South West Academic Health Science Network Summary report on the evaluation of ‘Wellbeing Exeter’ the Integrated Care Exeter Social Prescribing project.
This report includes findings from the Plymouth University Peninsula Schools of Medicine & Dentistry work and results of the data analysis undertaken by South West Academic Health Science Network (SWAHSN) with the help of Devon County Council Public Health Intelligence team and North Eastern and Western Devon CCG Business Intelligence team.

Plymouth University were commissioned to undertake an evaluation of the Integrated Care Exeter (ICE) Social Prescribing project (known as Wellbeing Exeter) by the SWAHSN reporting in 2017. This work extended a previous rapid evaluation of the initial ICE Social Prescribing pilot undertaken in 2016. 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 SWAHSN provided 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 options within their community, which is typically initiated by a referral from a primary care health professional (Husk et al., 2016*).

Through social prescribing 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 social prescribing service which is a way of empowering individuals to improve their health and wellbeing and social welfare by connecting them to non-medical and community support services.

# Table of Contents

**Executive Summary** ........................................................................................................... 4  
**Main report: Introduction** .............................................................................................. 7  
- Integrated Care Exeter (ICE) ................................................................................. 7  
- ICE’s Social Prescribing Pilot .................................................................................. 7  
- Wellbeing Exeter: a holistic approach to Social Prescribing ..................................... 7  
- Description of the Wellbeing Exeter model ............................................................... 8  
- Key aims of the Wellbeing Exeter evaluation .............................................................. 10  
**Results** ......................................................................................................................... 11  
**Summary** ....................................................................................................................... 32  
**Appendix 1** ................................................................................................................... 34  
**Appendix 2** ................................................................................................................... 34  
**Appendix 3** ................................................................................................................... 37  
**Appendix 4** ................................................................................................................... 38  
**Appendix 5** ................................................................................................................... 41
Executive Summary

Key findings from the qualitative evaluation conducted by Plymouth University

Outcomes of Wellbeing Exeter social prescribing

- Community Connectors connected clients to a range of opportunities within the community that were tailored to their individual needs.
- Community Connectors’ approach to supporting clients and the way they supported them helped clients to feel ready and make the first steps towards positive change.
- Clients’ narratives showed improvements to their mental wellbeing being, social engagement and 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 service were initially low, but they picked up significantly as GPs became more confident in the social prescribing offer (note 1).
- The open referral system (lack of an eligibility criterion) was deliberately designed to create an offer for the whole community, irrespective of age and condition and was popular with GPs. However, this did cause some concerns for some of the Connectors employed by delivery organisations who were used to working with particular groups. For some, the open referral system represented a significant change in practice and in a minority of cases resulted in some individuals initially feeling that this affected their wellbeing at work (note 2).
- In some cases, limited community capacity delayed client’s access to appropriate opportunities. In such cases, the Connectors felt a moral responsibility to maintain support for these clients until the community groups could address their needs (note 3).

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 and one-on-one work, the scheme is 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. It also indicated that there were opportunities to improve communication and the implementation of the scheme (note 4).

Recommendations

Establishing a shared understanding about who the service is aimed at
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.

**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. There is a great deal of existing experience and skill within the Connectors team. Connectors suggested in their data, that these experiences and skills could be more effectively matched to GP practices need 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.

**Collect data on why patients declined the referral to Wellbeing Exeter**

Data on the total number of patients who had declined the service and the reasons why were not available to the research team, GPs felt that it would create an administrate burden to collect this data. 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 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 either have 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 kept 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.

**Co-design of new communication strategies**

As in any collaboration, effective communication 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.

**Limitations of the work**

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. Frustrations identified by the University researcher regarding direct communication between Westbank and Age UK (Exeter) managers and the ICE Programme Delivery Team was a theme within the qualitative data collected. To present a more balanced perspective on this finding the research team 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 they been able to do this it would have enabled the analysis to provide a complete representation of the professional stakeholders’ perspectives on this issue.
Response from the Programme Board Director:

Note 1: Extensive communication between the participating GPs and the Wellbeing Exeter programme leadership was critical to establishing the right conditions for the scheme to flourish. 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.

Note 2: 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.

Note 3. Data collected and analysed by the Wellbeing Exeter programme leadership suggest that as the Connectors have become more closely involved and aware of the local community offers, this does not appear to have had a significant impact on caseload or length of active participation in the scheme.

Note 4: 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.
Main report: Introduction

Integrated Care Exeter (ICE)
Established in 2014, ICE was 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 aimed to shift the focus from “patients” to “people”, and from “What is the matter with you?” to “What matters to you?”

ICE’s Social Prescribing Pilot
One way in which ICE aimed to achieve its aforementioned objectives, was through the introduction of a new social prescribing scheme. 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, 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 GPs 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.

“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. So, the 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 sense of 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 ‘SP Holistic’ service, a more advanced model of social prescribing. Figure 1 provides the key processes within Wellbeing Exeter, alongside the (edited) associated features of a ‘SP holistic service’, to illustrate how the former maps onto the latter.
**Figure 1**: A comparison of key processes within Wellbeing Exeter and Kimberlee’s (2015) *template model of a ‘SP holistic service’*

<table>
<thead>
<tr>
<th>A selection of features from the SP Holistic model (Kimberlee, 2015)</th>
<th>Key processes within the Wellbeing Exeter social prescribing scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong></td>
<td>GPs make a referral to a community (third sector) organisation, who is serving as a social prescribing provider, by completing an electronic referral form.</td>
</tr>
<tr>
<td>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.</td>
<td>The social prescribing providers are established organisations with expert knowledge of the local assets within their community.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>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 or they choose to stop engaging.</td>
</tr>
</tbody>
</table>


**Description of the Wellbeing Exeter model**

Wellbeing Exeter, has developed from two 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...
(Exeter), Estuary 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. Devon Community Foundation was appointed as overall delivery lead 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, and Exeter Community Initiatives managed a parallel community building programme in seven Exeter neighbourhoods. 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.

Figure 2: The diagram below summarises information about these organisations.

**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.

<table>
<thead>
<tr>
<th>AgeUK Exeter</th>
<th>Westbank</th>
<th>Estuary League of Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>“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).</td>
<td>“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).</td>
<td>“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).</td>
</tr>
</tbody>
</table>
The role of the community connector is described in figure 3.

**Figure 3:**

*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 they 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 forms of community engagement 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.

**Key aims of the Wellbeing Exeter evaluation**

The overall aims of the evaluation were to describe how the (extended) social prescribing intervention is being 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.

(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 reported separately. See Appendix 5.
Results
What were the key processes underpinning the service implemented as planned?

<table>
<thead>
<tr>
<th>Key processes underlying the delivery of Wellbeing Exeter:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The referral process</td>
</tr>
<tr>
<td>- Community Connectors working with GP Practices</td>
</tr>
<tr>
<td>- One-on-one contact between clients and Community Connectors</td>
</tr>
<tr>
<td>- Connecting to existing community resources</td>
</tr>
<tr>
<td>- Coordination within the scheme</td>
</tr>
</tbody>
</table>

This section explores how each of the key processes underpinning the scheme are 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).

Referral Process
As planned, GPs from the participating practices continue to refer patients onto the Wellbeing Exeter scheme. Decisions on who to refer are based on the GP’s 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 the providers.

For the period that this report covers (November 2016 to March 2017) there have been 299 referrals from GPs to the two delivery partners (three from January 2017, when Estuary League of Friends in Topsham joined) whose data we had access to, with different referral rates between the participating GP surgeries (Table 1). For example, whilst GP Surgery 1 has referred 113 patients in total, 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 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 (between 20-40 patients) and which, in combination with surgeries 1 and 8, gave a mean referral (total) score of 36.

Some 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.
Table 1: Referral figures to Wellbeing Exeter (2 delivery providers only) November 2016 to March 2017.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate referrals and why</td>
<td>1 patient should have been referred to Bowel Management Service</td>
<td>1 patient unaware referral had been made – declined service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number November 2016 to March 2017</td>
<td>113</td>
<td>31</td>
<td>46</td>
<td>28</td>
<td>24</td>
<td>32</td>
<td>22</td>
<td>3</td>
<td>299</td>
</tr>
<tr>
<td>Number at March 2017</td>
<td>41</td>
<td>14</td>
<td>20</td>
<td>15</td>
<td>15</td>
<td>22</td>
<td>16</td>
<td>1</td>
<td>144</td>
</tr>
<tr>
<td>Number of Closed cases</td>
<td>72</td>
<td>17</td>
<td>26</td>
<td>13</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>2</td>
<td>155</td>
</tr>
<tr>
<td>Number Not taken up service yet (+ reason)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>On hold due to patient’s family commitments</td>
</tr>
</tbody>
</table>

Demographics and Time 1 questionnaire data of referred clients

Demographics (see Table 2 in Appendix 1)

**Age:** The (participating) clients (n=72) 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 %)

**Relationship status:** The majority of our client cohort were not in a current relationship at the time of data collection (57.5%). 41.2% 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.

There were 74 participants at T1 in total, 72 of the 74 these gave demographic details
A minimal amount of data of client’s ages was missing, therefore, the male and female percentages do not equal 100%
Missing data, means that the comparable scores do not add up to 100%

**Occupational role:** 68.1% of the client cohort did not appear to have an occupational role 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 (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.

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 collection.
Questionnaires were given to client participants to complete at two different time points. Time 1 (T1) was when they first joined and Time 2 (T2) one month after they had completed T1 questionnaire.

**Time 1 Cohort scores on loneliness, mental wellbeing, social inclusion and patient activation**

**Time 1 cohort scores (see Appendix 2)**

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 is being referred patients with the types of problems that they aimed to address and improve.


**Referral Process Feedback**

**Issues reported as impeding the referral process during baseline data collection**

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. The ICE Programme Director has explained that 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 and some subsequent delays in referral paperwork being available. 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 initially unavailable 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 to**

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 to Wellbeing Exeter. This, arguably, could have been the main reason for why referral numbers were so low at the start of the intervention. (note 5)

**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 to Wellbeing Exeter, as there was a lack of clarity on what issues/conditions the programme 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 people eligibility criteria 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 (T2) follow up perspectives on issues presented in Time 1 (T1) data**

**Difficulties remembering that there was a service to refer to**

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).

**A lack of clarity regarding who should be referred**

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 the remit of a voluntary sector service” (Focus group, Community Connector 2).

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.

“But 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 client’s backgrounds and issues. The time and knowledge to prepare could have been helped by GPs giving more case specific details on their referral forms. This would have helped to better match the Connector with the best-matched skills and experiences to the client and to ensure that sufficient support for the allocated Connector was put into place.

Whilst viewing such cases as being beyond the remit of social prescribing, 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 (note 6).

Response from the Programme Director

Note 5. These early teething troubles have not impacted on the overall delivery of the scheme as evidenced by the growing referral profile and the GPs advocating for continuation and expansion of the scheme and other voluntary and community sector organisations wising to join as delivery partners.

Note 6. This particular issue was raised early on in the pilot through the network leadership. Delivery providers were reminded that they were expected to return referrals back to the GP that they felt
were inappropriate. The number of inappropriate referrals remains very low, the leadership team have concluded that this is as a result of a number of reactions including:

- Better understanding of the purpose of social prescribing amongst GPs.
- Regular individual supervision helping deal with the emotional burden of working with people with complex needs and life histories and ensuring safeguarding protocols are in place and used.
- Improved triaging and allocation of referrals.
- Increased confidence of Connectors through experience and training of working with a wider range of people with a wider range of social issues than they had previously been to.

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 approach, 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).

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 Connectors and become familiar with what Wellbeing Exeter provided.

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.

One-on-one 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 client’s 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. 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, 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 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.

**Connecting to existing community resources**

During the evaluation period, 375 referrals were made to community organisations by the two delivery partners involved, the focus of this section is on what type of referrals were made.

Table 3 breaks down the type of connecting referrals made, by assigning them to a sub-group pertaining to the schemes objectives. As some clients were connected onto more than one type of activity the total (375) exceeds the number of GP referrals (299). Table 3 shows that clients were noticeably connected to services related to the category: ‘**Good physical, emotional and mental health and wellbeing**’ the most (260 out of 375). In comparison, clients connected to services relating to **housing** issues the least (15). 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 connecting referrals, n=375

<table>
<thead>
<tr>
<th>Referral Category</th>
<th>GP Surgery Referrals</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A place of my own:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>housing and housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>support Improved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>access to suitable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>housing Increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>access to housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>support Increase</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>access to support or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>adaptations to remain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>at home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good physical,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>emotional and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>mental health and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>wellbeing Reduced</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>isolation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved strategies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>for living well with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>physical /mental ill</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased healthier</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>lifestyle choices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased transport</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FinancialSecurity,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>employment and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>welfare benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased access to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and budgeting advice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved access to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>debt management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>support Increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>opportunities for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>employment or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Safe and sound:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>knowing someone is</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>looking out for me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased opportunities for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>developing personal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>relationships Raised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>future aspirations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced likelihood of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>crime and/or anti-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>social behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contributing citizen:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>to friends, family,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>community Increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>participation in</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>community life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>relationships increase</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>respite and/or support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>for carers Increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>opportunities for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>volunteering</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>94</td>
<td>21</td>
<td>12</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>28</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>260</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>39</td>
<td>8</td>
<td>6</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>26</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>20</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>29</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>22</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>260</td>
<td>47</td>
<td>30</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 4 breaks down these figures further by providing some brief examples of the type of 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 support 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 other organisations, the Connectors make substantial efforts to remedy these potential barriers. For example, when waiting times were an issue, Connectors would liaise with the provider and network with other (similar) agencies to ascertain if support could be offered 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).
Coordination within the service
Within the data, there were observable displays of commitment to the success of the programme from each delivery partner group (e.g. Community Connectors, GPs and voluntary sector organisations), albeit 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 service design discussions. This had some initial impact on the confidence of some Connectors about whether they fully understood what the scheme was offering, what their role within it was and, as a consequence, the right sort of promises that were being made to clients. (note 7)

Programme Director response
Note 7. The programme leadership were very aware of this and understood it to be connected to initial tensions between some delivery organisations management and the overall network support and leadership introduced through Devon Community Foundation. The leadership report that as relationships improved, and the networking and training and development programme has evolved, there are significant improvements in communication and engagement at all levels across the collaboration. However, this is an important learning point as the scheme expands and more delivery partners are introduced.
Summary findings ‘were the key processes underpinning the service implemented as planned?’

- GP referrals to social prescribing were initially low, but they picked up significantly in T2.
- In-house champions and continued reminding from the GP lead helped improve referral rates.
- To maintain, or further improve referrals these efforts need to be maintained until the awareness 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 service was for and what it offered. This had significant implications for the Community Connectors work and in some cases their wellbeing.
- Both the ICE board and Community Connectors were keen for Community Connectors to be based at participating surgeries and for them to be embedded into practice life.
- While Community Connectors did take part in practice meetings, they often could not work from within the surgery (hot desk/meet clients), due to a lack of space within the GP practices.
- Community Connectors felt that their specialised skill-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.

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 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.

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 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).

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 had 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 Wellbeing Exeter.

“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 opportunities was therefore seen as a positive approach to their problems and one that enabled clients to dictate their own pace. This point was highlighted in a follow up interview with the same person 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).

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.

The types of problems related to anxiety and loneliness that service users were experiencing
Throughout the clients’ baseline reports, social anxiety and loneliness were referenced 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. Exacerbating these feelings of loneliness is the fact that neither she, nor her husband, can drive. In addition, she was pre-occupied with the symptoms related to her husband’s deteriorating mental health, 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 Appendix 4, Vignette 2 for more details).

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 clients’ 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).

The benefits of this approach (based on Time 2 data)

- 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).
Summary finding ‘Has the Wellbeing Exeter Social Prescribing Service supported individuals to self-manage, reduce their isolation and improve their wellbeing?’

- 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.

Wellbeing Exeter’s impact on clients’ Health and Wellbeing

Comparison of T1 and T2 questionnaire data

Thirteen out of the 74 participants who completed a time 1 (T1) questionnaire filled out the same questionnaire at time 2 (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 and 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 participant 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 (PAM) 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 SP scheme.

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

- 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).

- 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).

- 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

- 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).

- 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).

- 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)

In two instances, clients provided follow-up data. One of these clients (Appendix 4) 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.
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 with key relationships and partnerships being identified and developed.

Wellbeing Exeter 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, yet one that is highly sought after. 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 with could be the reason behind why clients described the service as being different to other health care experiences and why they began to instigate change now, but hadn’t before.

Identified areas for improvement, highlighted by Community Connectors from some of the delivery organisations, have been concerned with the implementation of the pilot 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 issues (e.g. the triage system to compensate for the lack of knowledge from the referral forms), there were aspects to the service that have benefited from further re-design and/or further support. We have identified recommendations in relation to the main issues in the executive summary at the beginning of this report.

Three key concerns and associated recommendations:

Perceptions about level of complexity in some 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 provider has put in place processes, which support their Community Connectors to manage the more complex 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’s 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 be 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 Wellbeing Exeter was achieving positive outcomes for clients in spite of some early implementation teething problems.

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.
### Appendix 1

**Table 2:** Demographics of the T1 (questionnaire) WESPS cohort

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Marital Status</th>
<th>Employment</th>
<th>Accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-20</td>
<td>1</td>
<td>Male</td>
<td>White British/Irish</td>
<td>28</td>
<td>Owned property 94</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td></td>
<td></td>
<td>38.9</td>
<td>Supported housing 1</td>
</tr>
<tr>
<td>21-29</td>
<td>5</td>
<td>Female</td>
<td>Black British</td>
<td>13</td>
<td>Self-employed 0</td>
</tr>
<tr>
<td></td>
<td>70.8</td>
<td></td>
<td></td>
<td>18.1</td>
<td>Supported employment 1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td>Married</td>
<td>38</td>
<td>Hospital 3</td>
</tr>
<tr>
<td></td>
<td>2.8</td>
<td></td>
<td>Divorced</td>
<td>18.1</td>
<td>Rented (HA)* 20</td>
</tr>
<tr>
<td>30-39</td>
<td>11</td>
<td>Missing</td>
<td>White Other</td>
<td>5</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td></td>
<td>15.3</td>
<td></td>
<td></td>
<td>7.0</td>
<td>Rented (HA)† 5</td>
</tr>
<tr>
<td>40-49</td>
<td>7</td>
<td></td>
<td>Other Asian Background</td>
<td>1</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td></td>
<td>9.7</td>
<td></td>
<td></td>
<td>1.4</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td>50-59</td>
<td>8</td>
<td></td>
<td>Missing</td>
<td>2</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td></td>
<td>11.1</td>
<td></td>
<td></td>
<td>2.8</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td>60-69</td>
<td>10</td>
<td>Missing</td>
<td>Widowed</td>
<td>14</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td></td>
<td>13.9</td>
<td></td>
<td></td>
<td>19.4</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td>70-79</td>
<td>11</td>
<td></td>
<td>Separated*</td>
<td>2</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td></td>
<td>15.3</td>
<td></td>
<td></td>
<td>2.8</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td>80+</td>
<td>19</td>
<td></td>
<td>Widowed</td>
<td>0</td>
<td>Rented (private) 7</td>
</tr>
<tr>
<td></td>
<td>26.4</td>
<td></td>
<td></td>
<td>0.0</td>
<td>Rented (private) 7</td>
</tr>
</tbody>
</table>

* Separated but legally married.

### Appendix 2

**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 ESPS Exeter evaluation client cohort at T1

Figure 4: Aggregate patient activation scores for the Wellbeing Exeter ESPS evaluation T1 cohort
Figure 5: Comparison of T1 and T2 questionnaire scores for 13 follow up cases
**Appendix 3**

**Flow chart of Wellbeing Exeter’s evaluation client pathway**

1. **Referral process**
   - GP from a participating practice decides whether patient is eligible and would benefit from Wellbeing Exeter

2. **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.**

3. **Community Coordinator** makes appointment with participant for guided conversation

4. **Intervention**
   - If the patient declines the service, the GP is made aware and the case is closed
   - Coordinator 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.

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

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

7. **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.
## Appendix 4

### Vignette 1

<table>
<thead>
<tr>
<th>Vignette one</th>
</tr>
</thead>
</table>

**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; the 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 entitled 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 |
| WBE1006 | 16 | 5 | 11 | 62 |
| WBE1006b | 16 | 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 11 to 5 and social inclusion had also increased from 5 to a score of 11. Patient activation had surprisingly dropped, however.
Vignette 2

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.

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.

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.

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
rape, 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 these ladies are in the same boat as me and I was surprised really’.

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 schedule an appointment with her GP to discuss about counselling options.

<table>
<thead>
<tr>
<th>Recorded change in Measurements of loneliness, wellbeing, social inclusion and patient activation</th>
<th>WE</th>
<th>LGS</th>
<th>SI</th>
<th>PAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBE1002</td>
<td>17</td>
<td>15</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>WBE1002b</td>
<td>19</td>
<td>15</td>
<td>6</td>
<td>40</td>
</tr>
</tbody>
</table>

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.
Appendix 5

Quantitative work undertaken by the SWAHSN

- Linked primary and secondary care dataset (Royal Devon and Exeter NHS FT activity only) for the period Apr-14 through to Mar-17 for all patients that had a Social Prescribing READ code present on their primary care record
- Practices involved were
  - L83016 - St Thomas Medical Group
  - L83033 - Mount Pleasant Health Centre
  - L83036 - Topsham Surgery
  - L83040 - Pinhoe Surgery
  - L83079 - Ide Lane Surgery
  - L83655 - Wonford Green Surgery
  - Y00568 - Foxhayes Practice

Following charts provide an indication of the type of analysis.

1) Monthly referrals by practice
2) Cumulative referrals by month and practice
3) Demographic of patients referred to social prescribing
4) Numbers of GP events for a 12-month period for patients referred to social prescribing
5) Numbers of patients present on the GP register who had been referred to social prescribing during the period Apr-14 to Mar-17
6) Mean monthly GP events for patients present on the GP register who had been referred to social prescribing during the period Apr-14 to Mar-17
7) Mean monthly acute admissions (excluding regular day attendances) for patients present on the GP register who had been referred to social prescribing during the period Apr-14 to Mar-17
8) Mean monthly emergency admissions for patients present on the GP register who had been referred to social prescribing during the period Apr-14 to Mar-17

Further analysis is available from SW AHSN.
1) Monthly referrals by practice

- Vast majority of referrals from St Thomas
- Other practices started in Oct-16
2) Cumulative referrals by month and practice

- Vast majority of referrals from St Thomas
- Other practices Started in Oct-16
- Around 2/3rds or referral were from St Thomas
3) Demographic of patients referred to Social Prescribing

- Practice profiles show referrals were weighted toward older female patients.
- Wonford Green shows referrals weighted toward younger male patients, albeit on a very small sample.
4) Histograms of number of GP events for a 12-month period for patients referred to Social Prescribing

- Practice show a similar profile of number of GP events over a 12-month period
- Median 11 GP events
- Mean 15 GP events
5) Number of patients present on the GP register who had been referred to Social Prescribing during the period Apr-14 to Mar-17

- 23% of patients are not present (i.e. either join or leave) in practices for the entire period Apr-14 to Mar-17
- As such the cohort volume needs to be calculated and used to adjust the means event calculation
6) Mean monthly GP events for patients present on the GP register who had been referred to Social Prescribing during the period Apr-14 to Mar-17

- Different mean GP events for each practice's cohort
- Most around 1 GP event per patient per month
- Pinhoe and Foxhayes high around 2 per patient per month
- Topsham low at 0.2 GP events per patient per month
7) Mean monthly acute admissions (excluding regular day attendances) for patients present on the GP register who had been referred to Social Prescribing during the period Apr-14 to Mar 17

- Acute admissions lower at around 0.1 admissions per patient per month
- Topsham currently high at around 0.8 but practices other than At Thomas are very small samples
8) Mean monthly emergency admissions for patients present on the GP register who had been referred to Social Prescribing during the period Apr-14 to Mar-17

- Acute admissions lower at around 0.1 admissions per patient per month
- Topsham currently high at around 0.4 but practices other than St Thomas are very small samples