FINAL EVALUATION REPORT ON THE WELLBEING EXETER SOCIAL PRESCRIBING PILOT SCHEME

August 2017

V.4

Dr Hannah Wheat, Dr Deb Shenton, Mr Ben Fosh and

Dr Helen Lloyd

.

NIHR CLAHRC
South West Peninsula

NHS
National Institute for
Health Research

Wellbeing EXETER

PLYMOUTH UNIVERSITY PENINSULA
SCHOOLS OF MEDICINE & DENTISTRY

South West
Academic Health
Science Network

Contents

Executive Summary

Plymouth University were commissioned to undertake an evaluation of the Integrated Care Exeter (ICE) Social Prescribing project (known as Wellbeing Exeter) by the South West Academic Health Science Network (SWHSN), culminating in a report in August 2017. This work extended a previous rapid evaluation of the initial ICE social prescribing pilot. The aims of this evaluation were to provide an understanding of the social prescribing model through qualitative methods that would enable formative evaluation on the impact of the model on patient reported outcomes. The SWHSN are providing an analysis of the service utilisation outcomes.

The term social prescribing, in its broad sense, describes a patient's transition of care from primary care to non-clinical services within their community, which is typically initiated by a referral from a primary care health professional (Husk et al., 2016). Through a social prescribing scheme, patients are supported to connect with community networks, groups and organisations, which can help them to address their social, emotional and practical needs (The Kings Fund, 2017). The Wellbeing Exeter social prescribing pilot is an example of a 'holistic social prescribing' service (Kimberlee, 2015). GPs refer patients onto community organisations who signpost and introduce clients onto suitable services within the community. They also provide one-on-one support to help them address and self-manage their social, practical and emotional problems.

Key findings from the evaluation:

Outcomes of Wellbeing Exeter
- Community Connectors' connected clients to a range of opportunities and support services within the community that were tailored to their individual needs.
- Community Connectors' approach to supporting clients and the continuity of care they offered helped clients to feel ready and make the first steps towards positive change.

- Clients' narratives evidenced improvements to their mental wellbeing and levels of social engagement. They also displayed a growing sense of empowerment to begin to self-manage their own health and wellbeing.

The implementation of Wellbeing Exeter

- GP referrals to the social prescribing scheme were initially low, but they picked up significantly as time passed and after steps were taken to increase referral rates.

- The open referral system (lack of an eligibility criterion) was deliberately designed to create a scheme that offered something for the whole community, irrespective of age and condition and was popular with GPs. However, it did cause a lack of clarity about who the scheme was aimed at and what it offered. This sometimes resulted in the referral of people with significant needs (e.g. severe mental health issues) who also required input from other statutory services. Some Community Connectors felt ill equipped to meet individuals with such needs, and in these circumstances, they felt that this affected their wellbeing at work.

- In some cases limited community capacity delayed clients' attendance to recommended opportunities. In such cases, the Connectors felt a moral responsibility to maintain support for these clients until the community groups and statutory services could address their needs.

Conclusions

- The qualitative evaluation data suggests that Wellbeing Exeter is successfully functioning to deliver the type of support that is highly needed, yet often unavailable for patients within primary care. Through connecting service users to community groups and services and one-on-work, the scheme was helping people to improve their mental wellbeing, reduce loneliness, re-engage with their community and manage their own health.

- The qualitative data suggests that Wellbeing Exeter is delivering improvements in important outcomes. However, it also indicated that there were opportunities to improve communication and the implementation of the scheme.

- Professional groups within Wellbeing Exeter were instigating workarounds to problems affecting the delivery of the service. These solutions were mostly successful, but decisions were often not made as a collective whole, with at least one stakeholder group often missing from important discussions that led to change. The lack of communication, between all the professionals working within the scheme, was a common thread within the qualitative data.

Recommendations

- *Co-design of new communication strategies*

As in any collaboration, effective communications is key and Wellbeing Exeter leadership should ensure that there is ongoing effective communication with all delivery partners. Representatives from each professional group within Wellbeing Exeter should meet to discuss, co-design and agree upon new communications strategies for the service. If opportunities for group feedback were provided, professionals from each delivery group would need to be contribute. Enhancing communication within the service would help build on existing working relationships across the service, which arguably are also essential for the longevity of the service.

- *Establishing a shared understanding about who the service is aimed at*

The qualitative data shows that the open referral criteria is effectively enabling the people who are most likely to benefit from social prescribing (i.e. people who live alone and are experiencing social isolation) to be introduced by their GP to Wellbeing Exeter. An on-going feedback loop regarding the nature and complexity of referrals should be established to ensure that Community Connectors are appropriately trained and equipped to deal with a wide range of issues. Systematic feedback loops should also be established to ensure that GPs are aware of the limitations of social prescribing and do not inappropriately refer clinically unstable or unwell patients.

To continue to foster a shared understanding within the scheme, (particularly if it expands beyond the pilot), additional training could be offered to new and existing delivery partners. This further training should focus on the services' objectives; keeping GPs informed about the services' objectives and encouraging them to continue to refer onto the service and ensuring that the referral process is as effective and appropriate as possible. Literature outlining key processes, objectives and the referral process should

also be provided to GPs so that they have a constant source of support and guidance available within their practice.

- o *Workforce development: an appraisal of Community Connectors' existing skills, experience and future needs*

A shared understanding of the groups to whom the service is aimed will also enable an accurate appraisal of the Community Connectors' core training and support needs. This would enable support mechanisms that are vital to their role to be standardised. Extra support and training will be necessary if Connectors continue to manage clients with complex mental physical and social problems. There is a great deal of existing experience and skill within the Connectors team. Connectors suggested that these experiences and skills could be more effectively matched to GP practices needs' and their patient cohorts. Connectors who have already been trained and/or have a great deal of experience of working with patients with particular types of complex problems could be offered extended training, so that they can specialise in these areas of care and possibly act as a mentor to other, less experienced Connectors. This is already being done, to a certain extent, within the Connectors' team.

- o *Collect data on why patients declined a referral and why patients were not accepted onto Wellbeing Exeter*

Data on the total number of patients who had declined the service, and the reasons why, was not available to the research team. This is due to the pilot design not including a systemic way of recording this at the time of the GP consultation because GPs felt that it would create too much of an administrate burden. However, as Table 1 shows, there was some (limited) data in why patients were not taken on by Wellbeing Exeter, despite a referral being made and on why patients declined the offer. In the week April 22nd to the 26th, two clients were unaccepted by two SP organisations (AgeUK and Westbank). One patient needed specialist medical attention, one patient was not aware of the referral and declined the service and one patient had their referral on hold whilst they dealt with family issues. It is recommended that, in order to address why potential (appropriate) clients may decline the service, this type of data should be routinely collected and reviewed in each practice. If appropriate to do so, actions can then be taken to attend to clients' concerns that may be deterring engagement.

- *Standardisation of the plan of action*

The clients action plan (see section 2.1.3), captures clients' and Connectors' shared decisions on how the client will work with Wellbeing Exeter to improve their health and wellbeing. As it is in a paper format, the Connectors currently have to fill it out by hand. If they want to give the client a copy, they have either to fill out the same form again, or send it to them later via email. Due to the time taken to fill out a duplicate copy, the Connectors sometimes left the one copy with the client or just keep the document for themselves. There are, therefore, opportunities to standardise the plan of action process and to make the sharing of the document more straightforward, for example by all the Connectors emailing (or posting) a second copy of the plan to the clients after their meeting.

1.0 Introduction
1.1 Integrated Care Exeter (ICE)

Established in 2014, ICE is a formal strategic alliance of public, voluntary and community sector organisations, working together to provide the infrastructure and architecture for designing and delivering new and better ways of working. There is a shared model for population health, wellbeing, preventative care and support, shifting the emphasis from crisis intervention to helping people help themselves to stay well. The vision aims to shift the focus from "patients" to "people", and from "What is the matter with you?" to "What matters to you?" A Transformation Challenge Award (TCA) from the Department for Communities and Local Government supports the transformation work set out by ICE. This funding has enabled ICE to test out new roles in the voluntary and community sector; undertake test beds for new models of prevention and to track outcomes to inform whole system transformation.

1.2 ICE's Social Prescribing Pilot

The aims of the Wellbeing Exeter social prescribing pilot are to offer a personalised social prescribing service that encourages individuals to identify and accomplish their own health and social goals and to find out if the approach improves individual health and wellbeing and to establish whether this social prescribing model has the potential to reduce demand on traditional statutory services. The objectives of the pilot were to assist GP's with the referral process onto the scheme; enable connectors to provide befriending, coaching and mentoring support to individuals who are referred onto the service and to support individuals to make connections with community and voluntary groups, organisations and/or activities that are based around the individual's needs/goals.

Social Prescribing: an expanded definition

One way in which ICE aimed to achieve their aforementioned objectives, was through the introduction of a new social prescribing scheme. The term social prescribing, in its broad sense, describes a patient's transition of care from primary care to non-clinical services within their community, which is typically initiated by a referral from a primary care health professional (Husk et al., 2016). Through a social prescribing scheme, patients are supported to connect with community networks, groups and organisations, which can help them to address their social, emotional and practical needs (The Kings Fund, 2017). Individuals can be connected to a number of different activities such as cooking classes, craft sessions, befriending services, volunteering, sports and gardening. There will also often be a dedicated

staff member (e.g. connector, link worker or navigator) from the social prescribing scheme, who will work on a one-to-one basis with individuals to make sure they can make relevant connections. In sum, objectives of social prescribing are ultimately to improve individuals' health and wellbeing and to support them to take ownership (self-management) of their health through coaching, mentoring, emotional support, confidence building and improved collaborative action across several sectors (NHS Health Education England, 2016).

Wellbeing Exeter: a holistic approach to Social Prescribing

While there is a growing understanding about what social prescribing is across health and social care there is no standard and consistent definition (Husk et al., 2016) and the implementation of social prescribing can vary substantially. Kimberlee (2015) provides a helpful typology of various models, generated from focus group data, which details the type of differences that exist between social prescribing schemes. The social prescribing model closest to Wellbeing Exeter, is what Kimberlee (2015), refers to as a 'social prescribing Holistic' service, a more advanced model of social prescribing. Box 1 provides the key processes within Wellbeing Exeter, alongside the (edited) associated features of a 'social prescribing holistic service', to illustrate how the former maps onto the latter.

Box 1: A comparison of key processes within Wellbeing Exeter and Kimberlee's (2015) template model of a 'social prescribing holistic service'

A selection of features from the social prescribing Holistic model (Kimberlee, 2015)	Key processes within the Wellbeing Exeter social prescribing scheme
There is a direct primary care referral, usually from a GP practice, to an external social prescribing provider. This is often formalised in terms of a letter, form, an online application or even a telephone call.	GPs make a referral to a community (third sector) organisation, who is serving as a social prescribing provider, by completing an electronic referral form.
The social prescribing provider has a clear local remit and draws on local knowledge of local services and networks to connect patients to important sources of support and aid.	The social prescribing providers (e.g. Westbank, AgeUK and League of Friends) are established organisations with expert knowledge of the local assets within their community.
The social prescribing provider addresses the beneficiary's needs in a holistic way. A patient may be referred to a social prescribing project to improve e.g. diet, but in doing so the social prescribing project will look at all patient needs.	A team of Community Connectors manage the GP referral caseload. Connectors work on a one-to-one basis with referred clients to help them identify, manage and self-manage their health, social, practical and emotional needs. This involves connecting them with relevant community activities/organisations and supporting them to engage with them. Connectors seek to understand clients' needs in a holistic manner through one-to-one conversations. These conversations inform what the Connectors' focus on, in addition to any details provided on GPs referral forms.
There are no limits to the number of times a patient is seen on a social prescribing intervention. Time parameters may be set but the number of sessions offered can be more or less depending on the patient's needs discovered in the holistic approach. social prescribing interventions seek to improve beneficiary' wellbeing they may not necessarily initially Be concerned with addressing mental health issues A lot of patients who attend social prescribing interventions have undiagnosed mental health issues	While Connectors work to an approximate guideline of how many times they would expect to meet with referred individuals, ultimately the number of meetings will depend on an individual's needs and on whether the support they require from the community is available to them. Cases are not 'closed' until the individual is being sufficiently supported by the community.

An extended description of the Wellbeing Exeter model

Wellbeing Exeter has developed from 2 earlier prototypes (The St Thomas service and the Wellbeing Service) that ICE initially piloted in 2015/16 (for further details please refer to the Rapid review evaluation report by Callaghan, Shenton, Maramaba and Lloyd (2016). Two local Exeter surgeries were recruited for both pilots. The main difference between the two pilot services was that the Wellbeing Service was embedded into the primary care service, whereas the St Thomas pilot was not. In the Wellbeing service, the Connector was linked to each of their two practices and referrals went directly to them. In the St Thomas model, referrals from the GP practice went straight to the social prescribing organisation. The evaluation of these pilots has informed the development of this extended pilot. In the

extended pilot referral decisions were based on GPs' perspective of who may benefit from the system, rather than on an eligibility criterion. Three different voluntary and community sector organisations' (AgeUK, League of Friends and Westbank) served as the social prescribing providers i.e., managing referrals and supporting the staff (Community Connectors) to fulfil their roles. Community Connectors worked one-on-one with their clients (the referred GP patients), employing a guided conversation approach to support the clients' aims and connecting clients onto suitable voluntary services and groups within their community. Devon Community Foundation were appointed as overall delivery leads for the extended pilot to provide sector and system leadership and to act as commissioners/brokers for the delivery partnership. Exeter Community and Voluntary Services, in their role as an infrastructure support organisation were appointed to provide the operational network co-ordination role

> **Devon Community Foundation** (established in 1996), is a unique organisation, working with philanthropists and communities in Devon to manage high impact distribution of funds designed to achieve sustainable outcomes, awarding financial support on behalf of Fund holders and donors, which enable local people to achieve inspiring change in their communities. The Foundation is quality assured through UK Community Foundations and endorsed by the Charity Commission

AgeUK Exeter	Westbank	Estuary League of Friends
"We are a dynamic local charity offering a wide range of services, information, support and opportunities to over 1,200 older people and families in the city each week. Our services for older people cover information and advice, help with benefits, day care, community support, social and activity groups. Our main centre and offices are in St Thomas where we also have our 'Men in Sheds' workshop. We have a further centre - The Sycamores - in Mount Pleasant, behind Mount Pleasant Health Centre and our community staff and volunteers work right across the city" (Pinpoint Devon Community Services, 2017).	"The organisation has been providing practical help such as shopping, transport to and from medical appointments, befriending and support since its inception. Supporting carers has always been a priority. Quality and active day care continues to be provided at our Day Centre, which also provides home cooked meals and bathing services. The Healthy Living Centre was developed for the promotion and enabling of healthy living initiatives and activities. The overall aim is to empower and improve the health and wellbeing of local people, especially those who feel marginalised and socially excluded groups and individuals. They provide fitness classes, weight management, stress management and complimentary therapies. Workshops and training are also delivered both in house and through experts from other organisations" (Westbank, 2017).	"We provide tailored services and host social activities for people of all ages who require our help and assistance to live as independently as possible in their own homes. Range of services include Home Help, i.e. running errands, befriending service, Hair at home, handyman and gardening, Independent living i.e., transport/hire of minibus shopping 1-1 and fortnightly trips, nail service, telephone contact, befriending, emotional support and pastoral care, information on entitlement for government allowances. **Friendship activities** such as Day Centre, lunch club outings, IT training, friendship group, memory cafe, Christmas Day lunch, and information and support for carers. Funeral catering service, Charity Shops, Disco equipment hire" (Pinpoint Devon Community Services, 2017).

In order to extend and amalgamate the two initial pilot social prescribing schemes the Wellbeing Exeter model has made the following changes:

- The number of participating GP surgeries has increased.

- During the implementation of Wellbeing Exeter it was also decided that the community organisation 'League of Friends' would join the service as an additional social prescribing provider. The existing working relationship with AgeUK and Westbank has continued throughout Wellbeing Exeter. The majority of Connectors (5) came from Westbank. Two connectors were seconded from AgeUK and one participating GP practice was linked to one Community Connector from League of Friends. The League of Friends – GP partnership operated somewhat independently to the main service (Westbank-AgeUK + other participating GP practices).

  The re-design of the social prescribing scheme has had integration with primary care as its focus. All of the Connectors directly report to GP practices in order to embed the model into primary care practice. In comparison, the previous St Thomas pilot primarily concentrated on building community involvement and the Connectors were not assigned to specific GP practices. A flow chart depicting the client pathway through Wellbeing Exeter (and the evaluation) has been provided in Appendix 1.

- Neighbourhood Friends were highly involved in the two pilots. However, they were not part of the Wellbeing Exeter.

- The extension of the social prescrbing service has resulted in an increase in, and a change of role for, service support staff, now known as Community Connectors. These changes have been made to help more people access the service.

> *Community Connectors: a definition*
>
> Community Connectors provide a bridge between primary care and the community and offer a more informal level of social and emotional support, which GPs are often unable to provide due to their substantial workload. They aim to improve clients' health and wellbeing, reduce isolation and increase independence by providing tailored one-on-one support and by improving knowledge of, and access to, a wide range of community services and groups.
>
> They will:
>
> - Have one-on-one discussions with the client at their home or at a more convenient location, so that can have an informed understanding of their clients' problems, needs and wishes regarding what, how and when they receive support from the service.
> - Tailor suggestions for which services/groups within the groups would be most useful for them based on their discussions with the clients.
> - Help them to re-engage within their community and build their confidence by attending new clubs/services with them for the first time.
> - Work with services and groups within the community to build better working relationships and improved coordination.

1.3 Commissioning of the Wellbeing Exeter evaluation

The initial social prescribing pilots were evaluated by the University of Plymouth. When the extended, modified pilot was established, the University of Plymouth's evaluation contract was also extended by the South West Academic Health Science Network to cover the evaluation of its implementation and impact.

Key aims of the Wellbeing Exeter evaluation

The overall aims of the evaluation were to describe how the (extended) social prescribing intervention has been implemented and secondly, to evaluate what impact it has had on patients' health and wellbeing and on their service use e.g. the number of appointments they have with GPs.

Analytic foci:

1) **Whether the expanded model supports individuals' self-management of isolation and wellbeing**

    (1a) Do clients' depictions of their experiences evidence improvements in their wellbeing?

    (1b) Do clients feel more socially connected?

(1c) Are clients able to manage feelings of isolation and loneliness more effectively?

2) **To establish if there are changes in statutory health and care service utilisation over the period of the evaluation (e.g. general practice and secondary care utilisation and social care).**

This component of the evaluation is being conducted by the South West Academic Health Science network (SW AHSN) and is being reported separately.

2.0 Results

What were the Key processes underpinning how the service was implemented?

Key processes underlying the delivery of Wellbeing Exeter:

- The referral process
- Community Connectors working with GP Practices
- One-on-contact between clients and Community Connectors
- Connecting service users to existing community resources
- Coordination within the scheme

This section explores how each of the key processes underpinning the scheme were being implemented. The focus here is on the mechanisms that enable the actualisation of the process, rather than on the value of each process or their cumulative impact (this will be covered later in this section).

2.0.1 The Referral process

As planned, GPs, from the participating practices, have and continue to refer patients onto the Wellbeing Exeter scheme. Decisions on who to refer are based on the GPs' perspective of who might benefit from this service, rather than a predefined eligibility criterion. All GPs reference their referrals by assigning a computer code to a (referred) patient record in their practice database. This triggers the electronic transmittance of a referral form by the practice to Westbank and the League of Friends. Westbank manage the referrals for both their organisation and for AgeUK. League of Friends operates independently to this process and manage its own referrals. This is because they joined Wellbeing Exeter after it had begun operating and because they already had an established working relationship with the GP practice they worked with.

For the period that this report covers (November 2016 to March 2017), there have been 299 referrals from GPs onto AgeUK and Westbank for the Wellbeing Exeter service. Table 1 provides data on the Westbank and Age UK referrals (the two delivery partners whose data we had access to). It shows that there have been different referral rates between the participating GP surgeries. For example, whilst GP Surgery 1 has referred 113 patients in totals, GP Surgery 8 has only referred 3 patients; giving a range of 110. However, this variance can be explained, in part, by the GP practices all joining Wellbeing Exeter at different times, as GP surgery 1 was the first practice to join Wellbeing Exeter. Other reasons for the variance could be GP practice

size, patient cohort or other external factors. In addition, when you consider the spread of scores across the 8 surgeries, surgery 1 and 8's total referral scores are clearly distinguishable from the other surgeries, whose scores varied much less (were between 20-40 patients) and which, in combination with surgeries 1 and 8, gave a mean referral (total) score of 36.

In the planning phase, it was decided that in order for a clear record that a referral had been made, and coded as such on the medical records, GPs would be the only professional group who made referrals. As the scheme developed, GPs encouraged other clinical staff to refer. This development was described during a GP focus group when some GPs spoke about how they had begun to encourage their staff (mainly nurses) to also refer patients, who they felt might benefit from the scheme. GPs felt that nurses were often better placed to make the referrals onto Wellbeing Exeter. Their consultations with patients were longer and, due to their interactional style, were more likely to create the type of rapport and environment necessary for patient disclosure about the type of 'social' problems that Wellbeing Exeter could help with. Connectors also felt that enabling nurses to refer was a good idea, as their involvement could potentially reduce the workload of the GPs.

> "*The process of getting that referral through, [might] add to the GP's workload, when actually the district nurses are probably perfectly qualified to make that referral" (Interview: Community Connector 1).*

Table 1: Referral figures for the Wellbeing Exeter service (2 Service providers (Westbank and AgeUK) referrals only)

	GP Surgery 1	GP Surgery 2	GP Surgery 3	GP Surgery 4	GP Surgery 5	GP Surgery 6	GP Surgery 7	GP Surgery 8
Number of Referrals this week (22nd-26th April	3	0	1	4	1	2	0	0
No of Inappropriate referrals and why			1 x patient should have referred to Bowel Management Service	1 x Patient unaware referral had been made – declined service				
Total No's to date	113	31	46	28	24	32	22	3
Cumulative Total	299							
No's currently working with	41	14	20	15	15	22	16	1
No. Closed cases	72	17	26	13	9	10	6	2
No. Not taken up service yet (+ reason)							On hold due to patients family commit-ments	

Demographics and T1 questionnaire scores of referred clients
(Partial referral data - AgeUK and Westbank clients only)

Demographics (see Table 2)

Age: The (participating) clients (n=72[1]) ages were distributed across the 18- 80 range, but slightly skewed towards a more elderly population, which suggests that Wellbeing Exeter was being recognised by both health professionals and patients, as a service suitable for all age groups. The age categories with the highest frequencies were: 30-39 years of age (15.3%), 70-79 (15.3%) and 80+ (26.4%). The age categories with the lowest frequency were the 18-20 (1.4%) and the 21-29 (6.9%) groups. Whilst frequency scores do steadily rise as the age categories increase, (suggesting that the older a patient is the more likely they are to be referred onto Wellbeing Exeter), there is a frequency spike in the 30-39 age category and a dip in the 40-49 age category, which disrupts this overall pattern.

Gender: Figures from our client cohort suggest that females were referred onto the service more frequently than males (70.8% % Vs 26.4 %[2]).

Relationship status: The majority of our client cohort were not in a current relationship at the time of data collection (57.5%). 41.2%[3] of our client cohort were in a relationship (married, civil partnership and cohabiting) at the time of data collection. This notable gap between these two groupings (16.3%), could indicate that people using Wellbeing Exeter were typically not in a relationship and therefore, may be in greater need for an additional form of support (other than family) and may be more prone to loneliness.

Ethnicity: 85.9% of the evaluation client cohort were White – British/Irish. This statistic alone indicates a lack of ethnic diversity in the patients referred onto Wellbeing Exeter. However, a comparison of this statistic to the level of diversity in the Wellbeing Exeter locality (88.32% of Exeter's population was White – British or Irish in 2011 – Devon County Council, 2011), shows that this lack of diversity in the cohort simply mirrors the dispersal of ethnicity in its locality.

Occupational role: 68.1% of the our client cohort did not appear to have an occupational role[4]

---

[4] The assessment of whether or not the participants had an occupational role was based on, and consequently, restricted by, the data given in response to the questionnaire's demographic categories. A participant's occupational role, which did not fit our categories, could have been missed through this type of 'closed categories' data collect

i.e. were unemployed, not caring for someone, unable to work or retired. This finding could suggest that Wellbeing Exeter clients were in greater need of community engagement, where they have an opportunity to take on a role within a group or work towards a shared objective e.g. developing a community garden.

Accommodation status: 82.4% of our client cohort had a form of permanent housing (owned property or rented). This suggests that housing was not a typical concern for users of Wellbeing Exeter and is supported by signposting data provided by Westbank (see Table 3). This revealed that that 299 referred patients had been signposted 375 times (some clients were signposted to more than one community service/organisation/group). Out of these 375 signpostings, only 15 were to community services dealing with housing problems.

Table 2: Demographics of the T1 (questionnaire) Wellbeing Exeter cohort

Age	f	%	Gender	f	%	Ethnicity	f	%	Marital	f	%	Employment †	f	%	Accommodation	f	%
18-20	1	1.4	Male	19	26.4	White British/Irish	61	85.9	Married	28	38.9	Paid employment	9	10.3	Owned property	32	44.4
21-29	5	6.9	Female	51	70.8	Black British	2	2.8	Divorced	13	18.1	Self-employed	0	0.0	Supported housing	1	1.4
30-39	11	15.3	Missing	2	2.8	White Other	5	7.0	Single	13	18.1	Supported employment	1	1.1	Hospital	3	4.2
40-49	7	9.7				Other Asian Background	1	1.4	Civil partnership	1	1.4	Voluntary	1	1.1	Rented (HA)†	20	27.8
50-59	8	11.1				Missing	2	2.8	Cohabiting	1	1.4	Unemployed	7	8.0	Rented (private)	7	9.7
60-69	10	13.9							Widowed	14	19.4	Retired	37	42.5	With friends/family	5	6.9
70-79	11	15.3							Separated*	2	2.8	Unable to work	17	19.5	Other	4	5.6
80+	19	26.4							Missing	0	0.0	In Education	1	1.1			
												Looking after family	14	16.1			
Total	72	100.0		72	100.0		72	100.0		72	100.0		87	100.0		72	100.0

T1 cohort scores

When aggregated, the T1 cohort data suggests that clients typically entered the service with a low mental wellbeing score. The average mental wellbeing score for the clients was 16.83, nearly 7 points lower than the national average of 23.61 (CORC, 2011). The aggregate T1 cohort also had a medium to high score of loneliness; a low score for social inclusion and a medium to high score of patient activation (see figures 1-4 below). This suggests that for this cohort, mental wellbeing, loneliness and social inclusion were all identifiable areas requiring improvement and therefore, that Wellbeing Exeter are being referred patients with the types of problems that they aimed to address and improve.
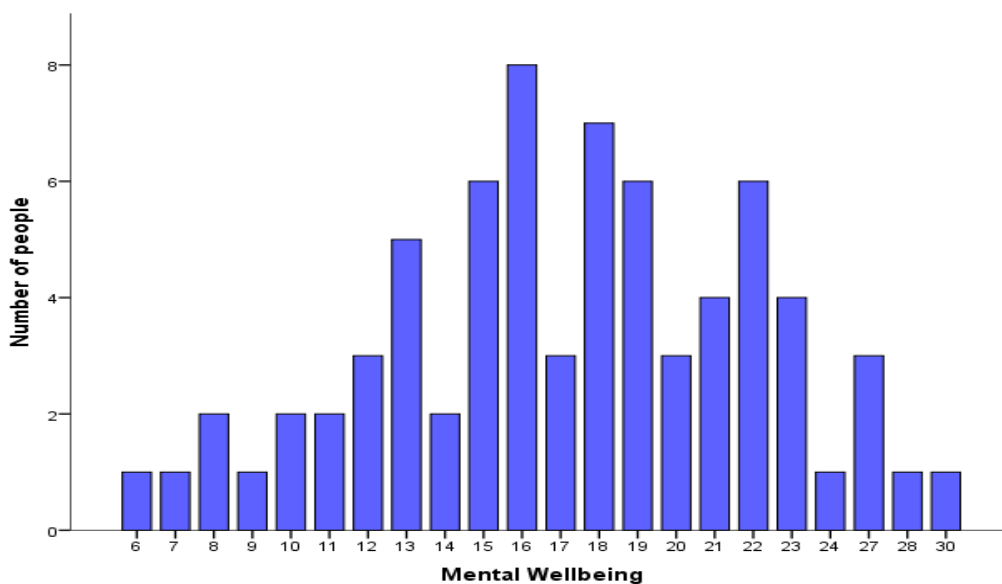

Figure 1: Aggregate mental wellbeing scores for the Wellbeing Exeter evaluation client cohort at T1
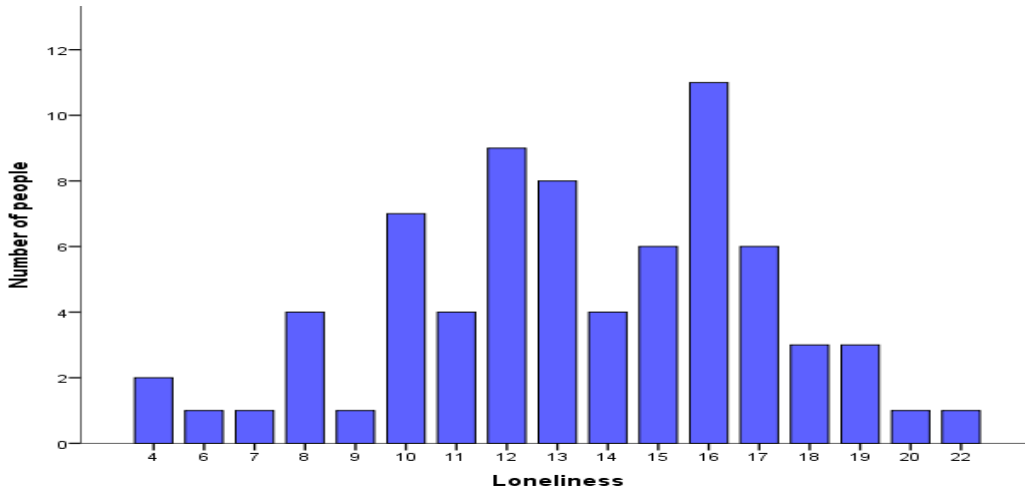
Figure 2: Aggregate loneliness scores for the Wellbeing Exeter evaluation client cohort at T1
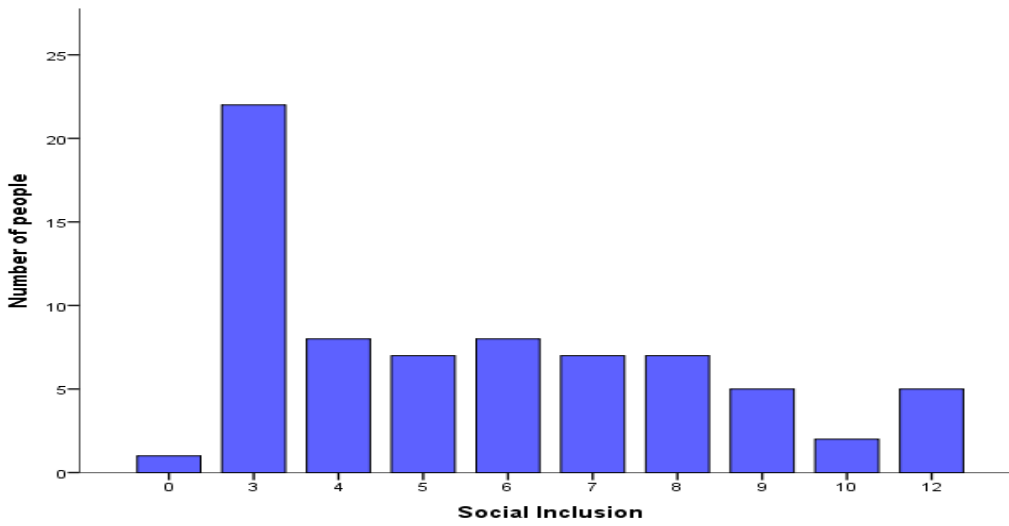

Figure 3: Aggregate social inclusion scores for the Wellbeing Exeter evaluation client cohort at T1
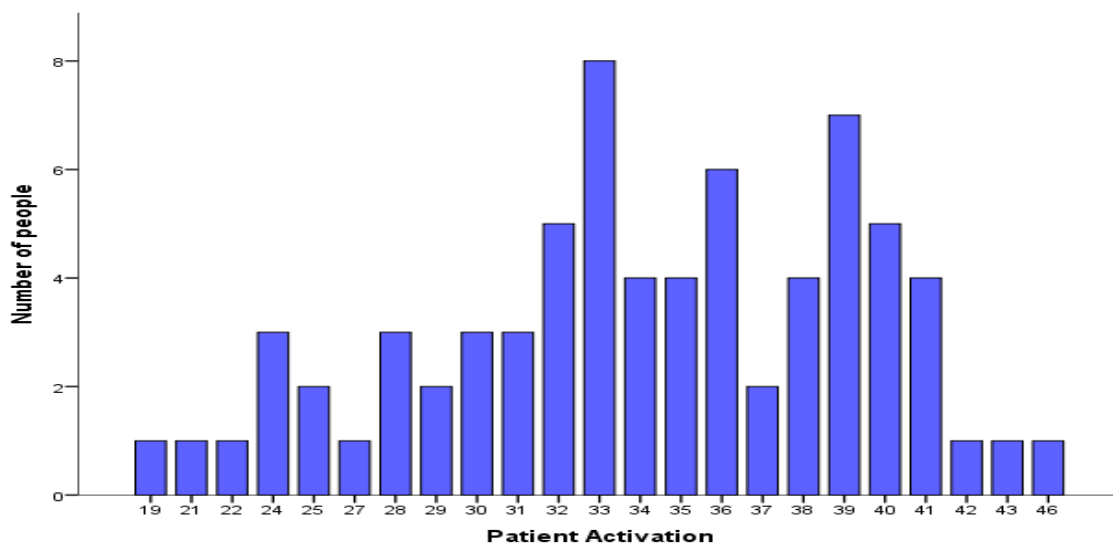

Figure 4: Aggregate patient activation scores for the Wellbeing Exeter evaluation T1 cohort

Issues reported as impeding the referral process during baseline data collection

An un-unified uptake and knowledge of the referral process

Although the referral process had been decided in the planning phase of the intervention, there were clearly communications issues and teething problems between different partners. An example is the delay in getting the referral forms into GP practices. A lack of knowledge and implementation of the referral procedure was reported as having significant ramifications on service delivery by some of the Community Connectors (from every organisation). In evaluation focus groups and interviews they described that when they had met with participating GPs to promote the service and encourage referrals, they observed that little, or no updated referral paperwork was available within the practice. This created concerns about whether the mechanisms were in place for the scheme to run effectively and about their ability to perform their role. In addition, it was reported that a lack of GP knowledge about the referral process was resulting in GPs turning to the Community Connectors for guidance and for the relevant materials. However, as these materials (referral forms), and/or answers were also often not available to the Community Connectors either, they were often unable to help. This inability to help created a sense of unease about how their role was being perceived by the GPs.

```
"I feel it does let us down a little bit that we haven't got everything
lined up, we haven't got the forms that we need, we haven't got…you would
have thought that even a month before you would have those things in place
and then do like a launch event or something" (CC 1).
 "The first question that the GPs ask was how do we refer in?  I personally
  felt extremely unprofessional, because I didn't have a referral form, I
didn't have any information about the service, I didn't have any guidelines
                at all" (Interview: Community Connector 2).
```

Difficulties remembering that there was a service to refer onto

Participating GPs, in contrast, focused on factors that impeded the decision to refer, rather than on the process itself when discussing the referral system. One particular problem, which was unsurprisingly more prevalent at the beginning of the intervention, was that GPs often forgot that there was an opportunity to refer onto Wellbeing Exeter. This, arguably, could have been the main reason for why referral numbers were so at the start of the intervention (21 referrals in first 4 weeks out of 299 in 6 months – data from correspondence with Westbank).

A lack of clarity regarding who should be referred onto the service

GPs stated that they were sometimes unsure of who they should be referring onto the service, as there was a lack of clarity on what issues/conditions the service was offering and were equipped to support. As one GP stated:

"I think we're still in the introductory phase for us, because I think one of the issues is that the clinicians aren't quite sure what they should be referring" (Interview: GP 1).

However, while GPs stated this may be causing some initial hesitancy to refer onto the service, they seemed to be relatively unconcerned about their lack of understanding about who Wellbeing Exeter catered for and were therefore, not striving for clarity. They felt reassured by the fact they had been given free rein to refer whomever they felt might benefit from the service and by their understanding that any potential problems arising from the absence of an eligibility criteria issue would be managed by the providers, who were notifying them of any inappropriate referrals:

"At Westbank, they've really just said, look if we can't deal with the problem that you've sent to us, then we'll let you know, we'll bounce that back to you. And they've been very good at that, and I think there's only been one so far, that they've had to do that on, but basically we're sending everything, and all social problems we're sending, and other things that we're not quite sure whether it would fit the mould"
(Interview: GP 1).

Time 2 (follow up) perspectives on the referral process
Subsequent perspectives on concerns presented in T1 data
  ❖ *Follow up on T1 concern: Often forgot to refer onto Wellbeing Exeter*

Since T1 data collection, the number of referrals being made by the GPs has substantially risen due to lead GPs' efforts to frequently remind their fellow GPs, through a number of mechanisms, which has partially contributed to this improvement in referral rates. However, GPs (in T2 data) were still reporting that they were forgetting to refer onto the scheme and warned that if the reminders stopped, the flow of referrals would notably decrease.

"The leader that's taking it back into the practice is on leave, for any time, the referrals actually dipped down….And I think that's key. And

then, when I got back from leave, suddenly, the referrals had picked up"
(Focus Group, GP 2).

Consequently, ongoing support from an in-house champion (GP lead) and the gradual embedding of the service into each participating General Practice, appears to be essential, if referral rates are to be maintained, or even increased further. GPs hoped that eventually these forms of encouragement would enable Wellbeing Exeter to become an ingrained part of practice activity and for it to be viewed as a key part of what they provide to patients, just as medication is currently thought of today.

"It's around how you embed it within the practice, really, and you champion taking it forward" (Focus Group, GP 1).

"We've just had continued battering from [name of person] and, erm, and we do it. And, erm, we, we now, it's in our psyche, and we do it"
((Focus Group, GP 2).

❖ *Follow up on T1 concern: A lack of clarity regarding who should be referred onto Wellbeing Exeter*

In their baseline data, GPs had mentioned that the open referral system might be causing some initial hesitancy to refer. However, in the T2 data, GPs had adopted a more positive stance towards the open referral system. They suggested that it was encouraging GPs to refer patients onto the service because it saved time (did not have to work out patient eligibility on a case-by-case basis) and because it enabled them to support patients who were in need of a different type of assistance and who they had previously struggled to support.

"I just refer anyone who it occurs to me that they might benefit with some things that I don't know about in the community. And if they're interested in engaging with something out there in the community that I can't directly deal with, then I refer them, and that seems to be...I've had no negative feedback about that" (Focus Group, GP 1).

"I think it's given me a lot more I can offer patients and it's made it a lot easier with those who I probably can't actually help that well anyway but try to" (Interview: GP 2).

The Community Connectors from the different providers, however, had a contrasting view on the open referral system. In their T2 data, they voiced concerns about whether they and the scheme were equipped to deal with the severity of problems, which were often mental health related, that some of the referred patients were seeking help for.

"We've had lots of cases that are really beyond our capabilities, I think, or beyond…not capabilities… Beyond the remit of a voluntary sector service"
(Focus group, Community Connector 2).

"We've had support to support somebody who was…husband was being tried for manslaughter, we've had paedophiles, child rape, and these people, they clearly need support, but not from the voluntary sector, but from the GP, because they've been told, don't think about it, just refer, that's what they're doing"(Focus group, Community Connector 3.)

The Community Connectors were also worried about how the level of need and complexity in the cases they were taking on was affecting their own health and safety, for example when visiting patients in their own homes and the emotional toll of listening to extremely sensitive and upsetting personal stories.

"Because of the cases that we're seeing, very difficult cases, and like [name of person] was saying, you kind of feel quite battered when you get one, two, three, four of those in a few days, it's tough going" (Focus group, Community Connector 2)

Connectors recognised that they were receiving such referrals due to the open referral system, and statutory services' current inability to meet need for their services within the community, rather than because of GP error.

"Beyond the remit of a voluntary sector service, I think. A lot of the referrals that have come through that are the top heavy ended ones, are people that clearly should be linked in with professional services" (Focus Group, Community Connector 2).

They suggested that they could have benefited from more time to prepare for the wider variation in clients backgrounds and issues, especially for the more difficult cases. The time and knowledge to prepare could have been helped by GPs giving more case specific details on their referral forms. This would have enabled the scheme to make sure that the Connector with the best-matched skills and experiences was allocated to the client and to ensure that that sufficient support for the allocated Connector was put into place.

"I had one [referral] from [name of place] as well, which was…they really didn't give enough information, so I went into a minefield, layers and layers of abuse, and actually all it said on the form was, possible safeguarding issues, but it was so much more than that, and that was from [name of place], so…if he'd put a bit more information on there, I would have picked up the phone and called, but because of what he put on there, it didn't raise enough to raise alarm bells to make that call" (Focus group, Community connector 4).

Whilst viewing such cases as being beyond the remit of social prescribing scheme, the Connectors have continued to offer support in many of these cases. The decision to maintain support for people with complex cases has been driven by fears about when the resource stretched, relevant statutory services would be able to give them the support they needed.

"So you feel you have to do everything you can to just find something for them, which might not be there, so yeah, so emotionally it's very difficult. You end up carrying… you're doing it for a longer period of time, you're not connecting them to services because they're not there, so you're trying to find a way to do that work for them yourself"
(Focus Group, Community Connector 3)

<div style="border:1px solid black; padding:10px;">

Implemented working solutions (T2 data)

Westbank (on behalf of Connectors at AgeUK, as well as Westbank) have implemented two new processes that aim to support Connectors with their management of complex cases.

Decisions on how to change the service would have been discussed and agreed upon with AgeUK in their regularly scheduled meetings.

1) **Regular supervision: helping Connectors deal with the emotional burden of working with people with complex needs and life histories and ensuring safeguarding protocols are in in place and used.**

   "It's looking at trying to put in place some safeguards to kind of triage what's coming in, but also to provide some supervision, some clinical supervision because of the cases that we're seeing, ..it was just decided within [name of place], because we raised it as an issue of what people were dealing with that we needed to put in place safeguards for the staff" (Focus Group 2, Community Connectors).

2) **An embedded triage system: addressing the lack of case specific information being transmitted through the referral process by creating a secondary referral process.**

   "The other thing that we're doing is that I'm triaging the calls before I allocate them, so I'm phoning them to find out what the doctor is saying that they want is what they want, and to get any information that I can, and from there, we can risk assess whether we need to send one person, two people.
   Whether it needs to be in their home, or whether it needs to be, as we did yesterday with someone who had been accused of an unpleasant offence, that we saw them at the GP surgery" (Focus Group 2, Community Connectors).

</div>

While these new processes helped support Connectors to work on the Complex cases that they felt were beyond the remit of their service and their training, they did not attempt to

reduce the number of complex cases they received.

Follow up (T2) concern: Patient hesitancy to accept Wellbeing Exeter referrals:

Within the T2 data, GPs reported a new concern that patients were sometimes hesitant to accept the offer of a referral.

> *"I've given them a leaflet, talked about it, said it's there. I also sort of say, it's only for a limited time, so if you do think it's something you would like to do, then best come back.   So, yeah, but I think, I don't know how you would tackle those, I think, sometimes, it's a bit of drip-feeding, really" (Focus Group, GP 2).*

However, GPs added that whilst patients may not initially be as enthusiastic as hoped about the service, the act of making the referral in itself had value, as it demonstrated support and interest in their patients' needs.

> *"It makes them feel that you're trying to think about them beyond what they've come to the practice for. So it can, indirectly, also just enhance your relationship with your patient, even if they don't directly take up a referral, they know that you would like to think that they could improve their lives better and we would love to be able to help them, even though they don't want that help at the moment, that would potentially improve your relationship with your patient, long term"(Focus Group, GP 2).*

2.0.2 Community Connectors working from within GP Practices

At the start of the process, it was decided that it would be useful to have a named Community Connector attached to each participating GP surgery, as it would allow the surgery staff and the GPs to put a face to the service and become familiar with what it provided. To facilitate integration, the 'attached' Community Connectors would be invited to GP meetings and have a desk space within the practice.

During T1 and T2 data collection, many Community Connectors reported feeling allied to one, or two specific surgeries. Some of the Community Connectors viewed the opportunity to work 'within-house' as a potentially beneficial strategy. It was enabling them to offer their clients a drop in service, in addition to home visits and consequently, make Wellbeing Exeter more accessible and appealing to a greater number of potential clients. During implementation of the service, the Community Connectors had taken part in some of the GP Practice meetings. However, some stated they did not feel fully embedded in their allocated surgery. One possible reason for why this might be the case, put forward by some of the Connectors, was

that the decision on how to assign Connectors to GP practices was not resulting in the best match for the practices' patient cohort, or for the Connector.

The belief that skill sets and working patterns should be considered when allocating Connectors to surgeries.

Connectors pointed out that the decision to base Community Connectors' surgery allocations on just their geographical locations had meant that in some cases there has been a lost opportunity to match existing (Connectors') specialised skills set to surgeries' population cohort and/or areas of provision within the surgery that required further support e.g. specialised mental health training.

> *"It depends what their needs are I suppose. It may not be us that are dealing with it, it might be that we feel that someone needs specific needs and someone else in the team is more equipped or has more experience in that, so that would then probably go off to them I think" (Interview: Community Connector 1).*

In addition, many of the Community Connectors were working on a part-time basis. Consequently, their shift patterns had a more significant impact on how quickly they could see a client after they had been referred onto Wellbeing Exeter, rather than their geographical closeness to the client. On occasion, it made more sense for clients to see a Connector who was not allocated to their particular surgery, but who, based on working patterns and client lists, could see the client more quickly. Connectors did not believe that this cross-surgery allocation caused any detrimental effect to the clients as once they were allocated to a client they remained responsible for managing that case and ensuring continuity of care.

2.0.3 One-on-contact between clients and Community Connectors

Once a Connector was assigned a client, they would call them to book a time and day to meet. They usually meet in the clients' home unless the client wanted it to be somewhere else or there was some concern about the safety of the Connector.

During the first meeting, a guided conversation takes place, and if possible, a co-designed plan of action is created. At the second meeting their possible participation in the evaluation and completion of the baseline measures (if consent to participate is given) as well as next steps with the agreed plan is discussed (what services have been identified as being relevant to the clients' needs and any problems which have arisen).

"My understanding is to go out, meet with the patient, talk to them about what they want to do, what is most important and what matters to them, and then build a little simple plan of what they will do, what I will do, and then a second meeting when we go through the questionnaire and get to know them a bit more and see how they're getting on, I guess, with whatever we had decided in the first meeting and then have a follow-up possibly as a third meeting. Or I guess it will depend on the patient. They might want to have somebody going with them out to the health walks or to a social group or something else, and then we might work with that as well"
(Interview: Community Connector 3).

The Connectors provided tailored individual support to each person, as each client will have differing issues or concerns.

"No, she discussed everything with me in full, made some suggestions. A couple of them I said, no, I'm not interested in that, and took forward the things that I was most interested in" (Focus group: client 2).

"The same. Exactly the same. I think she could work out what sort of thing I would like and what I wouldn't like, and sort of suggested stuff. Like I like walking, I've got a dog, so I need to get out to walk. So she just said, right, there's a local…there's a walking group, why don't you try and do that this week; or what is your aim to get yourself out, what do you think you can do this week to go back to [inaudible]. I said, well, actually I've done so and so. So yeah, she's…it's all been…I think she's took a lot of time to think about what the individual would like"
(Focus group, client 3).

One of the main objectives of Wellbeing Exeter is to connect clients onto activities, organisations and support groups in their local community that could provide suitable and sustainable support to their clients (see section below - 2.1.4). This community support should allow them to self- manage their conditions; engage with community activities and become empowered to make improvements to their health and wellbeing. Once this type of community support has been established, Connectors begin to reduce their contact with the client, but continue to be a point of access. However, as mentioned earlier (3.1.1), clients have often been unable to receive support from suitable services (voluntary and statutory) located within their community.

"[Thai Chi] Class available, which is in [name of place] which was an interest. I thought that's what I want. And you're told we're full, we have a waiting list. I mean to say, so many of those things are supposed to be there but, in effect, they're not because they haven't got the capacity" (Focus group: client 1).

Connectors have felt very conscious and frustrated about the fact that some of their clients faced long waiting lists, as they found they were signposting them to groups/activities/ services that had been disbanded, or did not hear back from those services and groups they

had contacted. For example, one client who attended a craft session found the first session
had been cancelled. The cancellation had not been publicised and the client felt quite let down
when she made it to the session, only to find that it had been cancelled.

> "*We went to a craft club last week but it wasn't on… I was looking forward
> to going to the craft club and then to find then…I think [name of woman]
> was a bit upset that it wasn't on…as well" (Interview: client 1).*

This experience may have deterred the client from attending this group in the session;
however, the Connector involved in this case took extra efforts to make sure this did not
happen by making sure she had the right date for the next session and by continuing to
support the client to attend.

> "*Which she did… So I went to the craft club and I can go now once a
> fortnight...or once a month it is" (Interview 2: client 1).*

Consequently, Connectors have had to extend their one-on-one contact with certain clients, to
make sure they are not left unsupported while they await service provision. The one-on-one
support that the Connectors have been offering has been greatly valued by the clients and this
is clearly visible in the later analytic sections on how clients' social isolation, anxiety and
wellbeing have been improved through the Wellbeing Exeter section 2.2.

2.0.4 Connecting (extended signposting work) to existing community resources

During the evaluation period, 375 referrals to community organisations by the two delivery
partners involved (Westbank and AgeUK) were recorded An upcoming section (2.2) includes
details about the benefits generated by the extensive signposting work of Wellbeing Exeter, the
focus of this section is on what type of referrals were made.

Table 3 breaks down the type of signposting referrals made by both social prescribing
organisations (not League of Friends, who were recording their data separately), by assigning
them to a sub- group pertaining to the schemes objectives. As some clients were signposted
onto more than one type of service the signposting total (375) exceeds the number of GP
referrals onto the scheme (299). Table 3 shows that clients were noticeably signposted to
services related to the category: '**Good physical, emotional and mental health and
wellbeing**' the most (260 out of 375 signposting referrals). In comparison, clients connected
to services relating to **housing** issues the least (15 signposting referrals). The demographics
of the T1 cohort showed that the majority of the participants had secure housing in place.

This suggests that this cohort did not require support from housing services (they may have access to this from other sources) and the clients were being signposted appropriately.

Table 3: Types of signposting referrals made by Westbank and AgeUK

	Referral Category				
GP Surgery Referrals	A place of my own: housing and housing support Improved access to suitable housing Increased access to housing support Increase access to support or adaptations to remain at home	Good physical, emotional and mental health and wellbeing Reduced isolation Improved strategies for living well with physical /mental ill health Increased healthier lifestyle choices Increased transport and/or	Financial Security, employment and welfare benefits Increased access to benefits and budgeting advice Increased access to debt management support Increased opportunities for employment or training	Safe and sound: knowing someone is looking out for me Increased opportunities for developing personal relationships Raised future aspirations Reduced likelihood of crime and/or anti-social behaviour	Contributing citizen: to friends, family, community Increased participation in community life Improved family relationships Increase respite and/or support for carers Increased opportunities for volunteering
1	5	94	21	12	13
2	1	28	5	5	3
3	4	39	8	6	1
4	1	26	6	1	3
5	2	20	4	1	1
6	1	29	2	5	1
7	/	22	1	/	1
8	1	2	/	/	/
Total	15	260	47	30	23
Cumulative total	375				

Figure 5 breaks down these figures further by providing some brief examples of the type of signposting work Community connectors did with individuals. The case study examples show that Community Connectors do not just give clients information about the organisation, they additionally supported the clients by coordinating and enabling access to appointments, attending sessions/meetings with the clients and by helping them to process and complete tasks advocated by the organisation. When problems arose that could potentially prevent the clients from working with external agencies, the Connectors make substantial efforts to remedy these potential barriers. For example, when waiting times were an issue, Connectors would liaise with the sought after service and network with other (similar) agencies to ascertain if support could be received by the client sooner. They also explored whether there are possible solutions to the barriers impeding support e.g. supplying transport to support groups within the community.

"But, you know, [name of connector] there for me to…I know for a fact if I rang her and said could you take me to so and so, or could you find a way of…the best…another thing is with me is buses and getting on trains. I don't like doing it. So she said to me, if I ever need to get to somewhere, she'll come along with me, which is nice to know"
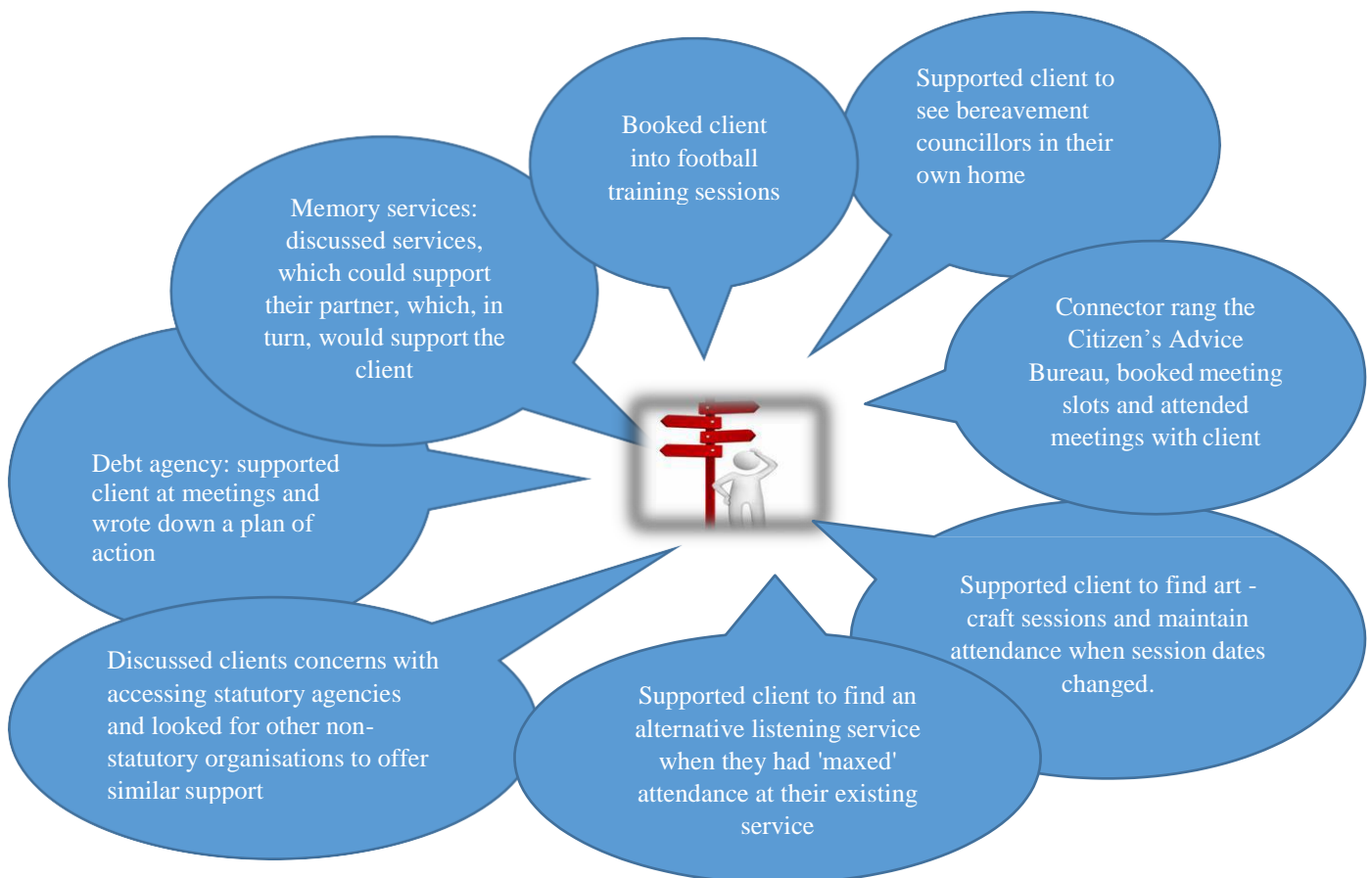*(Focus group: client 3).*

Figure 5*: Case study examples of signposting work done by Community Connectors*

2. 0.5 Coordination within the service

Within the data, there were observable displays of commitment to the success of the service from each delivery partner group (e.g. Community Connectors, GPs and voluntary sector organisations), albeit it to varying degrees between groups and individuals. However, some Connectors felt disconnected from the programme leadership and perceived that they individually were not able to fully input into how the scheme was designed and delivered. A number of reported consequences arising from their perceived lack of input are detailed below.

A lack of input from all stakeholders into service design

Community connectors from every social prescribing organisation commented on a breakdown in communication between the social prescribing providers/Connectors and with the ICE board. Some of the

Community Connectors stated that communication problems began during the planning phase of the service. The third sector organisation they work for were not asked to be part of this process and plans for implementation were not shared for discussion before decisions were made. Community Connectors and other staff at the third sector organisations felt that this lack of involvement showed a lack of acknowledgement of their extensive expertise in this area of community care.

'But we're, as far as I can tell, are being kept out of the development of the service anyway. The service is being project managed by an organisation that has, in my opinion, no experience of delivering operational service' (Interview: Community Connector, 1).

"We've not been involved in the discussions about it, so the form has been changed, and we haven't had a lot of input in designing any of that, which, to be honest, I was a bit surprised about actually, considering our experience of delivering a service, I mean we took over 2,000 referrals through [organisation}, but they've chosen not to use our expertise" (Interview: Community Connector, 1)

This lack of involvement in pre-implementation decision making also made the Connectors feel uneasy about whether they fully understood what the Wellbeing Exeter service was offering, what their role within this service was and, as a consequence, the right sort of promises were being made to clients.

"That to me just worries me a little bit, because there can a disconnect between what we're selling, that we're doing, and we don't want to promise something that we're not actually able to deliver. I'd much rather deliver a bit more than what is being portrayed" (Interview: Community Connector 3).

The breakdown in communication ultimately left the Community Connectors feeling as though they had no ownership of the service which generated a 'us' Vs them' mentality, rather than a sense of partnership.

"We all have to move into this new scheme. But that's not my decision, so we just have to, guess, do what it's been decided" (Interview: Community Connector 4).

Community Connectors also felt that communication between the different service professional groups has also been impeded by the fact that professional groups were only invited to attend certain Wellbeing Exeter planning meetings specific to them. In other words, they were not attending the same meetings as the GPs (data from observation notes). This meant that potential problems affecting how all the service professionals implemented the service and worked together, such as how and when referrals should be made, could not be resolved together.

Time 2 (follow up) perspectives on coordination within the service

While communication issues were reported on by all the Connectors from the social prescribing organisations, to varying degrees, the tensions between Westbank (the main provider of Wellbeing Exeter and the ICE delivery board were especially prominent in the T2 data. Working relations were tested when the end date for the service approached and the management team were seen to be hesitant to include the community services in the negotiations for an extension. Connectors and other staff members began to become fearful of whether or not their roles would be continued and when they sought information, reassurance or further information was not given.

> *"We've had a lot of kind of upset people because it's been so…different messages from different areas, so I think it was brought up to senior level within [place name] and we were told to just continue with what we're doing at the moment" (Interview: Community Connector 3).*

Implemented (failed) solution (T2 data)

The introduction of new mid-management liaison roles

More levels of staff were added to the management team. These new roles may have been introduced as a means of improving the communication flow between service level professionals and the management staff.

However, service level professionals (the Community Connectors) state that these new layers of management have created a further barrier to communication flow, rather than facilitated it. They felt that face to face contact between themselves and the Executive team was important and that the extra staff layers further prevented this from happening; reinforcing their perception of not being viewed as important to the scheme by the management board.

> *"We haven't even met half the project team. They've never come to discuss what skills have we got, what are the issues we're facing, so that whole disrespect for what we've done in the past, the skills that we've brought into the team, none of it's been recognised" (Focus Group: Community Connectors).*

Take home messages of section 2.0

❖   GP referrals onto Wellbeing Exeter pilot were initially low, but they picked up significantly over time

❖   In house champions and continued reminding from the GP lead about the scheme helped improve referral rates.

❖   To maintain, or further improve referrals these efforts need to be maintained until the service is fully ingrained into each general practice.

❖   Whilst the open referral system appealed to the GPs, it caused a lack of clarity about who the scheme was for and what it offered. This had significant implication for the Community Connectors' work and in some cases their wellbeing.

❖   Community Connectors felt that their specialised skills sets and working patterns should also be considered, alongside geographical location, when allocating them to specific surgeries. This would enable them to contribute more meaningfully to the practice they were assigned to and to provide a more effective service.

❖   Community Connectors connected clients to a range of diverse community support groups and activities.

❖   In addition to the clients to the community groups, the Community Connectors provided additional support to help maintain attendance and maximise the benefit of the organisation's support for the clients.

❖   Coordination within the scheme was affected by a breakdown in relationships and communication between some of the delivery partners and the leadership board.

❖   New system leadership roles were introduced to facilitate relationship building and improve communication flow between the delivery partners and the board. However, these new roles have were viewed by some as a barrier to communication flow rather than a facilitator.

❖   Front line staff ultimately want to be included in decisions regarding the scheme and for their work and expertise to be acknowledged. Face-to-face contact between the board and all the delivery partners would help to facilitate this.

2.1 Has the Wellbeing Exeter Scheme supported individuals to self-manage, reduce their isolation and improve their wellbeing?

The qualitative data, reported below, collected from both the Community Connectors and the Wellbeing Exeter scheme clients suggested that the approach to self-management taken by the Community Connectors had taken into consideration the clients' **readiness** to make such changes. Themes surrounding self-management support were related to either how they helped them to get ready for change, or how they supported them to take the first steps towards self-management. The next section has therefore employed the same distinction to help organise the findings.

2.1.0 How Wellbeing Exeter helped clients to contemplate the possibility of self-managing their condition, improving their wellbeing and reducing their isolation.
Providing time to talk, listen and reflect

Prior to being referred onto Wellbeing Exeter clients had not been given the opportunity to talk, be listened to and to reflect. For example, one client spoke of his frustration that a local service had recently proposed time restraints due to their lack of capacity:

> "If you had a drop-in centre where you could actually offload and somebody could take it on. I'm not expecting answers to say, yes, we can help you, but to listen.There's nowhere that you could go to except the [name of organisation] and [name of organisation] are so compact now that they limit themselves when they're open to do all the paperwork, he told me that. So, after that there's nothing"
> (Interview: client 2).

Such experiences had inhibited clients' abilities to self-manage their own issues and conditions as clients often felt confused about how to instigate change, due to the complexity and impact of their life circumstances and/or condition(s). Furthermore, as Community Connectors noted, it often took extended dialogue before clients clearly and directly present their problems. For example, one client initially stated that she suffered from poor sleep patterns and back pain. However, during extended discussions about when these problems had started, it emerged that the woman had experienced a traumatic event (sudden death of her son) and this had led to her feeling too fearful to leave her home. The psychological ramifications of this event, rather than the physical, was predominantly contributing to her reclusive state.

One-on-one time with a Community Connector who demonstrated active listening had helped the client mentioned above, and others, to reach a realisation about their situation that was necessary before they could start the process of moving forward. As one connector stated,

> "*I think sometimes just listening to people and somebody actually paying attention and being there, it's really powerful. And I've done some coaching or been coached myself and coached other people myself, and I find it a really amazing tool. We call it (…) coaching. But it's basically somebody being there and taking an interest and trying to help to move things forward'*
> *(Interview: Community Connector 3).*

Specific qualities to the listening process that clients reported as helping them to get ready to self-manage their issues and conditions are listed below:

❖ *Talking to someone whose role is to listen: not being concerned about being judged, or about a burden on the person disclosed to*

Some clients suggested that it was important to have a non-familiar person to listen to their concerns, as the act of sharing their concerns to family members and/or friends had negatively affected them.

> "*Was trying to share with my family who were just not understanding, so the frustration was bigger, so I was very tearful a lot of the time*" *(Interview: client 3).*

The providence of a non-judgemental listener was also very important to the clients

> "*The most beneficial thing about getting to know you all is the fact is that somebody's listening, that's…and that you can offload without having a finger pointed to you without saying, oh, you know, you're mad, you're being angry, and I said, well I've got to offload'*" *(Interview: client 2).*

❖ *Evidence of the clients' narratives informing the Community Connectors' recommendations*

One client spoke of how previous health professionals had listened, but has not used their narratives to make suggestions for what next steps should be taken by the client. Arguably creating a sense of hopelessness, rather than a strategy for self-management and improved wellbeing. In contrast, the Community Connectors used the conversations with clients to inform their suggestions and aimed to leave the clients with a set of positive next steps to take.

> "*So all these other people had come along and said, yes, okay, right, what's the problem. I've had three interviews now at the anxiety and depression clinic, and they've said, well, they can't help me*

> *anymore, they can't see me anymore but she's [the connector is]*
> *going to write to me and suggest some type of counselling which,*
> *would just be talking. Just to offload stuff, so that I can see my*
> *friends and be jolly and not be trying to offload, if I offload to*
> *just somebody who'll listen" (Interview: client 3).*

Some clients stated that this simple act of listening, aided the development of a therapeutic relationship between the Community Connector and themselves. Arguably, the specific qualities to how the Community Connectors listened (patiently, non-judgementally, without showing fatigue and with application), were the acts that helped make the listening process contribute positively towards the development of the therapeutic relationship. Such skills are typically developed through the training and experiences that health professionals (such as Community Connectors), receive whilst working in such roles, and consequently, may not be typically utilised in clients' conversations with friends and family. In sum, the Community Connectors' offered a unique type of listening experience, which encouraged clients to think about taking their first steps towards self-managing their health and wellbeing.

Support at the right time

Clients appreciated Community Connectors' acceptance of their attitude towards when services should be accessed i.e. when they felt the time was right. They also felt that this approach was essential to long term improvement and continued engagement with the service.

> *"She's done it very gradually as well over a period of time. It was just*
> *small steps, small steps, and then the steps are getting slightly, you*
> *know, bigger. And it's thanks to her actually because if it had been,*
> *right, I want you to go out there and do this huge thing, I would have*
> *cowered under the table and said, go away, I don't like you. But because*
> *of the way she's done it, it's worked…well, for both of us"*
> *(Focus group: client 3).*

One woman felt she wanted to move forward in her life, but she needed to find the best way to do that first.

> *"One of the things was maybe look to get back into work and look to*
> *have people come in and support mum instead of me taking her*
> *elsewhere, and so looking at other things that would help me to move*
> *forward whilst mum is still here. And that was quite positive"*
> *(Interview: client 3).*

However, she was unsure of what would be the best way forwards and of whether she had the confidence or ability to start this process right now.

"Because I'm a bit older and everything I was like, oh, going back to work, it's going to be so hard and I feel so sad that I gave work up… But because I'm still feeling a bit fragile, and mum's only just gone really, it's the first day of the first week that I'm without her and she's going to be gone for four weeks, which is quite a long time, so it will depend on how I feel at the end of that four weeks, I've got to sort of build my strength. I'm still a confident person really, but I still lack the confidence in areas that I haven't been for a while" (Interview: client 3)

Another client spoke of her need to focus on a trip to visit family abroad (current pressing issues) before she thought about what she needed to do to help herself.

I've got some time to get myself sorted out but, again, it's a big struggle. We've just had permission from the doctor that he can fly' (Interview: client 1)

Continued support for clients, even if they deferred access to services was therefore seen as a positive approach to their problems and one that enabled clients to dictate their own pace towards self-management. This point was highlighted in a follow up interview with the same service user quoted above. She reflected that she was now in a place where she could feel very positive about the future because she had been given time to clear her mind and relax before making any decisions.

"So far it's been excellent I would say; there's lots of support. I am now sort of re-engaging with the service for the next part of our journey with Mum's illness…" (Interview 2: client 4)

Co-creation of a plan of action

One strategy for helping clients to prepare mentally for taking the first steps towards a positive change was the co-creation of a plan of action with the clients. The plan of action is an A4 document that has sections for both the client and the Connector to write down what actions both the Connector and client have agreed to undertake, before their next meeting in order to meet the clients aims or goals i.e. it records the decisions the Connector and the Client reached together. It also has an entry slot for the next meeting data and the Connectors telephone number (a Single Point of Access). The sections are co-completed by the Connector and the client, based on their discussions and shared decision-making. A plan of action was noted to be very important to the self-management process by some of the clients.

"Yes, we did have a plan and it's gone forward very well" (Interview: client 5).

Throughout the clients' baseline reports, social anxiety and loneliness were referenced to as causative agents for their current (negative) state of health, wellbeing and confidence, as well as outcomes; restricting their ability to self-manage their health and social issues. For example, one woman stated that her anxiety had been aggravated by current financial problems. Her anxiety had become so acute, that she had started to hide herself away, unable to answer the door or the phone for fear of who was there. She spoke of keeping her curtains closed and never going out unless she had to. She was also trying to ignore her debt issues by not opening her post.

> "*The door knocks, I do sort of panic and I always look out the window – curtain first, usually it's someone I know, but if you're trying to avoid someone*" *(Interview: client 6).*

> "*[I don't open the post] I just "put it all in a bag" and remove it from sight*" *(Interview: client 6).*

For other clients, isolation and anxiety has been caused by a changing relationship with a loved one i.e. from being a friend/partner to becoming their carer or a partner leaving the relationship. One women talked of feeling very isolated due to her husband's illness of dementia, which prevents him from spending quality time with her. Exasperating these feelings of loneliness is the fact that neither her, nor her husband can drive, so they are unable to drive to places. In addition, symptoms related to her husband's deteriorating mental health, ware in her mind leaving him a changed man, who is unable to engage with her as he used to do due to long periods of absentmindedness

> "*What I miss most is my pal…My pal is in bed or sleeping, can't…he won't do anything outside, won't go down…if…I've got him to come down to [name of town] now and again but it's very rare, probably twice in a year*". *(Interview: Client 1).*

This type of loneliness is difficult to deal with. The client was willing to go out, but felt unable to leave her husband alone, or with a stranger for any length of time. She also thought that service/support group engagement would be impossible due to her local environment, which had no local amenities to hand, and necessitated a long bus journey to any facilities. These concerns were presented at an initial meeting with a Community Connector. The Connector responded to the client's needs (and concerns) by finding a local support group that created an opportunity for people to engage in craft exercises together. As the support

group was close by and at a suitable time (after her husband had gone to bed), the client felt able to leave her husband and attend the sessions. The client appreciated the opportunity to meet with other people who were experiencing similar issues and the Connector helped her to feel confident about attending these sessions and leaving her husband for short amounts of time (see Vignette 2 for more details).

2.2 How Wellbeing Exeter helped clients to take the first steps towards self-managing their condition, improving their wellbeing and reducing their isolation?

The Community Connectors employed a number of strategies for helping clients to overcome these feelings of loneliness and anxiety. These took into consideration some of the potential barriers that clients raised. These strategies are discussed below.

2.2.0 Community Connector strategies for addressing anxiety and loneliness

Active support during initial encounters with new services

Community Connectors would often accompany clients to their initial meetings with community and statutory services that the client had not previously been in contact with and

took notes on behalf of the client. This was highly appreciated by the clients who often lacked the ability to concentrate for long periods.

> "*She writes it all down for me because she knows I just – I sort of sit there and take it in but not taking it in. So yeah and then she texts me afterwards and says, 'this is what we need to do' so she texts me and tells me, yeah. (Interview: client 6).*

The connectors also provided emotional support and a sense of camaraderie, which again was highly valued by clients as it helped them manage anxieties about meeting new people and vocalising their problems to strangers.

> "*She – I don't know. When we are talking, if I start getting anxious when we're with someone, she [the connector] sort of, she like calms, she's just like, 'don't worry, don't get too stressed out"
> (Interview: Client 6).*

The Community Connectors would often arrange for these initial meetings to take place in the client's home. This helped with access issues and helped make the clients feel more comfortable during the encounter.

"Yeah, so she's already planned about me having a bereavement counsellor, and she's been to my house about three times I think, or four, because she also brought the bereavement lady – who's very nice – to introduce me, just short. So she'll be coming for the first time on Friday"
(Interview: client 5).

Being an on-going source of support in between meetings

Due to established rapport between the Connectors and the clients, the clients were able to contact the Connectors and ask for help in between appointment meetings. In one case, for example a client contacted their Connector and asked them for support with filling out financial paperwork that would help her secure debt relief.

"We had to do a form, fill out a form to get a debt relief order… But I couldn't quite work out how to do it so I did text [the connector] and she came round the next day and we went through it together and she did it all and I sent it off" (Interview: Client 6).

Helping clients to engage with relevant services and with others who have had similar experiences

Connectors suggested a range of different services located within the Community that could be relevant to the clients' specific issues and needs. In some cases, the clients were not even aware that some of these services existed and were pleasantly surprised by the type of practical support they could receive.

"Oh, I tell you one thing which [name of connector] did bring to my attention, which I brightened up about. That was a scheme whereby somebody would come along and cook with you.

.....

"Now I felt that was really novel. And I've lived alone for over 30 years, but I've never mastered the art of cooking and never really wanted to, it doesn't interest me. But I've got to provide food. And so that seemed a good idea to me, not only for me but to a lot of people, particularly men, I think, who find themselves they've never had to cook in their lives and then suddenly find they're having to put food in their mouths and that seemed a really practical idea" (Focus Group: client 1).

As mentioned previously, Connectors did not only suggest services, but they also coordinated with the services to arrange visits and transportation. Linking the clients to people who had similar experiences was also important to the Connectors.

"Most of those ladies are in the same boat as me and I was surprised really. I think by going out to it and getting your help is actually showing that this is a much wider...it's not just me on my own thinking that I'm going crazy" (Interview 2: client 1).

❖ *More motivated and optimistic about the future*

One of the clients quoted above, reported that the support she had received from the Connector to address her anxiety and loneliness had not only helped her to achieve her agreed goals, but had also helped her to start to feel positive about her ability to achieve goals on her own in the future. She was consequently feeling very motivated to make further changes.

> "*I just guess I feel more motivated and more supported to go and like and […] what I want to do is achievable if that makes sense"*
> *(Interview: client 6).*

In the client focus group, participants spoke of how they felt more optimistic about the future

> "*I'm quite optimistic about things working out and I haven't felt very optimistic for quite a long time. …. And it seems like things are turning around a bit"* *(Focus group: client 2).*

> "*And, you know, she's…yeah, it's been…for me, like you said, I do feel a lot more optimistic because she's given me some different ideas"* *(Focus group: client 3).*

Their newfound motivation was often linked to the support the Connector provided.

> "*And she's quite a cheerful person and says, why don't you join this, why don't you join that. And after a session with [name of connector] you do feel a bit sort of like, oh, yeah, come on, you can do this, you know*
> *(Focus group: client 3).*

❖ *Empowered to tackle issues, which were previously thought of as unresolvable*

Another client spoke of how the Connector's support had enabled her to change her perspective on what changes she could make to her life. Issues that she once thought of as unresolvable were now being transformed into new goals for her to address.

> "*It's opened avenues for me for thinking. I think some of the avenues that I thought to myself were untouchable, I didn't want to have to have problems inside my head and go along and blubber them all out and, you know, because somebody's triggered it off, or something like that".* *(Interview: client 1).*

Take home messages of section 2.2

❖ Community Connectors' strategies for helping clients to self-manage isolation and anxiety took into consideration clients' readiness for change. Clients appreciated this approach.

❖ The way in which the Connectors listened to the clients demonstrated a range of skills that clients may not have benefited from in everyday conversations with friends and family.

❖ Collectively, the opportunity to talk, reflect and the application of the Connectors' listening skills led to the development of a therapeutic relationship between the Connectors and the clients. It also enabled clients to reach a necessary realisation about when, what and how they needed to start making changes to their lives in order for their anxiety, isolation and general health to improve.

❖ Once clients were ready for change Connectors supported them through the first steps towards a pathway towards self-management, creating a sense of partnership and camaraderie. These pathways involved engagement with community groups and support from external services.

❖ The Connectors' support left clients feeling more motivated and equipped to deal with issues that they had previously seen as unresolvable and encouraged them to make new goals for the future.

❖ Limited third sector capacity delayed clients' attendance to signposted opportunities. In such cases, the Connectors felt a moral responsibility to maintain support for these clients until these services could address their needs.

2.3 Wellbeing Exeter's impact on clients' Health and Wellbeing

2.3.0 Comparison of T1 and T2 questionnaire data

Thirteen out of the 74 participants (working with AgeUK or Westbank Connectors) who completed a time 1(T1) questionnaire filled out the same questionnaire at the T2. This return rate meant that a t-test comparison of T1 and T2 scores would not be statistically meaningful. However, exploring the data through a comparison of the 13 T1 +T2 cases was conducted to detect trends. The comparison of T1 and T2 scores for the clients showed a comparable distribution of results (see Appendix 3).

A stacked relative bar graph was generated to visually demonstrate each participant's change in score on the four measures. The height of the bar indicates the degree of change (y-axis) for each participant (x-axis). Each measure is coloured differently (labels). This allows for a quick assessment of whether a participants score increased or decreased on each measure, and whether that participant's change in measure score is reflected across one, two, three or all four of the measures. It also indicates which of the four measures showed the largest amount of change in each participant. For example, we can see that the first participant showed improvements in all four measures, with the greatest change in loneliness, whereas the fourth participant showed improvements in three measures, with a reduction in the patient activation measure score.

In sum, the data shows that almost all participants improved in at least one Health and Wellbeing outcomes, only two participants did not. Seven out of thirteen participants showed improvement in at least two of the measures, while two of the thirteen participants showed improvement across all four measures. Of the thirteen participants, seven showed improved mental wellbeing, seven showed decreased loneliness, seven showed increased levels of social inclusion and six showed increased levels of patient activation.

However, in five cases clients scores for social inclusion and loneliness worsened and in six cases PAM scores and mental wellbeing worsened. It is important to note that there were no themes relating to symptom deterioration in the clients' qualitative data. Due to the length of time between T1 and T2 questionnaire completion and the shortage of T2 questionnaire data resulting in an inadequately powered sample we cannot draw inferences from this data in relation to the efficacy or otherwise of the social prescribing scheme.
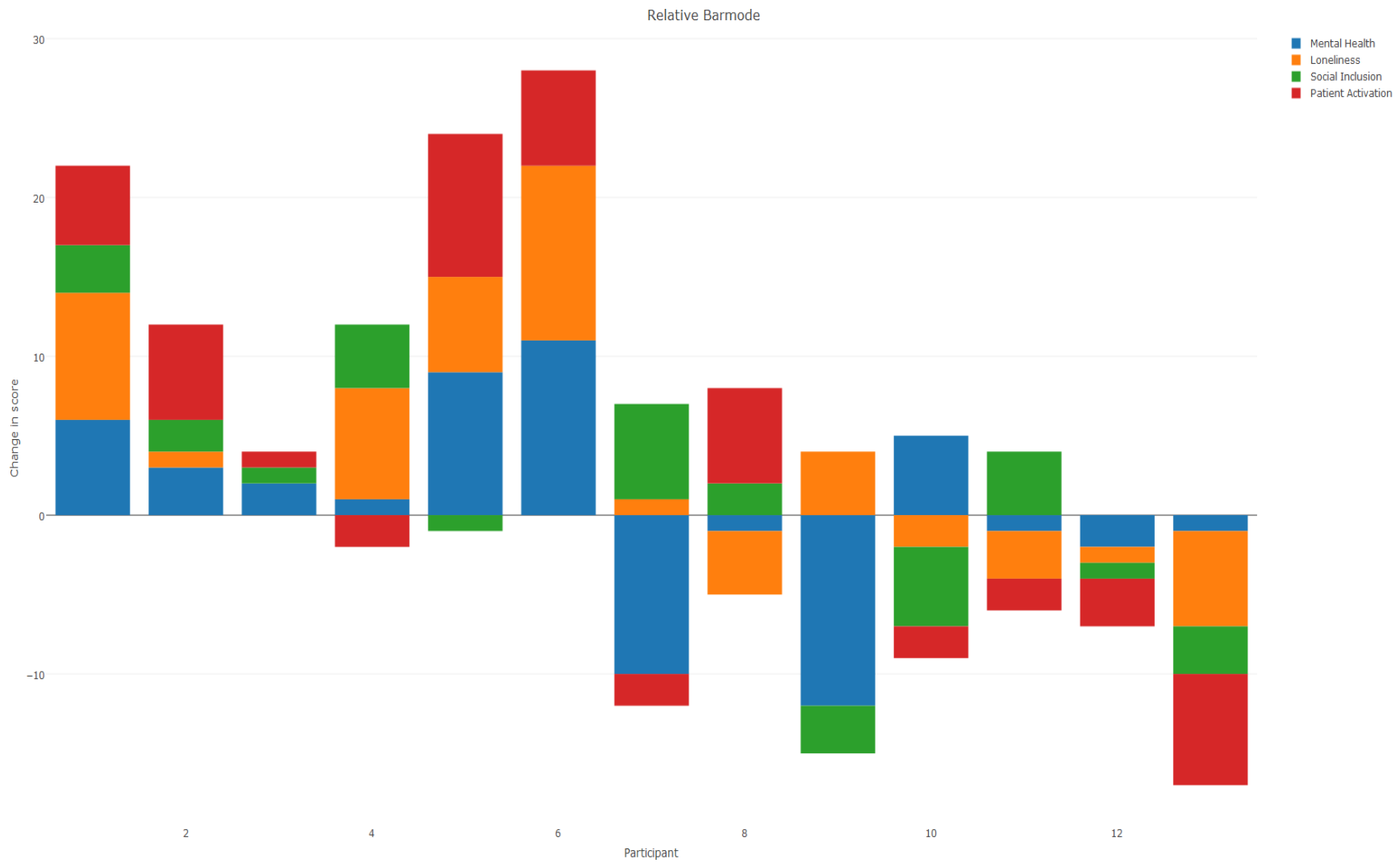
Figure 6: Comparison of T1 and T2 questionnaire scores for 14 follow up cases

2.3.1 Vignettes[6] of Wellbeing Exeter's impact

Follow up interview and questionnaire data from the Wellbeing Exeter clients was limited due to delayed implementation. This resulted in a delay in time 1 data collection and ultimately a narrowing of time between time 1 and time 2 data collection phases. The impact of this was that by the evaluation time period ended within insufficient numbers of people at a stage where time two data would have been due. However, in two instances, clients provided both sets of follow up data. One of these clients (Box 3) also shared their photo journal, which visually illustrated the issues they were facing at the time of referral. The data from both of these clients is presented here as vignette examples of Wellbeing Exeter service experiences, as in addition to providing complete data sets, the themes present in these cases were also highly representative of the themes uncovered from the larger dataset.

Box 2: Vignette 1[6]

	Vignette one
Problem faced prior to referral to the EXETER service	This client was *"at the end of her tether"* with caring for her mum. She was the main carer and had looked after her mum for the past 10 years. Caring for her mum had recently got more difficult due to the progression of her mum's dementia, the increased cost of respite care and a lack of support from her family. She was also increasingly exhausted and *"bored with the monotony of it"*. She spoke of starting to resent her mum for the continued workload and her family for not recognising her need for further support. She said she "was very down about it all and becoming very negative about everything", but was unable to talk to anyone about her feelings. Key themes: at crisis point, lack of support, mental wellbeing being negatively impacted on.
Initial steps taken after the referral	The client met with the connector and felt that she listened to her concerns and suggested a range of possible next steps. At this time point, she had been given a short reprieve of her caring role by her family and she felt she needed time to reflect on how she wanted to proceed with her caring role. She said the connector acknowledged her fragile state and did not press her to make plans immediately, but instead spoke of what might be possible in the future. One suggestion was voluntary work. This would help her to build her confidence level, which she felt had been affected recently *"I'm still a confident person really, but I still lack the confidence in areas that I haven't been for a while"*. Key themes: Listened to, time for reflection respected, suggestions tailored to need.
Progress at T2	At T2, the client was much more positive about how she was going to move forwards. She said the Connector and the service had *"been excellent I would say; there's lots of support. I am now sort of re-engaging with the service for the next part of our journey with Mum's illness…"* The plan now was to look at the additional financial support the client may be entitled to, as the Connector had realised she may not be currently receiving as much as she is entitlement to. She felt more in control of her mother's care, which was now being shared more by the family. This new found decisiveness and authority over the situation was clearly present in the way she spoke: *"Everybody needs to know the sort of care plan and the way forward that we plan to go"*. She also perceived the Connector to be supporting her family's needs as well as her own.

Recorded change in Measurement of loneliness, wellbeing, social inclusion and patient activation		Well being scale	Loneliness scale	Social inclusion	Patient Activation Measure
	WBE2006	27	12	5	54
	WBE2006b	28	5	11	52
	The chart above shows a slight improvement in wellbeing in a period of 2 months. Her sense of (measured) loneliness had dropped from 12 to 5 and social inclusion had also increased y from 5 to a score of 11. Patient activation had surprisingly dropped, however.				

[6] Brief evocative description, account, or episode

Box 3: Vignette 2

	Vignette two
Problem faced prior to referral to the Wellbeing Exeter service	This individual has a long history of poor health issues. Her most pressing concern was the deterioration of her husband's health. His conditions included diabetes and dementia. Her role as carer for her husband has confined her to her own home. **The person's avenue of freedom - the view from outside of their home. The path shows her route away from her home, but at the end it's blocked, restricting her and reducing the scope of her world. Symbolic of how she feels about her role as carer for her husband.** She is unable to drive, due to her own poor health and cannot leave her husband for a long length of time. Cumulatively, these factors have impacted significantly on her feelings of loneliness and isolation. The client talked about how she used to enjoy doing things with her husband, but due to the continued decline in his ability to walk and remember things, she now feels like she no longer has the company of her husband. Instead, she is caring for a stranger. **This is her husband's 'world'. He uses it to buy things associated with his hobbies, such as an online virtual train driving game. The client is excluded from this activity. His preoccupation with the computer and her exclusion from this activity (as well as his dementia) adds to her feelings of loneliness.** She feels her life is now consumed by her husband's illness and she has no time for herself. These feelings of loneliness and isolation have made her feel angry towards the person who she feels she should know and love: *"I've got to do his lunch and I've got to make sure he has a drink then. In my head it's like that all from the time I get out of bed, you know, and some days I just can't cope with it".* The full time role as carer and her own health issues are making her feel exhausted and she is struggling to reconcile with her new role and the impact it is having on her life: *"I'm getting exhausted and tearful, and with the frustration of not being able to walk properly, because my legs are playing up and my feet playing up with damned arthritis, it's just too much for me to deal with two lives. I'm having a hard job with just one and it sounds like it's an old*

	rope, you know, people do it all the time, but it is, this is new to me because I've been an active person but my body's saying… Key themes: Loneliness, changing relationships with loved ones, the impact of taking on a carer's role, anger, struggling to cope.
Initial steps taken after the referral	The connector looked at finding some services, which could support her and tap into her existing interests and explored how problems with accessibility (lack of transport) could be resolved. The Connector listened to the client in a non-judgemental way. Key themes: Suggestions tailored to need, additional assistance with barriers to engagement, non-judgemental.
Progress at T2	At the T2 interview, the client was still finding some of the issues with her husband's health difficult at times. However, she stated she felt less lonely as she had been to a community group (craft session) that the Connector has linked her to. The craft sessions had motivated her to use her own sewing machine again and to explore new areas of crafting. Whilst this had been a significant benefit, the most important advantage to attending the group sessions was that many of the women in the sessions were also going through similar experiences: "*most of those ladies are in the same boat as me and I was surprised really*". **The Connector has encouraged the person to undertake craft activities, both in the home using her equipment and by attending crafting sessions outside of the home.** She also remarked that some of the women did not want to sell or give their crafting items to others. She felt she understood this as "*when you're in the situation that we are in having to care, everything is giving out and out and out. You don't get anything back. So when you've achieved something that's something I suppose nature gives you back, so you hang onto it, you know*". She stated that she would only give her things to those who she knew would respect the true value of it, as she has to give of herself all the time. Although attending a crafting session once a month was not a big change to her lifestyle, it did appear to have made an impact on her mental wellbeing and social inclusion scores at T2 (see comparison between T1 and T2 scores below). Furthermore, the way in which the Connector had listened to her anger problems (non-judgementally) had helped her to acknowledge her anger issues and feel ready to seek help. Consequently, she is going to a schedule an appointment with her GP to discuss about counselling options.
Recorded change in Measurements of loneliness, wellbeing, social inclusion and patient activation	 |	WE	LGS	SI	PAM
---	---	---	---	---
WBE1002	17	15	5	39
WBE1002b	19	15	6	40	 The chart shows a 2-point improvement in wellbeing, a 1 point improvement in social inclusion and a 1 point improvement in patient activation. Her sense of (measured) loneliness has remained static at 15 points. It is possible that loneliness scores did not change as they are associated with her relationship with her husband, whereas the social inclusion score improved as this is related to community engagement, an area of need addressed by the Community Connector.

2.3.2 The value of Wellbeing Exeter

Within the various types of data collected from clients and the health professionals involved a number of participants commented on what they perceived the value of Wellbeing Exeter to be. In some cases, comments may be extensions on themes already expressed in the results section. These are documented below.

Clients' perspectives

2.3.2.1 The Wellbeing Exeter process enables clients to decide when it is the right time for them to take initial steps with new community contacts.

"At the moment it's giving me ideas and whether it can meet my needs and how to get myself introduced into these areas I think the service could do me well" (Interview: Client 2).

2.3.2.2 Offers an additional layer of support external to the usual statutory agencies, which offers different things and delivers their service in a new way.

"I think the service is so vitally important to have it so that you don't have it via the NHS, that you don't have to have it…if you've got any emotional or mental issues, you don't want to go to [place], you don't necessarily want to go with hospitals if you're not happy with hospitals. You want something that's independent from those things"

"That's what really pleased me and why I think it's essential in the country, is that people are more likely to want an approach, something that's away from the health service, whether it's the mental or the physical" (Interview: Client 5).

2.3.2.3 The Community Connectors were highly valued.

"The connector was 'really friendly, really nice, um, and supportive" (Interview: Client 7).

"She [the connector] came round and she was just lovely, she was really nice, yeah, she helped me out so much that day" (Interview: Client 6).

Professionals' perspectives

2.3.2.4 It is helpful as a linking service; enabling people to access to the correct service.

"I think for a lot of patients [the connector] is going to be able to navigate through some potentially difficult agencies, often patients will end up ringing a couple of wrong numbers or they'll be floundering about who it is they need to talk to, and actually, to a certain extent. I know her role isn't necessarily navigating the journey but she should be able to help with that. So, I think she will make it better for patients, yeah. Make it much smoother for them" (GP1).

2.3.2.5 It enables clients to express and prioritise their own needs.

"We'll prioritise their needs. You know, if it's something that they need, I don't know, they need a befriending service…so that if they [the connector] go to somebody's house, and they found they didn't have any food, or a carer had gone into hospital, that they could phone. So, at the moment, my understanding…[is] that we would then pick that up and either try and get a community connector around their straightaway, or get a volunteer, if it was a bit of shopping or whatever. So, we'd use one of our League of Friends volunteers for that" (Staff member from one of the community organisations).

2.3.2.6   GPs stated that they thought the service delivered many benefits for them. It was envisaged that, given time, the service might decrease GP workload. It has also helped to support people who they have struggled to help in the past.

"So the value for the Practice is being connected with voluntary sector organisations, I think they were a massively untapped resource for us, so it's having the connection which in itself is a good thing 'cause that develops relationships locally. And I think probably in terms of other stuff it's just reducing workload and giving GPs and others a useful way to help people who we previously have not really been able to help so much" (GP1)

3.0 Summary

Wellbeing Exeter is a new scheme, which is developing rapidly to meet the needs of clients and is in the process of establishing a presence within the third sector landscape, key relationships and partnerships are being identified and developed.

Wellbeing Exeter had clearly had a positive impact on many of its clients' lives and has been able to achieve its intended outcomes; to improve clients' health and wellbeing. The holistic approach the Community Connectors took with the clients seemed to be key to enabling change to occur. Connectors gave clients the time to talk and reflect in a safe environment. This enabled the connectors to make suitable signposting suggestions, which helped several clients to re-engage with their community. It also allowed clients to reach necessary realisations about when, what and how they needed to start making changes to their lives in order for their anxiety, isolation and general health to improve. Clients also continued to benefit from continuity of care from their Connectors, a rare experience in today's health care system. Individual connectors maintained contact with their clients, supported them through their first steps with services they signposted them to and made sure sufficient support was in place before they began to reduce contact. The sense of security that the continuity of care provided the clients could be the reason behind why clients described the service as being different to other health care experiences and why they begun to instigate change now, but hadn't before.

Identified areas for improvement, highlighted by Community Connectors from all of the social prescribing organisations, have been concerned with the implementation of the pilot service and/or the availability of resources within the community (both voluntary and statutory), rather than its outcomes, which both clients and the Community Connectors felt were being realised.

Whilst successful trouble-shooting efforts had been made for some of these problems (e.g. the triage system to compensate for the lack of knowledge from the referral forms), there were aspects to the service that could still benefit from some further re-design and/or further support. We have identified recommendations in relation to the main areas of concern in the executive summary at the beginning of this report. These have been proposed as suggestions, rather than directives and are intended to help promote solution focused discussions, rather than conclude the conversation.

Three key concerns and associated recommendations were that:

Perceptions about the level of complexity in some of the cases referred onto Wellbeing Exeter is concerning. There should be a shared understanding about what the service offers and who it is for so that GPs can refer more appropriately and there is less risk of patients being bounced back and forth between different health care services.

The community organisation serving as the main service provider has put in place processes, which support their Community Connectors to manage the influx of severe patient cases, which were originally seen as being beyond their remit. Further support for Connectors could include specialised training in areas such as abuse (perpetrators and victims).

Community Connectors could still be further embedded into the GP practices. However, it is important to note that this process takes time and the evaluation only covered the initial phase of the service.

Unfortunately, the evaluation was unable to statically measure Wellbeing Exeter ability to significantly achieve its intended outcomes (reduce loneliness and improve mental wellbeing, social inclusion and patient activation). However, there is an opportunity to use the evaluation as a starting place for further and more extensive measurement and self-reflection, as there seems to an appetite for a measurement system to be embedded into the service. As the Connectors became used to integrating the collection of questionnaire data into their meetings with clients, the first step towards embedding measurement into the service has already been made. In addition to helping the service track change, the collection of data on the key outcomes would also be useful for the clients, as they would be able to monitor their own progress and perhaps become better aware of triggers, which affect their wellbeing and health. The plan of action would be a suitable place for documenting changes in measurement scores,

In summary, and from the data that was collected as part of this evaluation, it would appear that the Wellbeing Exeter was achieving positive outcomes for clients in spite of early implementation teething problems.

4.0 Limitations of the evaluation data

There were some issues relating to the implementation of Wellbeing Exeter and the methodological processes that impeded data collection and the scope of the analysis for the evaluation. They should be kept in mind when reviewing the results section.

Low referral rate at the start of the scheme

Wellbeing Exeter started later than predicted. When it did start, referral rates were initially lower than expected. Some of the reasons for initial low referral rate were that:

- Some of the GP surgeries did not agree to join until a later date
- GPs were initially confused about who to refer and often forget to refer (see section 2.1.1 for further details).
- There was a delay in getting the Wellbeing Exeter referral forms and system ingrained into each surgery's computer system.

Recruitment onto the evaluation and data collection was consequently also delayed, due to the initial low referral rate. Wellbeing Exeter started at the end of November, but the evaluation did not receive their first completed T1 questionnaire until January. The time span of data collection for the evaluation was very short in comparison to standard evaluations (4 months Vs 12 months) therefore any delay to recruitment would always have had serious implications to data collection for this evaluation. Specific details on how it affected data collection are provided below.

Client interviews

The research lead was unable to contact many clients for a baseline (T1) interview during the scheduled T1 data collection period. Consequently, T1 client interviews were conducted at a later date than the scheduled in the evaluation plan. This later T1 interview date had ramifications for the T2 interview date, as it meant that less time would have passed before their T2 interview.

The lack of time that had elapsed between T1 and proposed T2 interviews was noted by some clients. Some clients declined to do the follow up (T2) interview because they felt nothing had happened in relation to Wellbeing Exeter since the T1 interview e.g. they were waiting for services to get in touch.

Another explanation for why no intervention work had been carried out since T1 interviews is linked to one of the qualitative findings we reported on earlier: that clients valued Connectors' willingness to wait until they were ready to start working with them to make

positive changes to their health and wellbeing (see 2.2.1). While, this approach appears to be a key reason for why and how the service was able to achieve its objectives, it unfortunately did not facilitate the collection of follow up questionnaires, as clients were not immediately engaging in Wellbeing Exeter activity. Furthermore, while the mental preparation was necessary for change this was not a recordable outcome through the selected questionnaires, which were matched to Wellbeing Exeter's objectives. Only two T2 interviews were conducted in total and the lack of activity between T1 and T2 interview dates was clearly the main reason for why this was the case.

Questionnaire data
Due to the late recruitment start, the time frame for collecting T2 questionnaire data was notably shortened and the number of clients eligible for competing T2 questionnaires (not enough time had passed since T1 questionnaire completion) was also reduced.

Late inclusion of one of the GP surgeries and community organisations

One GP surgery and the community organisation League of Friends joined Wellbeing Exeter and the evaluation at a later date than the other practices. They worked together, as they felt that their existing close relationship was already working well. While this partnership did integrate the Wellbeing Exeter process into their system, they operated independently of the other delivery partners. Their late inclusion also resulted in delayed referrals. T1 data from this League of Friends-GP surgery partnership was not returned to the lead researcher until the evaluation was substantially underway. The Connector attached to this partnership was unable to present many T1 questionnaires and there was no time for any client interviews or follow up (T2) questionnaires to be obtained. In sum, whilst the T1 questionnaires returned from this branch of Wellbeing Exeter have been analysed with the other questionnaires, and the connector did attend the focus group, we have little information to examine if there is any difference between the separate branches of Wellbeing Exeter.

Date retrieval methods

As Community Connectors recruited and collected data on behalf of the research lead, it was difficult for the research lead to drive data collection and pursue T2 follow up questionnaires. However, due to the nature of, and processes within the intervention being evaluated it would

not have been possible for the lead researcher to have recruited or collected the questionnaire data.

The evaluation was focused on whether Wellbeing Exeter was achieving its intended outcomes and on whether the scheme was implemented as planned. Consequently, data was collected from the practitioners delivering the service and the clients. As the ICE Programme Delivery Team were not directly involved in the delivery of the service, they were not interviewed for this evaluation. However, the frustrations identified regarding direct communication between Westbank managers and the ICE Programme Delivery Team was a predominant theme within the qualitative data collected, it would therefore be irresponsible to not highlight this within the report. However, to present a more balanced perspective on this finding we acknowledge that it would have been desirable to conduct interviews with members of the ICE Programme Delivery Team, but the nature of this rapid evaluation made this unfeasible within the time frame. Had we been able to do this it would have enabled the analysis to provide a complete representation of the professional stakeholders' perspectives on this issue. To mitigate this we have included a number of clarification comments provided by the ICE Programme Director at the end of this report. We have not included these in the body of the report because they are not research findings.

5.0 Responses to the report by the ICE Programme Director

<u>Executive Summary</u>

❖ Pg. 2 - The implementation of Wellbeing Exeter (point 1 – GP referrals)

Report text: GP referrals to the social prescribing service were initially low, but they picked up significantly as time passed and after steps were taken to increase referral rates.

Response: *"The role of the Wellbeing Exeter operational network co-coordinator was equally critical enabling face to face conversations and relationship building at General Practice level".*

❖ Pg. 2 - The implementation of Wellbeing Exeter (point 2 – open referral system)

Report text: The open referral system (lack of an eligibility criterion) was deliberately designed to create a scheme that offered something for the whole community, irrespective of age and condition and was popular with GPs. However, it did cause a lack of clarity about who the service was aimed at and what it offered. This had significant implication for the Community Connectors' work and in some cases they felt that this affected their wellbeing at work

Response: *"This issue is being resolved through the network co-ordination meetings where issues of concern are raised and addressed through the workforce training and development programme".*

❖ Pg. 2 - The implementation of Wellbeing Exeter (point 3 – limited community capacity)

Report text: In some cases limited community capacity delayed clients' attendance to recommended opportunities. In such cases, the Connectors felt a moral responsibility to maintain support for these clients until the community groups and statutory services could address their needs.

Response: *"However, the quantitative data (collected and analysed by the Wellbeing Exeter programme leadership) suggests that as the Connectors have become more*

closely involved and aware of what the local community offers and this does not appear to have had a significant impact on caseload or length of active participation in the scheme".

❖ Pg. 2 - Conclusions (point 2 – opportunities for improvement)

Report text: The qualitative data suggests that Wellbeing Exeter is delivering improvements in important outcomes. However, it also indicated that there were opportunities to improve communication and the implementation of the scheme.

Response: *"Feedback from all delivery partners has been collated by the programme leadership as an integral part of the project and issues and suggestions for improvement have been addressed throughout the life of the pilot. By the time of publishing this report they key issues identified by the Plymouth research have been resolved".*

Results
❖ Pg. 20 – 2.1: What were the Key processes underpinning the service implemented as planned? (*An un-unified uptake and knowledge of the referral process*)

Report text: Although the referral process had been decided in the planning phase of the intervention, there were clearly communications issues and teething problems between different partners. An example is the delay in getting the referral forms into GP practices.

Response: *"GPs challenged the amount of information being asked for by some of the delivery partners and they strongly advocated for only the Wellbeing Exeter logo being on the forms so as not to confuse patients: there was some initial resistance to this from some delivery organisations".*

❖ Pg. 20 - 2.1: What were the Key processes underpinning the service implemented as planned? *(Difficulties remembering that there was a service to refer onto)*

Report text: Participating GPs, in contrast, focused on factors that impeded the

decision to refer, rather than on the process itself when discussing the referral system. One particular problem, which was unsurprisingly more prevalent at the beginning of the intervention, was that GPs often forgot that there was an opportunity to refer onto Wellbeing Exeter. This, arguably, could have been the main reason for why referral numbers were so at the start of the intervention (21 referrals in first 4 weeks out of 299 in 6 months – data from correspondence with Westbank).

Response: *"These early teething troubles have not impacted on the overall delivery of the scheme as evidenced by the growing referral profile and the GP's advocating for continuation and expansion of the scheme and other voluntary and community sector organisations wising to join as delivery partners".*

References

Pinpoint Comm8unity services in Devon (2017). AgeUK Exeter. Accessed at:
https://services.pinpointdevon.co.uk/kb5/devon/services/service.page?id=zJQ3foUxrBA on
June the 21st, 2017.

CORC. (2011). WEMWBS Population Norms in Health Survey for England data 2011.
Accessed at: http://www.corc.uk.net/media/1243/wemwbs_populationnorms2011.pdf on May
the 10th, 2017

Devon County Council. (2011). *Census Profile*. Accessed at:
http://www.devon.gov.uk/census_profile-exeter.pdf on May 10th, 2017.

Pinpoint Community Services in Devon (2017). Estuary League of Friends. Accessed at:
https://www.pinpointdevon.co.uk/ on June 26th, 2017.

Health Education England (2016). Social prescribing at a glance, North West England.

Husk, K., et al (2016).What approaches to social prescribing work, for whom, and in what
circumstances? A protocol for a realist review, *Systematic Reviews,* **5**:93

Integrated Care Exeter (2017) Integrated Care for Exeter Review Draft June 2017 Accessed
at:
http://democracy.devon.gov.uk/documents/s7662/Integrated%20Care%20for%20Exeter%20
Review-%20June%202017.pdf on June 21st, 2017.

Kimberlee, R. (2016) What is the value of social prescribing? *Advances in Social Sciences
Research Journal*, 3 (3). pp. 29-35.

Callaghan, L., Shenton, D., Maramba, I & Lloyd, H. (2016). A rapid evaluation of two
models of social prescribing in Exeter: the St Thomas ICE Project and the Wellbeing Referral
Service. Un-published report by Plymouth University.

The Kings Fund (2017) *What is Social Prescribing?* Accessed at:
https://www.kingsfund.org.uk/topics/primary-and-community-care/social-prescribing on 5th
May 2015.

Westbank (2017) Our Story. Accessed at https://www.westbank.org.uk/our-story on June
21st, 2017.

Appendix 1: Flow chart of Wellbeing Exeter's evaluation client pathway

Referral process

GP from a participating practice decides whether patient is eligible and would benefit from Wellbeing Exeter

If a referral is made, a social prescription (referral) is sent to either the delivery partner Westbank or League of Friends (LoF). The receiver of the referral enters the details of the case onto their database; assesses whether they can accept the referral and assigns coordinators to the case. If the referral is inappropriate, the GP is made aware that this is the case

Intervention

Community Coordinator) makes appointment with participant for guided conversation

If the patient declines the service, the GP is made aware and the case is closed

Cooordinator and client meet – they discuss which services and support may be most helpful. Connector sends update and (if requested) informs GP surgery. Number of meetings between client and Connector vary from client to client, but typically will span across a few weeks.

Client exists the service when the support initially agreed to is in place. The connector informs GP that the case is closed

Evaluation

At the second appointment the Connector introduces the evaluation and seeks consent from the client. If consent granted, Connector collects questionnaire data from the client. Data sent directly to researcher.

If permission given, researcher contacts client about participating in an interview and photo diary –data collected.

Follow up questionnaire with participant within 3 months of baseline questionnaire completion.
Follow up interview, photo diary and focus group data collected

Appendix 2: Methods

Data used to assess whether Wellbeing Exeter has been implemented as planned and whether the intended outcomes of the Wellbeing Exeter intervention have been realised.

Data collected from a set of patient-reported measures

One questionnaire was given to client participants to complete at two different time points. Time 1 (T1) was when they first joined Wellbeing Exeter and time 2 (T2) was one month after they had completed the T1 questionnaire. The questionnaire requested demographic details and details of their current state of wellbeing (Warwick Edinburgh Scale); loneliness (De Jong Scale); social engagement (SI scale) and the degree to which they self-manage their health (PAM). These different states all mapped onto the core outcomes that Wellbeing Exeter wanted to improve. To measure each of these different outcomes, an existing measure (questionnaire) that reliably tapped into each targeted state/outcome was selected and integrated into the one evaluation questionnaire. The measures used to assess the intended outcomes of Wellbeing Exeter are listed in Table 6, alongside an accompanying statement detailing what they will assess and some descriptive details about the measures.

Table 6: Measures for the Wellbeing Exeter evaluation

Measures (Questionnaire)	Assesses	Comments
De Jong Loneliness	Whether an individual becomes less lonely	De Jong Loneliness questionnaire has 6 items, has been validated and is well used
Short Warwick Edinburg Mental Wellbeing Scale (SWEMWBS)	Whether an individual's level of wellbeing improves	SWEMWBS has 7 items, is well used and has been validated
Three questions[8] from the Social Inclusion (SI) scale	The level of engagement an individual has within their community	SI discusses aspects of interaction within community settings

Qualitative data

Client participants

Seven clients were to be interviewed twice; once at the start of the referral process (T1) and then either at the end of the participants contact with Wellbeing Exeter, or at 6 months, whichever (T2) time point came first. This would give a total of 14 client interviews for the evaluation. The selection of clients for interviewing would be based on: a) whether a

---

[8] Not all of the SI's questions were directly relatable to the aims of Wellbeing Exeter e.g. 'I felt it was unsafe to walk alone in my neighbourhood by daylight" and 'I felt free to express my beliefs (e.g. political or religious beliefs)'. Consequently, the three questions that focused on an individual's level of self-motivation, social engagement and wellbeing were just selected for this evaluation.

participant indicated that they would be happy to contacted about the possibility of being interviewed (option given in consent form) and b) whether an individual's involvement could widen the level of diversity within our interviewee sample (e.g. in terms of their age, type of long term disability, level of education etc.)

Semi structured interviews were used to allow comparisons across the data, but also personalised issues of interest to each participant to emerge. The T1 interview schedule included questions about their experience of the service so far; what problems they were getting support for and how these problems had been affecting them prior to their referral. The T2 interview schedule focused on their extended experience of Wellbeing Exeter and its impact on their lives.

Interviewed patients were also asked to keep a photo journal/ diary of their experiences. It was hoped that these diaries would add a deeper level of understanding to the longitudinal analysis of participants' experiences, help inform our patient interviews and empower the participants to have a more active role in the evaluation. A focus group with clients, who had not been interviewed, was also collected towards the end of the evaluation, so that clients' perspectives could be compared and contrasted further during the analysis. The schedule for the focus group drew on the questions from the T1 and T2 interview schedules.

Health professionals
Three GPs were due to be interviewed about how Wellbeing Exeter was being implemented, their role in Wellbeing Exeter, what benefits they thought Wellbeing Exeter might offer patients and their practice (outcomes) and what may facilitate or impede its aims from being realised when Wellbeing Exeter first started (T1). A focus group with 7 GPs (a GP from each practice) would then be scheduled for the end of the evaluation (T2), to explore whether their T1 perspectives had changed or persisted and to gather reflections on how the service may have evolved since T1. The same amount of data, at the same time points, was also due to be collected from Community Connectors. However, the interview and focus group schedules (questions) were modified to suit the professionals' different role within Wellbeing Exeter.

All of the qualitative approaches used to collect data from both participants groups (staff and clients) are listed in Table 7, alongside an accompanying statement detailing what each type of data intended to explore and when it was due to be collected.

Table 7: Qualitative approaches for data collection from participants

Qualitative approach	Purpose of data collection	Time points for data collection
Interviews	Whether the individual has experienced person centred coordinated care before joining wellbeing Exeter and during Wellbeing Exeter	These questions will be asked at baseline and end of contact or 6 months
Interviews with Diary and photos	The journey of individuals through the process to better understand the individuals experience	Interviews to be taken throughout the individuals access with the service
Interviews with staff (Connectors and GP's)	During interviews we will ask whether any of the above has changed between data collection time points	At baseline, end of contact or 6 months

Recruitment

Recruitment process

Ethical approval was sought and obtained through Plymouth University's Faculty Research Ethics Committee (FREC). Every Wellbeing Exeter client (referred patient) was invited to participate in the evaluation at the second meeting with his or her allocated Community Connector. The Connectors recruited the clients on behalf of the research team. Clients were given information sheets about the evaluation and if they agreed to participate were asked to complete a fill in a consent form. Once consent had been collected, the Connectors asked the clients to complete the evaluation questionnaire via a Tablet. Clients who felt uncomfortable about using about using the Tablets were given a paper version of the questionnaire and a return envelope. Clients were encouraged to answer without support from the Connector. The data from the electronic version was downloaded to the research team once the Connector had internet access. Consent forms and paper questionnaires had the same anonymised ID label, so that they could be sent separately and respondent identification could be avoided. A question within the consent form asked clients if they would mind being contacted about the possibility of being interviewed. Every client who ticked the yes box to this question was contacted by the research team. As only 7 client participants were required to take part in the interview stage, and due to the low numbers of people being referred at the start of the process, every client who was contacted about being interviewed was asked to take part.

Potential health professional participants were asked to participate over the telephone, by email and at the end of scheduled Wellbeing Exeter meetings. Information sheets and consent forms were also issued and collected from this participant group.

Data collected

Table 8 compares figures on how much data was targeted and how much data was actually collected for analysis. The extent of the difference between the two vary for each type. Reasons for the variations are included in the Executive summary.

Table 8: Comparison of figures for data targets and data collected

		Targets for data collection	Data collected
Questionnaire data			
	T1	All clients asked to take part in questionnaires at baseline	74 clients answered questionnaires
	T2	If one month had elapsed since the completion of a T1 questionnaire the client was asked to complete a T2 questionnaire	13/74 completed a T2 questionnaire
Clients' qualitative data			
	Interviews	7 Interviews	6 Clients were interviewed
	Photo journals	7 Clients to take part in photo journals	2 clients provided follow up journals
	Focus Group	6-8 Clients to take part in one focus group	3 Clients took part in one focus group
Professionals' qualitative data			
	GP interviews	2-4 GP s to be interviewed at T1	2 GP interviewed at T1
	GP Focus Group	6-8 GPs to take part in focus group	4 GPs took part in the focus group
	Service provider staff interviews	2-4 Interviews at baseline with staff	3 Interviews at T1
	Service provider staff focus groups	Between 6-8 participants in a focus group	7 took part in a focus group

The analytic process

The questionnaires

Four sections within the questionnaire tapped into the four different states/outcomes Wellbeing Exeter was focused on. Each section was independently scored. A score for each question, in each section, contributed to a cumulative total for each section (outcome). Scores on the loneliness scale were converted into either 1 (lonely) or 0 (not lonely) before being added. High scores of mental wellbeing, social inclusion and patient activation were considered good, high scores on the loneliness measure were considered bad. The relationship between each score was then compared through SPSS to see whether they correlated. T1 scores for the client who completed the questionnaire at baseline were then aggregated. Demographic details of the 72^9/74 participants who provided these data were also collated through SPSS software.

There was insufficient T2 follow up questionnaire data (13 out of the baseline 74) to conduct a t-test analysis of Wellbeing Exeter outcomes (please see limitations in the Executive summary). However, a basic comparison of T1 and T2 scores for the 13 clients who did complete a T2 questionnaire was conducted and is presented in the results section 2.3.

Interviews, Focus Groups and Photo diaries
All of the audio recordings of the interviews and focus groups were transcribed. NVivo software was used to store, manage and analyse the data. The lead researcher applied a thematic analysis approach to the two sets of participant (professionals and clients) data. See Box 4 for a summary of some of the key steps taken during a thematic analysis.

Interview and focus group data for each time point (T1 and T2) were analysed separately, compared and then integrated. Follow up interview and questionnaire data from the Wellbeing Exeter clients was not as forthcoming as hoped. However, in two instances, clients provided interviews, T1 and T2 questionnaire data. In addition, one of these clients shared their photo journal, which visually illustrated the issues they were facing at the time of referral. The data from both of these clients was collated and presented as client case study examples of Wellbeing Exeter.

In addition to the data collected from focus groups and interviews with the health professionals involved in Wellbeing Exeter, ethnographic observational notes at relevant meetings with all professional groups were collected. These provided context to the data and were used to supplement points made within the results section and the discussion.

---

[9] 2 Participants who completed the T1 questionnaire omitted this data

Box 4: Key steps taken during a thematic analysis

Key steps taken during a thematic analysis

❖ *Coding each segment of talk.*
This involved applying a descriptive term (code) to each distinguishable unit of talk. Codes were either:
Deductive – predetermined, based on the aims of Wellbeing Exeter and the objectives of the evaluation e.g. establishing barriers and facilitators to implementation, or **Inductive** – generated from the data e.g. 'non-judgemental'

❖ *Establishing themes*
Once all the transcripts were coded, the lead researcher looked for themes within and across the interview data set e.g. 'communication'. These themes were then refined and reviewed over several stages, enabling themes to be collapsed into each other and/or for new themes to emerge from one theme.

❖ *Exploring links between themes*
Links between themes were explored and the overall story/message that the themes present was considered. This involved looking at deviant cases as well as the recurrent themes within the data set.

Appendix 3: Demographics for time 2 evaluation participants

Age	f	%	Gender	f	%	Ethnicity	f	%	Marital	f	%	Employment †	f	%	Accommodation	f	%
18-20	0	0.0	Male	2	15.4	White British/Irish	11	84.6	Married	7	53.8	Paid employment	2	12.5	Owned property	8	61.5
21-29	2	15.4	Female	11	84.6	Black British	0	0.0	Divorced	2	15.4	Self-employed	0		Supported housing		
30-39	1	7.7	Missing	0	0.0	White Other	1	7.7	Single	1	7.7	Supported employment	0		Hospital		
40-49	1	7.7				Other Asian Background	0	0.0	Civil partnership	0	0.0	Voluntary	1	6.3	Rented (HA)†	1	7.7
50-59	1	7.7				Missing	0	0.0	Cohabiting	1	7.7	Unemployed	0		Rented (private)	2	15.4
60-69	3	23.1							Widowed	2	15.4	Retired	6	37.5	With friends/family		
70-79	0	0.0							Separated*	0	0.0	Unable to work	1	6.3	Other	1	7.7
80+	5	38.5							Missing	0	0.0	In Education	0		Missing	1	7.7
												Looking after family	6	37.5			
Total	13	100.0		13	100.0		13	100.0		13	100.0		16	100.0		13	100.0

* Separated but legally married.

† Housing association