they would be put into a setting like residential home setting… for me, it’s personally difficult dealing with these cases in terms of, like, these people are really vulnerable.*” (CC5FU)

**Signposting**

The availability of local resources for onward referral varies across the different areas. Some areas have a number of established services, whilst rural areas have less resources. Most Connectors will signpost onto further provision if they feel this is appropriate, although this is not always possible due to the high turnover of services:

*“So yeah, we kind of signpost if it’s appropriate. Sometimes it’s difficult to signpost because services aren’t available. At the time when you find a service, it’s available to signpost. When you make contact with that service, ready to signpost, it’s not there.”* (CCFU17)

A common issue shared by Connectors is the lack of services available for younger service users compared to older service users. An exception to this was for individuals who suffer with health issues and mobility limitations who tend to require a longer term befriending service. Many Community Connectors discussed the lack of befriending services or high waiting lists in their areas. The demand for these services post intervention, compared to their availability, is high, particularly for house bound individuals:

*“In fact, yeah I mean a lot of them want a longer term befriending service. And we’ve got quite a good network in [name of area]. Could do with more but I guess that’s just the way that you know councils run and funding goes. But yeah I mean a lot of people I’ve been referring are signposting is to longer-term befriending services.*” (CCFU16)

*“It’s for people who have been on their own for a very long time. And the twelve weeks just doesn’t cut it for them or it’s not enough and they just want a bit more, like I said they want someone to come in on a regular basis, rather than just coming in for that short period. So yes, signposting for them is actually what it says on the tin…It’s formal befriending for longer term.”* (CCFU17)

*“And, there isn’t enough of it [in this area]. There’s loads for older adults and even that, it’s post code based. So, when I go to, for example, an older adult in [this area] who wants befriending and I call the organisation up I have to tell the post code. And, it’s hit and miss if they can do it or not…. And, depending on age if they don’t fall within the right catchment age there really isn’t a support for them. So, then we’re left wanting. They’re not ready to go to classes. So, what can we do?”* (CCFU18)

In some cases, referrals from other BRC programmes (such as the resettlement following hospital discharge) result in signposting back into this provision. This is because some individuals spend a period of time in hospital during the support of the Community Connectors. Signposting back into statutory services also occasionally occurs, particularly in the case of service users with complex needs (notably extreme mental health issues). Views on this signposting loop were mixed, some connectors felt this was inevitable whilst it made others “*sad*”:

*“We’ve come across a few of them recently which I’m not happy about. Kind of you know their workload has been so heavy and you know signposted, they’ve referred over a service user who is still struggling with their home environment. Or you know they need help in terms of panic buttons or proper equipment going in.*

*And social services have just referred over to us, thinking that we can help, but they need to be, and I can’t make a phone call to them or send an email across and say you know at the moment they still need input from yourselves…. Then please do refer back over to us.”* (CCFU17)

**Volunteer role and remit**

When we interviewed the volunteers, the programme was in the early stages of development and thus unsurprisingly many of the volunteers described their job role as “evolving” and “developing”. Most acknowledged that their role within the scheme was in its early stages and “needs time to develop”. For some the job role was not initially clear but most felt that their role involved understanding people’s needs, establishing appropriate activities, connecting people back into their communities by encouraging them to have a social life, reducing dependence and building confidence. Two Volunteers described their role as “providing companionship”, or “a bit of befriending” in the short term, alongside encouraging clients to attend activities.

Volunteers’ views on their workload within the role were mixed. One volunteer who had been without a service user for over 2 weeks at the time of interview did not feel “inundated with work” and questioned whether the service was receiving enough referrals. Another volunteer felt that the service would get more out of volunteers if they were able to, but was adamant that volunteering needed to fit around family life given the unpaid nature of the role:

*“I mean it’s like most organisations, they would try and squeeze you till the pips hurt. So you have to be careful. I find it like that… not pressure so much but I am sure that you know if they thought they could get more out of me, they would. But I mean, I’m married and I’m retired. I’ve done my working life so my time’s my own. That’s the way I look at it… And it’s a voluntary role so I do the best I can but in my time.” (V3)*

A couple of experienced volunteers felt that their experience had not been utilised appropriately within the programme and that they could have contributed much more to the service user experience and the development of the overall service. One volunteer offered their training and managerial experience to assist with training but this offer was not taken up by the BRC. For this volunteer there was little acknowledgement of the prior roles or skillsets of volunteers which the BRC could tap into.

The amount of training attended by the volunteers varied with one volunteer receiving no formal training to undertake their role. Others attended multiple sessions including the BRC introductory training, health and safety, sensitivity training, safeguarding and loneliness in the community. Although the 3-day introductory training to the BRC gave a “useful” overview to BRC activities, aims and remit, a few volunteers described the training as “intense” and discussed issues with the organisation and delivery of the sessions. One volunteer discussed how there were multiple cancellations and changes to the location of the training prior to its delivery. They also described how the system and computer had crashed during the session, which made the overall experience “a little chaotic”, and a “bit unfortunate”. Another volunteer with a background in training and staff development described how the training could be more “organised”, “robust” and “reliable” after also experiencing cancellations.

However, others commented that the training gave them a sound foundation to undertake their role, or validated knowledge they had already acquired through their previous roles.

One experienced volunteer with a background in training was “really impressed” with the content of the training sessions and felt there was a lots of opportunities and support for volunteers if they wished to attend further training.

It was suggested that further training could be provided on the availability/access to resources within communities to assist volunteers to undertake their role. Further more intensive training in areas more relevant to the role such as safeguarding and mental health was also suggested by a number of volunteers. Another volunteer who was a carer for their parents felt that training in wheelchair handling would also be useful to assist users with mobility issues when outside of the house.

**Engagement with Co-op**

Connectors have had varied engagement with the Co-op since the start of the service. A small number have had some communication, ranging from meetings to having stands at events. However, most have had little to no contact with Co-op reps in their area, with one Community Connector stating they had received a “*mixed*” bag in terms of how the service has been received by the Co-Op. One Community Connector reported contacting their local Co-op for food donations to support a lunch club they were running but were declined this request. Others had contacted their local reps but did not receive a response:

*“I’ve tried on many occasions, trying to form contacts with the leads in [this region] because we all have kind of a lead within the Co-op, and try and make communication with them. It’s really difficult…when you don’t have it filtered down from the top, then you know the staff at the bottom aren’t going to know anything. I find it really difficult to communicate with them. I find it really difficult for us to all work together. I’ll be honest, we haven’t really had much to do with the Co-op.”* (CC17)

One volunteer felt that the Co-op shops could do more to assist with referrals due to their contact with vulnerable people, as well as schools as a means of picking up neglected children whose parents may need more support.

**Potential challenges associated with service delivery**

A number of potential challenges in delivering the service were identified.

**Workload**

It is clear that most of the Community Connectors feel overwhelmed with the workload and targets and often give more than their contracted 21 hours to the job each week, although for some this has been alleviated through the additional funding that they have received through the Boost Plan. Administrative tasks were often cited as time consuming and potentially falling by the wayside with not all Community Connectors routinely filling in trigger group, goal and referral information:

*“It’s very challenging, I’ll be honest, yes it’s really tough. It’s really tough. I mean I love the work but yes, the hours and everything, it’s really challenging. It does feel like a full-time job in 21 hours…with more hours and more realistic targets and expectations it could be a very enjoyable job. But as it is at the moment, yes it is very hard and very challenging because I’m by myself. So why am I doing this, you know, the Volunteers, and the people that at least walk in, that’s what, kind of keeps me here.” (CC7)*

Other Community Connectors highlighted how they are filling a gap for a lack of statutory provision and in some instances acting as case workers for service users. Inevitably, due to the needs and requirements of their service users, they found that the job could often be emotionally and physically demanding:

*“How am I finding the workload? Stressful.”* (CC4)

However, when we interviewed Community Connectors 12 months later to explore the impact of the Boost Plan funding it was clear that it was contributing towards improving the Community Connector’s workload. Some Community Connectors had hired support workers with their boost funds.

Some support workers had responsibility for their own caseload whilst also assisting with assessments and administrative duties, leaving the Community Connector to concentrate on developing partnerships and referral routes. This support was particularly useful in areas struggling with volunteer recruitment:

*“She’s attending meetings, she’s set up a couple of craft clubs… it’s alleviated a lot of the pressures, communications wise. She’s, sort of, taken it on herself to keep an eye on all of the volunteers, so yes, made a big difference.”* (CC15)

Some Community Connectors had been given extra working hours as part of the Boost Plan, either as stand-alone support or in addition to the hiring of support workers. Despite extra support, referral rates were mixed across the areas, with some Community Connectors describing how the “*service had really taken off*” in recent months whilst for others this was *“up and down”.* Waiting lists still remain high in some areas despite support from the Boost Plan, and managing caseloads alongside administrative duties remains an ongoing challenge. Despite this, the support received through the Boost Plan was very useful to most areas:

“*So, now it is a lot better and we’ve got the additional thing from the Boost Plan having a team support worker. He’s full-time…. Which allows me to do more visits, so I can actually even increase it. And, again if you look at the figures in [this area] you can see without even talking to me in year one and from year two and when the Boost Plan started it just shot up.”* (CC18)

**Management**

On the whole, the Community Connectors spoke highly of their managers and the support that they had received from them. However, it was clear that there had been some challenges for a small number of Community Connectors in terms of not having management in place during the initial stages of the programme roll out:

*“Well we’ve had quite a few challenges with our manager. Again I think it’s a similar problem. He was so overworked that he didn’t have time to manage the Connectors. So he very much sort of had to be self-sufficient from the start. Like I know there’s four of us in the [this area] and we didn’t have any induction or anything which was quite tricky. And then we sort of had to hit the ground running. And then our manager’s been off since December. But it’s not the worst thing ever because it does mean we’ve become quite self-sufficient. But sometimes we are not always one hundred percent sure that we are doing things in the right way.”* (CC4)

*“I've only just had a change in manager over the last couple of weeks so it's, kind of, hard for me to talk about my relationship with my new manager because that's still, kind of, evolving. But the line manager I had before was absolutely fantastic. I actually don't know what I would have done without her. I think, you know, when things have been overwhelming, trying to fit things in with the 21 hours then she's been there to, kind of, listen and to brief with. And, yes, I think if I hadn't have had such a great manager it might have been a different outcome I think.”* (CC7)

Building on this, management was still inconsistent across the areas in Year 2 of the evaluation, with one area changing managers several times and another still operating without a manager due to ongoing sickness:

*“It’s been a real big challenge actually because as a co-ordinator I’ve worked in a Red Cross previously so I have had that experience so you know I kind of appreciate and understand where it’s coming from. But having a change of three different managers on such a new project, information doesn’t get filtered through you know as quickly as possibly it would be helpful for me running the project. In terms of having a support worker you know information wasn’t given to me until you know months and months. And other areas had already employed support workers so I guess that has an impact on the project running because I didn’t get as much help as I could I guess around that aspect.”* (CC17)

**Goal setting and targets**

Goal setting is not always undertaken by all Community Connectors and this is echoed in the quantitative data. For some Community Connectors, further information about how to use the online recording systems may be needed. For others, the goal setting took time to develop rather than something that could be done at an early meeting and perhaps this may explain why they do not record them on the system. Two Connectors spoke of feeling pressured to get service users onto the BRM system to meet targets even when they might not be achieving what is required of the programme. This raises concerns about the potential detrimental impact of high targets:

*“We’ve recently been asked to start doing coffee mornings and group sessions, which I’m more than happy to do if that’s what my manager and her managers asking us to do as a team. Where people could come along for say 12 weeks and we could get different people to come in and do session for them…and I know some of my colleagues in [name removed] area having been doing it and it’s been very successful. But when I discussed it with my line manager I said ‘well what do you mean by successful?’ and she said, well look on BRM. She said, there’s 8 referrals on BRM. So she’s had this coffee morning and she’s taken eight referrals which is fantastic. And I’m like yes, that’s brilliant. I said so what has she done? Are the UCLA scores being done? No. Are the top three goals been done? No.”* (CC9)

It was suggested that the targets lacked a person centred approach and did not take into consideration the complex nature of loneliness, focusing more on “*getting as many people through the door”* rather than supporting clients:

*“And it was like, you know, if you were to take this many people, and you were to take this many people, think how quickly you could, you know, those numbers. There was just no understanding at all. In fact, they wanted a suggestion about you know, how we could up our referral rates, and we were saying but the suggestion that was given, that wouldn’t have been the population that needs that support, if that makes sense?”* (CC7)

**Volunteer recruitment/engagement**

Whilst volunteer recruitment no longer falls as a job for Community Connectors, potentially reducing their work load, there were mixed feelings about the centralised system. Some said that this was “working okay”, whilst others wanted to retain the responsibility for volunteer recruitment:

*“I think I would be better off recruiting my volunteers because I need to see them rather than be given a stranger to work with.”* (CC2)

This suggests that perhaps greater communication between central volunteer recruitment and the individual Community Connectors might be beneficial, but it is important to keep the Community Connectors sense of ownership about their local service.

Many Community Connectors discussed the challenge of volunteer recruitment and how this was impacting on their workload and service delivery. The number of volunteers engaged with the different areas varied, ranging from none in some areas to 14. One area with high levels of volunteer recruitment had 6 of their previous service users currently volunteering with the service (see separate service model case study).

Those with low levels of volunteer recruitment discussed a number of barriers to retaining volunteers. Volunteers often fit their role around other aspects of their life (such as searching for longer term work or University) with some only wishing to commit small amounts of time to the service in the short term. This is particularly problematic given the service model is based on providing 12 consequent weeks of support with a client, leading two Connectors to provide 12 “sessions” rather than 12 weeks. Despite the new centralised system, Community Connectors discussed the resource intensive nature of volunteer recruitment/engagement alongside managing their own caseloads, partnership working with external agencies and administration. It was hoped by some Connectors that with the support from the Boost Plan they will have further time to concentrate on volunteer engagement. Examples of engagement activities included monthly team meetings, quarterly meetings with guest speakers from inside and outside the BRC, team building events and weekly email updates.

Although challenging, many Community Connectors spoke positively about their volunteers with one describing how they were *“amazing”* and would often “*go above and beyond for their service users”.* Volunteers in this area came from a variety of backgrounds and experiences, such as a retired mental health nurse, and would provide ongoing support to service users on a weekly basis.

Despite a centralised recruitment system, it is clear there are differences across the locations in the numbers of volunteers involved with the service, and how they are being utilised. This has potential implications for the success of the programme, and adds pressure to the workload of Community Connectors who have to manage their own caseloads:

“*Every monthly meeting when we talked about issues I literally didn’t used to say because I sounded like a broken record saying I have zero volunteers. I don’t have enough volunteers. So, it was like that. Everyone saw that… And, what I did is I would try and manage around it and I’ll ask them if I can’t visit you I can offer you a mix of visits and over time support. So, luckily I didn’t have to turn anyone away. But I felt that because of the capacity issue there was a lot of potential that was not really discovered in [this area] …if you look at the referral numbers you can see that.”* (CC18)

**Transport**

Transport remains a “*very, very important*” factor in the success and longer term sustainability of the programme, particularly for individuals with mobility issues:

*“The majority of our service users have a health issue... From that health issue a lot of them have a mobility issue… If it’s a new referral pathway I always make sure if it’s their remit to do that to sort out the mobility transportation, that’s done before it comes to us. Otherwise it becomes such an issue.*” (CC18)

Some Community Connectors transport service users to activities in their own vehicles, although there appears to be inconsistencies across the service in terms of whether Connectors felt this within their remit.

The availability of transport post intervention is particularly important and is dependent on local resources and whether the area is urban or rural. Some Community Connectors will make efforts to ensure sustainable transport is in place for service users so they can continue attending activities at the end of the intervention. For example, one Community Connector applies for a car sharing scheme for service users whilst others arrange bus services. One area will not take on referrals unless transportation is already in place, suggesting this was the responsibility of social workers. However, this is not always possible in rural areas were transport options are limited. The difficulties in supporting these individuals were discussed by both volunteers and Community Connectors alike:

*“I think it’s really important because I think that’s the one thing that let’s our service users down. Without transport, they are not able to get out and about. And in order for you to use, in order for them to access services you know. And it may be just the one class they want to get to, having that vehicle or having somebody being able to take them on a weekly basis, is consistency…consistency is really, really important. And without transport it’s a breakdown in accessing services. So Connecting Communities isn’t really working for them because they are not connecting them because of transport.”* (CC17)

*“I think transport is a major issue for a lot of people and that’s why they’re isolated. And having us for a short period of time is amazing for them and then they’re stuck then when we leave. I think if we had some wee kind of side project around transport, for certain purposes, would be good. Like people with mobility issues or who can’t drive anymore for health issues.”* (CC19)

*“…I’ve been working with a lady and it’s over three months now ... she wants to get out, we can’t get her out because she’s wheelchair-bound…I’ve sourced 20 odd clubs for her. I’ve taken a lot of time with this one service user…I don’t have many volunteers and I had to initially go to her house, help her in and out of her wheelchair, right, push her out, you know and actually take her to a club, you know. And the transport problem, it’s the biggest problem there, but people seem to get the impression from our leaflet that we will provide transport and we will go and sit with them for an hour and just talk.”* (CC11)

**Lessons learnt for operational delivery**

From the qualitative data, we can identify a number of lessons learnt relating to service delivery:

1. Community Connectors deliver a wide range of interpretations of the programme. This is suitable in the sense that the models can be adapted to reflect local need. However, some appear to be more proactive/successful than others in developing local networks and thus establishing a local model
2. There is much ambiguity regarding what constitutes a complex case and whether these cases are suitable for the programme. More detailed guidance on what constitutes a complex case and when a case should be classed as an inappropriate referral needs to be provided by the BRC and cascaded to local teams and to current and future referral routes
3. Guidance concerning re-referral into the programme needs to be provided by the BRC and cascaded to local teams
4. Given the short term of the existing model it is vital that sustainability is explored. In the case of CC15, whereby service user groups become self-sustaining, the short term nature of the intervention is overcome
5. The ending of support can prove to be difficult for both service user/Connector/ volunteer. Further guidance and training from BRC regarding when to cease contact and how to withdraw from the relationship is required
6. It would be beneficial to draw on examples of good practice in relation to recruiting young people to the programme. For example, Community Connector 19 developed a young person’s choir in order to appeal to a specific need in the area
7. Given that management arrangements of local teams appears to be fragmented, it is clear that further attention needs to be given to strengthen this area and ensure that clear communication and guidance is in place

# Section 7 – Conclusions and recommendations

This study is the first to evaluate a national social prescribing intervention to alleviate loneliness. Previous evaluations of social prescribing interventions have generally been small scale, focusing on one locally developed service. Little is also known about the impact of social prescribing interventions to address loneliness, which is the primary objective of this project.

This research frames loneliness as a serious public health issue. Our results demonstrate that loneliness is incredibly complex, requiring a tailored approach adopted to the service user’s individual needs. A number of interpretations of the Community Connector’s service model are being adopted across the UK. Despite this heterogeneity, our results demonstrate that the service is having clear positive impacts on loneliness and general wellbeing. A number of challenges have also emerged including potentially inappropriate referrals which may have resulted in an overrepresentation of those with mobility issues, physical health and mental health problems within the programme. The following section provides an overview of these successes and challenges, along with key overarching findings and recommendations for future practice and service delivery.

**Nationally implemented but locally developed: differences within the service model**

It is clear from both the quantitative and qualitative work that there are differences in how the service model is being developed and implemented across the UK. This is particularly the case in the recording of statistics, the length of the intervention and the acceptance and handling of complex referrals. Although such heterogeneity presents challenges, these differences demonstrate that services are tailoring and personalising support to the individual needs of their population and to fit in with other services in the area. Such tailoring also demonstrates that the broad nature of the service specification is appropriate for the role in practice.

**Duration and content of the programme**

Our qualitative data shows that while some Connectors and volunteers attempt to adhere to the 12-week support period others continue to provide support for their service users over a number of months. The qualitative data suggests that many service users desire longer term support and that Connectors feel the length of intervention should be flexible according to the service user’s needs. Despite this finding, the quantitative analysis indicates that in reality service users are receiving a much shorter amount of support, with the median length of support being about 4 weeks rather than the anticipated 12 weeks. We were unable to explore why people are moving through the service much quicker than anticipated. However, it is clear that the service is having a positive impact on individuals despite it not being delivered as per the service specification. For example, there is no difference in outcomes between those who had 5 contacts compared to 11. Whilst some individuals received longer support than the 12 weeks, this was a relatively small proportion of services users. At the other end of the spectrum, approximately a third of service users only had a single face to face appointment. This requires further exploration as it appears outcomes are better for service users who have more than one contact.

**Service user demographics and trigger groups**

Considerably more females (65%) than males (35%) were referred to the Community Connectors programme. Similar results were observed for the subgroup of “trigger group” users. The gender imbalance does reflect similar schemes, but the BRC may wish to revisit the referral pathways to ensure more male representation. For example, exploring whether male Connectors/volunteers had managed to recruit more males, as appeared the case in one scheme who had developed ‘male’ orientated activities. Almost half of service users were aged over 70 years, with only 13% of service users being under the age of 40 years. The Community Connectors programme had aimed to recruit people across the age spectrum, but the trigger groups themselves are generally more likely to reflect an older demographic, such as those living without children at home/recently retired. The BRC has been proactive in addressing this age difference through linking in with organisations such as Homestart. The success of this approach is being explored by the BRC.

Almost half of service users were recorded as belonging to a trigger group (n=2764, 48%). Of these service users, by far the largest trigger group was individuals experiencing health issues (n=2511, 43.4%). The second largest group is individuals with mobility limitations (n=1319, 22.8%) and this is also reflected in the qualitative work. The other trigger groups are much smaller, comprising less than 10% of service users. This finding indicates that the service is not reaching all the trigger groups as much as it had initially envisioned. However, to address this the BRC is being proactive such as working with Cruse and Homestart to try and reach service users from other trigger groups.

A strong finding from our qualitative work was the difficulty in supporting individuals with mobility limitations and/or health conditions, particularly in terms of sourcing transport and appropriate activities (see Impact and sustainability). These individuals also generally received more service than users not in these trigger groups. **Recommendation: Given the over representation of these individuals within the programme, further guidance may be required to assist Community Connectors to support these individuals.** Our quantitative work shows that those service users without a trigger group recorded appeared to be getting less support than those in a trigger group and were also less likely to have an improvement in their loneliness. Young parents also received less contacts but this did not have a detrimental impact on their loneliness outcomes.

**Impact and sustainability**

Despite challenges there are clear examples of positive impacts from the programme on levels of loneliness and general wellbeing. The quantitative data indicates that a larger proportion of service users experience improvement in their loneliness and wellbeing, and for some the improvement is such that they would no longer be classed as lonely. This was also reflected in the matched comparator work which shows that the service has an impact over and above what would be expected if the service was not available. The impact of the service on the services users we spoke to cannot be underestimated, particularly in terms of the development of confidence and self-esteem. Community Connectors and volunteers were also able to give examples of service users for whom they felt the service has had a very positive impact. It is clear from the qualitative work that service users did not view their contacts with Community Connectors as *appointments* as one may view a medical appointment, but as *social contacts*, demonstrating the value of the programme to its service users.

Findings from the quantitative sustainability work demonstrate that service users experience an improvement at the end of the programme but this improvement dips 3 months’ post service. Almost two thirds of service users experienced some deterioration in their loneliness in the period after finishing in the Community Connectors programme. Findings from the qualitative sustainability work suggest a number of possible barriers to service users sustaining improvement. Sourcing sustainable transport post intervention remains a key factor for the success of the intervention – particularly for those service users who relied on their Community Connector to transport them to activities. Transport is particularly integral for those with mobility limitations which impact on their abilities to engage with community activities outside of the home. Even when sustainable transport was sourced, some service users did not desire signposting or were unable to continue with their activities due to their health conditions. Interestingly, in the quantitative work signposting did not emerge as an important factor in whether someone maintained their improvement. However, this might be due to the fairly small sample size or because the signpost variable only captured if a signpost was actually made, not whether a service user actively engaged with this signpost. Some service users who had initial improvement at their first interview described a dip in their wellbeing 3 months’ post service desired longer term support. This further reinforces the need for a flexible approach to the length of intervention in order to sustain impact post programme.

It is clear from the qualitative work that many service users experiencing health issues and/or mobility limitations often desired longer term support in their home but befriending services for onward referral were not always available. It was suggested that the BRC could add a befriending element to the service to tackle this gap in service provision, although the resource implications of this are acknowledged. Even when transport was sourced, some service users did not desire signposting or were unable to continue with their activities due to their health conditions. This has implications for the sustainability of the intervention given that the service model is based around signposting service users to community activities.

**Volunteers**

The original specification for the service was built around the concept that the majority of the support would be provided by volunteers. Each service would also have approximately 10 volunteers responsible for their own caseloads. This would give Community Connectors capacity to concentrate on other duties such as building relationships with external organisations, sourcing referrals and managing volunteers.

The service being delivered in practice is quite different in that less than 20% of service users have had any of their support delivered by volunteers. However, this varies considerably across schemes, with some schemes not having any service users receiving support from volunteers whereas others had over half of their service users receiving volunteer support. Many Community Connectors discussed the challenge of volunteer recruitment and engagement in the qualitative interviews. The numbers of volunteers engaged with the service across the different areas ranged from 0 to 14, with the majority of services having low numbers of volunteers. Connectors outlined a number of challenges to retaining volunteers, including fitting their role around their everyday lives (such as searching for longer term work) and only wishing to commit small amounts of time. This contravenes the service model of providing 12 consequent weeks of support with the same client – leading some services to provide 12 “sessions” rather than weeks. It was clear that recruiting volunteers was incredibly resource intensive for Connectors who implemented a number of strategies to keep them engaged such as monthly meetings, team building events and presentations from guest speakers. There appeared a tradeoff for Connectors as recruiting, training and supporting volunteers was reported to require a lot of resources, which reduced how much time connectors had to deliver support. Whilst the proportion of service users receiving volunteer support did increase from when the programme started in 2017, the proportion remained fairly static at about 18% throughout 2018, indicating that volunteers may play a minimal role in delivery unless a different approach is taken. **Recommendation**: **future resource may be better allocated to the hiring of more paid staff to deliver the service. Evidence from the BRC Boost Plan suggests that hiring support workers/allocating extra hours to Community Connectors has been extremely useful**.

**Telephone versus face to face support**

The quantitative data suggests that telephone contacts are usually very short, with the majority being less than 15 minutes’ duration. We explored how telephone support is used within the interviews. Most Connectors use the telephone to check the status of a referral, information sharing or to check progress against key milestones – not as formal support. However, some Connectors do offer telephone support in replacement for face to face contact but this is usually for clients who suffer with mental/physical health issues or may be *“embarrassed*” about their living situation.

This would suggest that most contacts through the service take place face to face. However, the quantitative data suggests that half of service users are only having 1 or 2 face to face appointments and three quarters are receiving five or less.

This differs to the service specification where it was anticipated that service users may have up to 12 weeks of appointments. However, findings from the quantitative data also differ from the qualitative interviews where a key finding was that service users often desire longer term, face to face support within the programme. We were unable to explore the possible reasons why there tended to be a small amount of face to face contacts, e.g. whether the original referral was inappropriate, whether the support was not appropriate, or whether one appointment was sufficient to meet service user needs. It would also be interesting to explore the origin of referrals to determine who had only one appointment and where they were signposted onto. It is clear from the quantitative data that service users are more likely to experience improvement if they move beyond one face to face appointment. **Recommendation: it is important that the BRC explore the reasons why many service users only have one appointment.**

**Referrals**

It is clear from the quantitative data that referrals are coming into the service from a range of sources but particularly self-referrals (discussed below), NHS (22.1%) and Local Authority (18.6%). The latter two indicate that the Community Connector programmes have a presence in their locality, that the programmes are filling a gap in statutory service provision and meeting the needs of the local area.

Over 90% of referrals were accepted into the service. However, interviews with Community Connectors suggest that there had been an increase in referrals deemed inappropriate or “*too complex*” for the programme, such as those with severe mental and physical health issues. The strategies to manage complex referrals varied across the areas. **Recommendation: further guidance on the acceptance and handling of complex cases would be beneficial. Further networking opportunities between mental health and social services may also be beneficial to improve knowledge of the service’s remit.** Despite a large number of service users being accepted onto the programme, only 3702 (64%) were recorded as having any telephone or face to face contact. It is not clear what has happened to these service users, e.g. whether no contact has been made by the Community Connector or whether they have received support - this has not been formally recorded. **Recommendation: as over a third of service users are not recorded as having any contact this needs further investigation at an operational level.**

**Self-referrals**

Self-referral is becoming an increasingly common source of referral and numbers have increased from 17% described in the interim report (August 2018) to 32.1%**.** This suggests that Community Connectors are widely promoting their services and that schemes are well known in their localities. However, there is some evidence that self-referrals may be people who have already accessed the Community Connector programme and Connectors themselves are unsure about how to manage these. **Recommendation: the BRC needs to consider operationally how to manage service users who want to re access the programme, and provide further guidance to Connectors on this.**

**Signposting**

About a quarter of service users are recorded as being signposted (but it is known that this is under reported). However, it indicates that service users may not be accessing the Community Connectors programme with the intent of being connected with other activities but view the programme itself as the support. The majority of service users who were signposted received one signpost (63%). By far the most common signpost was to the third sector/community activities (66.2%), especially to age specific charities and mental health charities. The trajectory of referrals comes from statutory services but signposts are primarily to third sector/community activities. This indicates that the Community Connectors programme has helped service users to access a wide range of support, which may have enabled service users to access more appropriate support.It is clear from our qualitative work that when signposting has occurred it can have very positive outcomes for service users, but a number of factors can influence their ability to sustain these post service (see Impact and sustainability). **Recommendation: further guidance is needed for Connectors so that they do record signposting activity and more consideration is needed about how to sustain service users access to signposted activities once they are no longer getting support to attend within the programme.**

**Data recording issues: missing data**

There is currently no system in place for quality control of data collection and inputting. This has resulted in a number of problems within the evaluation such as large amounts of routine data (e.g. gender and age) missing, and it is understood that there are paper UCLAs in schemes which have not been entered onto the online system. Some schemes appear better at data entry than others, for example there are some schemes who have no service users with a start and end UCLA recorded. It is clear that a lot of important data is not being captured in the service, which may be due to Community Connectors not prioritising this aspect of the role. There is also evidence that those who do not fall into trigger groups are more likely to have missing data for age, gender and UCLA scores. This makes it difficult to assess outcomes for users in the service and has implications for the generalisability of findings. **Recommendation: BRC need to integrate data recording into the job specification for the Community Connector role, address it in supervision/performance reviews, deliver further training and provide greater feedback about the positive impact of collecting the data. Centrally, there also needs to be streamlining of what data Connectors are asked to collect and consideration of administrative support for Connectors or that more data be inputted centrally.**

**Management**

In general Community Connectors spoke highly of their area managers and the management of the service more widely. However, it was clear that management structures continued to be inconsistent across some areas, leading to key information not being filtered through. **Recommendation: further attention needs to be given to strengthen this area and ensure clear communication and that guidance is in place.**

# Section 8 – References

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# Section 9 – Appendices

Please note, all appendices are provided in a separate document.

1. A small subset n=14 completed the wellbeing measures but could not be matched in the service user data [↑](#footnote-ref-1)
2. The team discussed with BRC using an approach of providing the Community Connectors service later for some service users to generate a control group but this was considered inappropriate for people in need [↑](#footnote-ref-2)
3. Interquartile range is a statistical test, which looks at the middle 50% of service users. This test is used so that the average is not impacted by users who may have been at the lower or upper extremes of support. [↑](#footnote-ref-3)
4. Trigger groups were coded 0 or 1 and given the level of missing data in the other variables it may be that this was a system generated variable that did not rely on data entry [↑](#footnote-ref-4)
5. 95% CI is the 95% Confidence Interval. This is a statistical test which means that we can be 95% certain that if we provided the service again under the same conditions that people would have an improvement of between 1.7 and 1.9 UCLA points). [↑](#footnote-ref-5)
6. Note these numbers are smaller compared to initial analysis because we include the UCLA baseline scores and therefore restrict to those who have end-of-service scores [↑](#footnote-ref-6)
7. Values between 0.2 and 0.5, 0.5 to 0.8, and 0.8 or more denote ranges containing small, medium, and large effect sizes, respectively, according to Cohen’s criteria (Cohen, 1992) [↑](#footnote-ref-7)